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

Inpatient Reimbursement for General Acute Care Hospitals

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

Inpatient Reimbursement for General Acute Care Hospitals

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

Inpatient Reimbursement for General Acute Care Hospitals

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

REIMBURSEMENT FOR HOSPITAL SERVICES ATTACHMENT 4.19-A

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

Inpatient Reimbursement for General Acute Care Hospitals Based On DRG Weights And a Statewide Base Rate

1. Effective date

(a) Effective for inpatient services with discharge dates on or after August 3, 2009 and through June 30, 2011, general acute care hospitals will be paid in accordance with the New Jersey Medicaid Diagnosis Related Groups (DRG) Reimbursement System described in this subchapter.

(b) If the initial rate year is a partial year, all rate setting components used to calculate inpatient reimbursement delineated below will remain the same for the second rate year, except that the final rates will be increased by the economic factor applicable to that rate year as described in Section 6(c). For the third and subsequent rate years, the statewide base rate will not change until rebasing occurs as explained in Section 6(e), add-on amounts will be calculated annually in accordance with Section 7, and the DRG weights will not change until recalibration occurs as delineated in Section 3.

Section 2. Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Add-on amount" means an amount, calculated as a percentage of the Statewide base rate, which is added to the Statewide base rate, and which is determined on a hospital-specific basis using criteria established by the Division that recognizes the additional costs associated with treating a high volume of Medicaid and other low income patients.

"Delegated" means a Quality Improvement Organization's process by which hospitals are authorized to have in-house medical staff conduct utilization review. A delegated hospital would be subject to oversight by the QIO for compliance and continued authority.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, procedures, age, sex and discharge status.

"DRG weight" means the factor derived by measuring the relative weight of the Statewide average cost of a specific DRG to the Statewide average cost for all DRGs for the purpose of calculating the payment for that specific DRG.

"Final rate" means a hospital's inpatient rate per case, which includes the Statewide base rate and the hospital's add-on amounts, if applicable, for a given rate year.

"Non-delegated" means the Quality Improvement Organization retains responsibility to perform all of the utilization review activities in a hospital.

"Quality Improvement Organization" or "QIO" means an organization, which is composed of or governed by active physicians, and other professionals where appropriate, who are representative of the active physicians in the area in which the review mechanism operates and which is organized in a manner that insures professional competence in the review of services; formerly known as a peer review organization or a utilization review organization.

"Rebasing" means setting the Statewide base rate using a more current year's claim payment data.

"Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

"Statewide base rate" means a rate per case, which applies to all general acute care hospitals based on the total Medicaid inpatient fee-for-service payment amount estimated for a given rate year.

"Utilization review" means: 1. A review of medical necessity and/or appropriateness conducted during a patient's hospitalization, consisting of admission and continued stay certification; or 2. A medical record review performed after a patient has been discharged.

3. Calculation of the DRG weights

(a) A Statewide relative weight for each DRG was developed using the most recent available audited Medicare cost report data and Medicaid paid claims data for the same year. The cost data used excludes direct and indirect medical education costs. In the initial rate year, 2003 audited Medicare cost report data and 2003 Medicaid claim data were used to develop the DRG weights.

(b) Charges from the Medicaid claims were converted to cost by multiplying the routine cost center per diem costs from the Medicare cost reports times the number of routine days from the Medicaid claims using a hospital specific crosswalk between revenue codes and hospital cost centers, and multiplying the ancillary cost center cost-to-charge ratios from the Medicare cost reports times the ancillary charges from the Medicaid claims using a hospital specific crosswalk between revenue codes and hospital cost centers.

(c) The calculated routine and ancillary costs were aggregated by DRG and were used to develop total Statewide costs for each DRG.

(d) The formula used to calculate a DRG weight is as follows: the Statewide average cost per inlier case for a specific DRG divided by the Statewide average cost per inlier case for all DRGs.

