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State/Territory Name: **New Jersey**

State Plan Amendment (SPA) #: **15-0008**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

MAR 10 2016

Valerie Harr
State Medicaid Director
Department of Human Services
Division of Medical Assistance and Health Services
State of New Jersey
P.O. Box 712
Trenton, New Jersey 08625-0712

RE: TN 15-0008

Dear Valerie Harr:

We have received the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-0008. Effective October 1, 2015, this amendment proposes to update the reference to the International Classification of Diseases Version 10 (ICD-10) for inpatient services.

We conducted our review of the submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This letter is to inform you that New Jersey 15-0008 is approved effective October 1, 2015. We are enclosing the CMS-179 and the approved plan pages.

If you have any questions, please contact Charlene Holzbaur at (609) 882-4103 ext. 104.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 15-0008-MA

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Social Security Act 42 U.S.C. 1396r-4; 42 U.S.C. § 1320d-2(c); 45 CFR 160.103, 162.100; and 162.1002.

7. FEDERAL BUDGET IMPACT:
No fiscal impact is anticipated.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
- Attachment 4.19-A Page I-39, I-253, VI-2, + VI-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
- Attachment 4.19-A Page I-39, I-253, VI-2, + VI-3

10. SUBJECT OF AMENDMENT:
International Classification of Diseases, 10th Revision (ICD-10)

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTA
☒ OTHER, AS SPECIFIED:
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Elizabeth Connolly

14. TITLE: Acting Commissioner,
Department of Human Services

15. DATE SUBMITTED: December 31, 2015

16. RETURN TO:
Valerie J. Harr, Director
Division of Medical Assistance and Health Services
P.O. Box 712, Mail Code #1
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
MAR 10 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FALC

23. REMARKS:

The State requested 'pen + ink' changes to Boxes 8, 9, + 15

16. Payment for readmissions

(a) For New Jersey hospitals, where a patient is readmitted to the same hospital for the same or similar diagnosis within seven days, the second claim submitted for payment will be denied. The same or similar principal diagnosis is defined as principal diagnoses with the same range of characters in the same diagnosis group, in accordance with the International Classification of Diseases, 10th Edition, Clinical Modification published by Practice Management Information Corporation. For these readmissions, the two hospital inpatient stays shall be combined on the same claim form for reimbursement purposes.

(b) The denial and subsequent combination of claims specified in (a) above may be appealed by following the process specified in (b) 1 through 3 below:

1. For a hospital with non-delegated utilization review, the hospital shall request an appeal through its QIO. Hospitals that are delegated for utilization review shall request an appeal through the hospital's appeal process and obtain a final appeal decision from its Physician Advisor (PA).

2. An appeal that is approved by the QIO or PA shall be submitted to the Division's fiscal agent, along with a letter from the hospital's QIO or PA, on the QIO's or hospital's letterhead, with a determination that the two hospital stays should not be combined, including the reason supporting its determination, along with an original signature of the hospital's Physician Advisor or QIO Physician Advisor.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of New Jersey

BASIS OF PAYMENT – HOSPITALS REIMBURSED UNDER THE DIAGNOSIS RELATED GROUPS (DRG) SYSTEM – INPATIENT SERVICES

DMAHS will include the diagnosis in the assignment of the DRG for those diagnoses that are coded as "W" for the POA Indicator.

1 Unreported/ not used

- DMAHS will include the diagnosis in the assignment of the DRG for those diagnoses that are coded as "1" if those diagnoses are exempt from POA reporting under the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.
- For diagnosis codes described at Section 1886(d)(4)(D)(iv) of the Social Security Act, DMAHS will not utilize the diagnosis in the assignment of the DRG for those diagnoses that are coded as "1"
- DMAHS will deny a claim where the POA indicator is coded as "1" and the diagnosis code does not appear on the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.

The diagnosis codes matching CMS/ Medicare's final rule are included in 42 CFR Parts 434, 438, &447 [CMS-2400-F]. For the most current list of excluded diagnosis codes, DMAHS will utilize the most recent update to Section 5001(c) of the Deficit Reduction Act of 2005.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of New Jersey

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

Reimbursement for all inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider-Preventable Conditions are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

Beginning October 1, 2011, all institutions as defined in Attachment 4.11-A of the State Plan must use particular coding options which will be used by DMAHS to determine the existence of HCAC and OPPC. Methodology for HCAC and OPPC for acute care hospitals' inpatient claims is laid out in Section I of the Reimbursement for Hospital Services Attachment 4.19-A of the State Plan. For all non-acute, Hospital based Rehabilitation, and Hospital based Psychiatric institutions, the methodology and procedures for identifying HCAC and OPPC are as follows:

HCAC: all institutions must use one of the Medicare based POA Indicators for every diagnosis on the Uniform Billing (UB) claim form for all inpatient claims. Claims received without a POA Indicator will be denied. The POA indicator options and definitions are as follows:

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if the condition was present at the time of the inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/not used.

- DMAHS will deny a claim where the POA indicator is coded as "1" and the diagnosis code does not appear on the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of New Jersey

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

The diagnosis codes matching CMS/Medicare's final rule can be located at 42 CFR Parts 434, 438, & 447 [CMS-2400-F]. For the most current list of excluded diagnosis codes, DMAHS will utilize the most recent update to Section 5001(c) of the Deficit Reduction Act of 2005.

DMAHS will retroactively review all paid non-acute, hospital-based psychiatric and hospital-based rehabilitation claims with diagnoses coded with N, U, or 1 indicators.

- DMAHS will compare all diagnoses with N, U, or 1 indicators to the HCACs identified in 42 CFR 447.
- If an N or U diagnosis is included on the HCAC list, DMAHS will cut back portions of the per diem payment related to the diagnosis if such costs can be reasonably identified.
- For diagnoses with indicators of 1, DMAHS will also recover portions of the per diem payment related to the diagnosis if such diagnosis codes are also described at Section 1886(d)(4)(D)(iv) of the Social Security Act and such costs can be reasonably identified.
- DMAHS shall seek no recovery related to an indicator of 1 if such diagnoses are exempt from POA reporting under the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

Other Provider Preventable Conditions (OPPCs): No payment shall be made for inpatient services for OPPCs. OPPCs are the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

OPPCs will be identified by DMAHS using External Cause of Injury (ECI) Codes listed on the UB. Specifically, the three Medicare National Coverage Determinations as defined above will be reported to DMAHS using one of the following three ECI codes:

E876.5 – Performance inappropriate operation/invasive procedure (wrong operation/ correct patient)

E876.6 – Performance of operation/invasive procedure on patient not scheduled