(e) DRGs that did not have sufficient Medicaid claim volume to develop a statistically valid weight using the DRG weight setting methodology in (d) above had a weight derived from additional sources. For these DRGs, charity care claim volume was added to the Medicaid claim volume using the methodology in (d) above to establish a stable DRG weight. In cases where using this secondary data set did not yield a stable DRG weight, the normalized DRG weight from the corresponding New York AP DRG Grouper was used.

(f) An annual inflation factor was used to calculate inflation of routine and ancillary cost data. The inflation factor used was the excluded hospital market basket percentage increase, which is used by the Center for Medicare and Medicaid Services (CMS) for hospitals excluded from its Inpatient Prospective Payment System (IPPS), and is published in the Federal Register annually by CMS. The excluded hospital inflation factor has also been referred to as the economic factor recognized under the CMS Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248, (TEFRA) target limitations.

1. Routine costs were inflated from the midpoint of the provider's cost report period to the midpoint of the rate year.

2. Ancillary costs were inflated from the last date of services provided to the midpoint of the rate year.

(g) Recalibration is the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

(h) Recalibration of the DRG weights may be done to adopt the most current Grouper version available, or may be done to use more current claims and cost report data, or both. DRG weights will be recalibrated at the discretion of the Division with the approval of the Commissioner of the Department of Human Services.

(i) The DRG weight is multiplied by the hospital's final rate, as described in Section 6 in order to determine DRG reimbursement.

4. List of DRG weights

(a) Initial DRG weights used to calculate reimbursement amounts for inpatient hospital services under this subchapter are as follows:

DRG	Description	DRG WEIGHTS
001	Craniotomy Age >17 W CC	3.2119
002	Craniotomy Age >17 W/O CC	2.7378
006	Carpal Tunnel Release	0.6633
007	Periph & Cranial Nerve & Other Nerv Syst Proc W CC	2.3212
008	Periph & Cranial Nerve & Other Nerv Syst Proc W/O CC	1.4428
009	Spinal Disorders & Injuries	1.5828
010	Nervous System Neoplasms W CC	1.2829
011	Nervous System Neoplasms W/O CC	1.2829
012	Degenerative Nervous System Disorders	1.0623
013	Multiple Sclerosis & Cerebellar Ataxia	1.0800
014	Stroke With Infarct	1.4805
015	Nonspecific CVA & Precerebral Occlusion W/O Infarct	0.9027
016	Nonspecific Cerebrovascular Disorders W CC	1.8880
017	Nonspecific Cerebrovascular Disorders W/O CC	0.9870
018	Cranial & Peripheral Nerve Disorders W CC	1.2094
019	Cranial & Peripheral Nerve Disorders W/O CC	0.7888
020	Nervous System Infection Except Viral Meningitis	2.0891
021	Viral Meningitis	0.7901
022	Hypertensive Encephalopathy	1.0677
023	Nontraumatic Stupor & Coma	0.8133
024	Seizure & Headache Age >17 W CC	0.7922
025	Seizure & Headache Age >17 W/O CC	0.6931
034	Other Disorders Of Nervous System W CC	0.7574
035	Other Disorders Of Nervous System W/O CC	0.7574
036	Retinal Procedures	0.9625
037	Orbital Procedures	1.0429
038	Primary Iris Procedures	0.6729
039	Lens Procedures With Or Without Vitrectomy	0.8409
040	Extraocular Procedures Except Orbit Age >17	0.6970
041	Extraocular Procedures Except Orbit Age <18	0.6444
042	Intraocular Procedures Except Retina, Iris & Lens	0.8700
043	Hyphema	0.6383
044	Acute Major Eye Infections	0.4071
045	Neurological Eye Disorders	0.7626
046	Other Disorders Of The Eye Age >17 W CC	0.7899

047	Other Disorders Of The Eye Age >17 W/O CC	0.5328
048	Other Disorders Of The Eye Age <18	0.6672
049	Major Head & Neck Procedures Except For Malignancy	2.0797
050	Sialoadenectomy	0.9585
051	Salivary Gland Procedures Except Sialoadenectomy	0.8633
052	Cleft Lip & Palate Repair	0.6552
053	Sinus & Mastoid Procedures Age >17	0.7550
054	Sinus & Mastoid Procedures Age <18	0.9076
055	Miscellaneous Ear, Nose & Throat Procedures	0.9325
056	Rhinoplasty	0.7115
057	T&a Proc,exc Tonsillect &/or Adenoidect Only,age >17	0.5500
058	T&a Proc,exc Tonsillect &/or Adenoidect Only,age <18	0.6663
059	Tonsillectomy &/or Adenoidectomy Only, Age >17	0.4575
060	Tonsillectomy &/or Adenoidectomy Only, Age <18	0.5894
061	Myringotomy W Tube Insertion Age >17	0.7150
062	Myringotomy W Tube Insertion Age <18	0.5835
063	Other Ear, Nose, Mouth & Throat O.R. Procedures	1.0437
064	Ear, Nose, Mouth & Throat Malignancy	1.0927
065	Dysequilibrium	0.6643
066	Epistaxis	0.8008
067	Epiglottitis	0.8089
068	Otitis Media & Uri Age >17 W CC	0.5855
069	Otitis Media & Uri Age >17 W/O CC	0.4129
070	Otitis Media & Uri Age <18	0.3632
071	Laryngotracheitis	0.3000
072	Nasal Trauma & Deformity	0.5475
073	Other Ear, Nose, Mouth & Throat Diagnoses Age >17	0.7211
074	Other Ear, Nose, Mouth & Throat Diagnoses Age <18	0.5273
075	Major Chest Procedures	2.8947
076	Other Resp System O.R. Procedures W CC	2.5834
077	Other Resp System O.R. Procedures W/O CC	1.4352
078	Pulmonary Embolism	1.6340
079	Respiratory Infections & Inflammations Age >17 W CC	1.5052
080	Respiratory Infections & Inflammations Age >17 W/O CC	1.1537
082	Respiratory Neoplasms	1.5074
083	Major Chest Trauma W CC	1.0603
084	Major Chest Trauma W/O CC	0.6111
085	Pleural Effusion W CC	1.3240
086	Pleural Effusion W/O CC	0.8868
087	Pulmonary Edema & Respiratory Failure	1.2195
088	Chronic Obstructive Pulmonary Disease	0.9119
089	Simple Pneumonia & Pleurisy Age >17 W CC	0.9960
090	Simple Pneumonia & Pleurisy Age >17 W/O CC	0.7394
092	Interstitial Lung Disease W CC	0.9300
093	Interstitial Lung Disease W/O CC	0.7222
094	Pneumothorax W CC	1.1413
095	Pneumothorax W/O CC	0.6000

096	Bronchitis & Asthma Age >17 W CC	0.6430
097	Bronchitis & Asthma Age >17 W/O CC	0.5777
099	Respiratory Signs & Symptoms W CC	0.5831
100	Respiratory Signs & Symptoms W/O CC	0.5723
101	Other Respiratory System Diagnoses W CC	0.6374
102	Other Respiratory System Diagnoses W/O CC	0.5144
103	Heart Transplant	34.0923
104	Cardiac Valve Procedures W Cardiac Cath	6.0292
105	Cardiac Valve Procedures W/O Cardiac Cath	5.5656
106	Coronary Bypass W PTCA	7.1925
107	Coronary Bypass W Cardiac Cath W/O PTCA	5.2123
108	Other Cardiothoracic Proc W/O PDX Cong Anomaly	3.4442
109	Coronary Bypass W/O PTCA Or Cardiac Cath	4.0944
110	Major Cardiovascular Procedures W CC	3.1909
111	Major Cardiovascular Procedures W/O CC	2.2527
112	Percutaneous Cardiovasc Proc W/O AMI, HFI Or Shock	1.5467
113	Amputat For Circ System Disord Except Upper Limb & Toe	3.0628
114	Upper Limb & Toe Amputation For Circ System Disorders	1.5233
115	Prm Card Pacem Impl W AMI,hrt Fail Or Shk,or Aicd Lead Or Gn	4.7185
116	Other Permanent Cardiac Pacemaker Implant	2.8361
117	Cardiac Pacemaker Revision Except Device Replacement	2.1148
118	Cardiac Pacemaker Device Replacement	2.0903
119	Vein Ligation & Stripping	0.8080
120	Other Circulatory System O.R. Procedures	2.2466
121	Circulatory Disorders W AMI & Major Comp, Discharged Alive	2.3300
122	Circulatory Disorders W AMI W/O Major Comp, Discharged Alive	1.2617
123	Circulatory Disorders W AMI, Expired	3.2313
124	Circ Disorders Except AMI, W Card Cath & Complex Diag	1.3771
125	Circ Disorders Except AMI, W Card Cath W/O Complex Diag	1.0818
126	Acute & Subacute Endocarditis	3.1835
127	Heart Failure & Shock	0.9707
128	Deep Vein Thrombophlebitis	1.0677
129	Cardiac Arrest, Unexplained	1.0190
130	Peripheral Vascular Disorders W CC	1.0381
131	Peripheral Vascular Disorders W/O CC	0.8431
132	Atherosclerosis W CC	0.8361
133	Atherosclerosis W/O CC	0.6472
134	Hypertension	0.6183
135	Cardiac Congenital & Valvular Disorders Age >17 W CC	1.4104
136	Cardiac Congenital & Valvular Disorders Age >17 W/O CC	0.7695
137	Cardiac Congenital & Valvular Disorders Age <18	1.3098
138	Cardiac Arrhythmia & Conduction Disorders W CC	0.9526
139	Cardiac Arrhythmia & Conduction Disorders W/O CC	0.5514
140	Angina Pectoris	0.7001
141	Syncope & Collapse W CC	0.8193
142	Syncope & Collapse W/O CC	0.6086
143	Chest Pain	0.5705

144	Other Circulatory System Diagnoses W CC	1.0176
145	Other Circulatory System Diagnoses W/O CC	0.5703
146	Rectal Resection W CC	2.8110
147	Rectal Resection W/O CC	1.8643
148	Major Small & Large Bowel Procedures W CC	2.9382
149	Major Small & Large Bowel Procedures W/O CC	1.7707
150	Peritoneal Adhesiolysis W CC	2.1968
151	Peritoneal Adhesiolysis W/O CC	1.0354
152	Minor Small & Large Bowel Procedures W CC	2.1639
153	Minor Small & Large Bowel Procedures W/O CC	0.9690
154	Stomach, Esophageal & Duodenal Procedures Age >17 W CC	2.9951
155	Stomach,esophageal & Duodenal Procedures Age >17 W/O CC	2.0702
156	Stomach, Esophageal & Duodenal Procedures Age <18	1.4695
157	Anal & Stomal Procedures W CC	1.3642
158	Anal & Stomal Procedures W/O CC	0.6035
159	Hernia Procs Except Inguinal & Femoral Age >17 W CC	1.0172
160	Hernia Procs Except Inguinal & Femoral Age >17 W/O CC	0.8174
161	Inguinal & Femoral Hernia Procedures Age >17 W CC	1.0643
162	Inguinal & Femoral Hernia Procedures Age >17 W/O CC	0.6314
163	Hernia Procedures Age <18	0.6330
164	Appendectomy W Complicated Principal Diag W CC	1.7225
165	Appendectomy W Complicated Principal Diag W/O CC	1.0711
166	Appendectomy W/O Complicated Principal Diag W CC	0.8884
167	Appendectomy W/O Complicated Principal Diag W/O CC	0.7135
168	Mouth Procedures W CC	1.2265
169	Mouth Procedures W/O CC	0.8354
170	Other Digestive System O.R. Procedures W CC	2.0783
171	Other Digestive System O.R. Procedures W/O CC	1.2233
172	Digestive Malignancy W CC	1.3410
173	Digestive Malignancy W/O CC	1.1295
174	G.I. Hemorrhage W CC	1.1336
175	G.I. Hemorrhage W/O CC	0.8787
176	Complicated Peptic Ulcer	0.8519
177	Uncomplicated Peptic Ulcer W CC	0.8292
178	Uncomplicated Peptic Ulcer W/O CC	0.5684
179	Inflammatory Bowel Disease	0.9008
180	G.I. Obstruction W CC	0.8663
181	G.I. Obstruction W/O CC	0.6297
182	Esophagitis,gastroent & Misc Digest Disord Age>17 W CC	0.9212
183	Esophagitis,gastroent & Misc Digest Disord Age>17 W?o CC	0.6924
185	Dental & Oral Dis Exc Extract & Restorations, Age >17	0.5204
186	Dental & Oral Dis Exc Extract & Restorations, Age <18	0.4979
187	Dental Extractions & Restorations	0.7625
188	Other Digestive System Diagnoses Age >17 W CC	0.7488
189	Other Digestive System Diagnoses Age >17 W/O CC	0.5612
191	Pancreas, Liver & Shunt Procedures W CC	4.4938
192	Pancreas, Liver & Shunt Procedures W/O CC	2.2530

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193	Bil Tract Proc W CC Exc Only Tot Cholecyst Or W/O CDE	3.3680
194	Bil Tract Proc W/O CC Exc Only Tot Cholecystect W/O CDE	2.1308
195	Total Cholecystectomy W C.D.E. W CC	2.3683
196	Total Cholecystectomy W C.D.E. W/O CC	2.0276
197	Total Cholecystectomy W/O C.D.E. W CC	1.9304
198	Total Cholecystectomy W/O C.D.E. W/O CC	1.5425
199	Hepatobiliary Diagnostic Procedure For Malignancy	2.3890
200	Hepatobiliary Diagnostic Procedure For Non-malignancy	2.3407
201	Other Hepatobiliary Or Pancreas O.R. Procedures	3.0256
202	Cirrhosis & Alcoholic Hepatitis	0.9693
203	Malignancy Of Hepatobiliary System Or Pancreas	1.4648
204	Disorders Of Pancreas Except Malignancy	0.8555
205	Disorders Of Liver Except Malig,cirr,alc Hepa W CC	0.9435
206	Disorders Of Liver Except Malig,cirr,alc Hepa W/O CC	0.7797
207	Disorders Of The Biliary Tract W CC	1.2594
208	Disorders Of The Biliary Tract W/O CC	0.6050
209	Major Joint&limb Reattach Proc Of Low Ext, Exc Hip,exc Comp	2.0846
210	Hip & Femur Procedures Except Major Joint Age >17 W CC	2.0344
211	Hip & Femur Procedures Except Major Joint Age >17 W/O CC	2.0344
212	Hip & Femur Procedures Except Major Joint Age <18	1.2522
213	Amputat For Musculoskelet System & Conn Tissue Disorders	1.4896
216	Biopsies Of Musculoskeletal System & Connective Tissue	2.6531
217	Wnd Debrid&skn Grft Exc Open Wnd,ms & Conn Tis, Exc Hand	3.0053
218	Low Extrem & Humer Proc Exc Hip,foot,femur Age>17 W CC	1.9093
219	Low Extrem & Humer Proc Exc Hip,foot,femur Age>17 W/O CC	1.2956
220	Lower Extrem & Humer Proc Except Hip,foot,femur Age <18	0.9052
221	Knee Procedures W CC	1.7213
222	Knee Procedures W/O CC	0.9898
223	Maj Should/elbow Proc, Or Oth Upper Extremity Proc W CC	1.5593
224	Should,elbow Or Forearm Proc,exc Maj Joint Proc, W/O CC	0.8492
225	Foot Procedures	1.4314
226	Soft Tissue Procedures W CC	1.7577
227	Soft Tissue Procedures W/O CC	1.0753
228	Major Thumb Or Joint Proc,or Oth Hand Or Wrist Proc W CC	0.9984
229	Hand Or Wrist Proc, Except Major Joint Proc, W/O CC	0.7499
230	Local Excis & Removal Of Int Fix Devices Of Hip & Femur	1.7811
232	Arthroscopy	0.8089
233	Other Musculoskelet Sys & Conn Tiss O.R. Proc W CC	2.7434
234	Other Musculoskelet Sys & Conn Tiss O.R. Proc W/O CC	1.5108
235	Fractures Of Femur	1.0601
236	Fractures Of Hip & Pelvis	0.9657
237	Sprains, Strains, & Dislocations Of Hip, Pelvis & Thigh	0.8497
238	Osteomyelitis	1.4275
239	Pathological Fx & Musculoskelet & Conn Tiss Malignancy	1.5322
240	Connective Tissue Disorders W CC	1.2740
241	Connective Tissue Disorders W/O CC	0.7303
242	Septic Arthritis	0.9319

243	Medical Back Problems	0.9272
244	Bone Diseases & Specific Arthropathies W CC	0.8025
245	Bone Diseases & Specific Arthropathies W/O CC	0.5620
246	Non-specific Arthropathies	0.6331
247	Signs & Symptoms Of Musculoskeletal System & Conn Tissue	0.5222
248	Tendonitis, Myositis & Bursitis	0.6866
249	Malfunction, Reaction Or Comp Of Orthopedic Dev Or Proc	0.8072
250	Fx,sprn,strn & Disl Of Forearm,hand,foot Age>17 W CC	0.8497
251	Fx,sprn,strn & Disl Of Forearm,hand,foot Age>17 W/O CC	0.4161
252	Fx, Sprn, Strn & Disl Of Forearm, Hand, Foot Age <18	0.4382
253	Fx,sprn,strn & Disl Uparm,lowleg Ex Foot Age>17 W CC	0.8595
254	Fx,sprn,strn & Disl Uparm,lowleg Ex Foot Age>17 W/O CC	0.5851
255	Fx, Sprn, Strn & Disl Of Uparm,lowleg Ex Foot Age <18	0.5207
256	Other Musculoskeletal System & Connective Tissue Diag	0.6853
257	Total Mastectomy For Malignancy W CC	0.8564
258	Total Mastectomy For Malignancy W/O CC	0.7984
259	Subtotal Mastectomy For Malignancy W CC	0.9239
260	Subtotal Mastectomy For Malignancy W/O CC	0.7501
261	Breast Proc For Non-malig Except Biopsy & Local Excision	0.9888
262	Breast Biopsy & Local Excision For Non-malignancy	0.8243
263	Skin Graft &/or Debrid For Skn Ulcer, Cellulitis W CC	2.1984
264	Skin Graft &/or Debrid For Skn Ulcer, Cellulitis W/O CC	1.3353
265	Skin Graft &/or Debrid Exc For Skin Ulcer, Cellul W CC	2.4912
266	Skin Graft &/or Debrid Exc For Skn Ulcer, Cellul W/O CC	1.3766
267	Perianal & Pilonidal Procedures	0.5370
268	Skin, Subcutaneous Tissue & Breast Plastic Procedures	0.9150
269	Other Skin, Subcut Tiss & Breast Procedure W CC	1.2870
270	Other Skin, Subcut Tiss & Breast Procedure W/O CC	0.8575
271	Skin Ulcers	0.9387
272	Major Skin Disorders W CC	0.8414
273	Major Skin Disorders W/O CC	0.5086
274	Malignant Breast Disorders W CC	2.3640
275	Malignant Breast Disorders W/O CC	1.1423
276	Non-maligant Breast Disorders	0.5689
277	Cellulitis Age >17 W CC	0.8916
278	Cellulitis Age >17 W/O CC	0.7008
279	Cellulitis Age <18	0.4676
280	Trauma To The Skin, Subcut Tiss & Breast Age >17 W CC	0.6124
281	Trauma To The Skin, Subcut Tiss & Breast Age >17 W/O CC	0.4417
282	Trauma To The Skin, Subcut Tiss & Breast Age <18	0.2834
283	Minor Skin Disorders W CC	0.6276
284	Minor Skin Disorders W/O CC	0.4573
285	Amputat Of Low Limb For Endocrine,nutrit& Metabol Disord	2.3424
286	Adrenal & Pituitary Procedures	2.6281
287	Skin Gft & Wound Debrid For Endoc,nutrit & Metab Disord	1.9038
288	O.R. Procedures For Obesity	1.8395
289	Parathyroid Procedures	0.7632

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290	Thyroid Procedures	0.7371
291	Thyroglossal Procedures	0.6944
292	Other Endocrine, Nutrit & Metab O.R. Proc W CC	3.8309
293	Other Endocrine, Nutrit & Metab O.R. Proc W/O CC	1.4722
294	Diabetes Age >35	0.9008
295	Diabetes Age <36	0.6764
296	Nutritional & Misc Metabolic Disorders Age >17 W CC	0.7876
297	Nutritional & Misc Metabolic Disorders Age >17 W/O CC	0.7871
298	Nutritional & Misc Metabolic Disorders Age <18	0.3656
299	Inborn Errors Of Metabolism	0.5845
300	Endocrine Disorders W CC	0.9237
301	Endocrine Disorders W/O CC	0.6695
302	Kidney Transplant	3.8473
303	Kidney, Ureter & Major Bladder Proc For Neoplasm	2.1690
304	Kidney, Ureter & Major Blad Proc For Non-neoplasm W CC	1.5144
305	Kidney, Ureter & Major Blad Proc For Non-neoplasm W/O CC	1.0775
306	Prostatectomy W CC	2.2061
307	Prostatectomy W/O CC	1.2270
308	Minor Bladder Procedures W CC	2.2232
309	Minor Bladder Procedures W/O CC	1.4349
310	Transurethral Procedures W CC	0.9179
311	Transurethral Procedures W/O CC	0.6970
312	Urethral Procedures, Age >17 W CC	1.4077
313	Urethral Procedures, Age >17 W/O CC	0.7106
314	Urethral Procedures, Age <18	1.0129
315	Other Kidney & Urinary Tract O.R. Procedures	2.2568
316	Renal Failure	1.2065
317	Admit For Renal Dialysis	0.3869
318	Kidney & Urinary Tract Neoplasms W CC	1.7384
319	Kidney & Urinary Tract Neoplasms W/O CC	0.7141
320	Kidney & Urinary Tract Infections Age >17 W CC	0.9014
321	Kidney & Urinary Tract Infections Age >17 W/O CC	0.6656
322	Kidney & Urinary Tract Infections Age <18	0.4835
323	Urinary Stones W CC, &/or Esw Lithotripsy	0.7778
324	Urinary Stones W/O CC	0.4667
325	Kidney & Urinary Tract Signs & Symptoms Age >17 W CC	0.9620
326	Kidney & Urinary Tract Signs & Symptoms Age >17 W/O CC	0.5335
327	Kidney & Urinary Tract Signs & Symptoms Age <18	0.4658
328	Urethral Stricture Age >17 W CC	1.0243
329	Urethral Stricture Age >17 W/O CC	0.6299
330	Urethral Stricture Age <18	0.8271
331	Other Kidney & Urinary Tract Diagnoses Age >17 W CC	1.3084
332	Other Kidney & Urinary Tract Diagnoses Age >17 W/O CC	0.6631
333	Other Kidney & Urinary Tract Diagnoses Age <18	0.8585
334	Major Male Pelvic Procedures W CC	1.5420
335	Major Male Pelvic Procedures W/O CC	1.5420
336	Transurethral Prostatectomy W CC	1.5327

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337	Transurethral Prostatectomy W/O CC	0.6790
338	Testes Procedures, For Malignancy	0.9888
339	Testes Procedures, Non-malignancy Age >17	0.6935
340	Testes Procedures, Non-malignancy Age <18	0.6146
341	Penis Procedures	1.6573
342	Circumcision Age >17	0.6326
343	Circumcision Age <18	0.3295
344	Other Male Reproductive Sys O.R. Procs For Malignancy	1.5836
345	Other Male Reproductive Sys O.R. Procs Except For Malig	1.0892
346	Malignancy, Male Reproductive System, W CC	1.8396
347	Malignancy, Male Reproductive System, W/O CC	0.9936
348	Benign Prostatic Hypertrophy W CC	0.9761
349	Benign Prostatic Hypertrophy W/O CC	0.6583
350	Inflammation Of The Male Reproductive System	0.6482
351	Male Sterilization	0.3150
352	Other Male Reproductive System Diagnoses	0.4422
353	Pelvic Evisceration,rad Hysterectomy & Rad Vulvectomy	1.4018
354	Uterine,adnexa Proc For Non-ovarian/Adnexal Malig W CC	1.5764
355	Uterine,adnexa Proc For Non-ovarian/Adnexal Malig W/O CC	1.0415
356	Female Reproductive System Reconstructive Procedures	0.7491
357	Uterine & Adnexa Proc For Ovarian Or Adnexal Malignancy	1.9768
358	Uterine & Adnexa Proc For Ca In Situ & Nonmalig W CC	1.2104
359	Uterine & Adnexa Proc For Ca In Situ & Nonmalig W/O CC	0.7887
360	Vagina, Cervix & Vulva Procedures	0.7142
361	Laparoscopy & Incisional Tubal Interruption	0.7562
362	Endoscopic Tubal Interruption	0.4751
363	D&C, Conization & Radio-implant, For Malignancy	1.0020
364	D&C, Conization Except For Malignancy	0.7612
365	Other Female Reproductive System O.R. Procedures	1.4257
366	Malignancy, Female Reproductive System, W CC	1.9507
367	Malignancy, Female Reproductive System, W/O CC	0.9892
368	Infections, Female Reproductive System	0.5480
369	Menstrual & Other Female Reproductive System Disorders	0.6368
370	Cesarean Section W CC	0.9584
371	Cesarean Section W/O CC	0.8416
372	Vaginal Delivery W Complicating Diagnoses	0.6571
373	Vaginal Delivery W/O Complicating Diagnoses	0.5468
374	Vaginal Delivery W Sterilization &/or D&C	0.8190
375	Vaginal Delivery W/O.R. Proc Except Steril &/or D&C	0.6132
376	Postpartum & Post Abortion Diagnoses W/O O.R. Procedure	0.5045
377	Postpartum & Post Abortion Diagnoses W/O.R. Procedure	1.0646
378	Ectopic Pregnancy	0.7727
379	Threatened Abortion	0.5187
380	Abortion W/O D&C	0.4373
381	Abortion W D&C, Aspiration Curettage Or Hysterotomy	0.4776
382	False Labor	0.3145
392	Splenectomy Age >17	2.4662

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393	Splenectomy Age <18	1.6437
394	Other O.R. Procs Of The Blood And Blood Forming Organs	1.3978
395	Red Blood Cell Disorders Age >17	0.7442
397	Other Coagulation Disorders	0.8622
398	Reticuloendothelial & Immunity Disorders W CC	1.3019
399	Reticuloendothelial & Immunity Disorders W/O CC	0.6136
401	Lymphoma & Non-acute Leukemia W/Other O.R. Proc W CC	2.9221
402	Lymphoma & Non-acute Leukemia W/Other O.R. Proc W/O CC	1.8017
403	Lymphoma & Non-acute Leukemia W CC	1.4177
404	Lymphoma & Non-acute Leukemia W/O CC	1.0859
406	Myelopro Disord Or Poor Diff Neopl W Maj O.R. Proc W CC	3.3865
407	Myelopro Disord Or Poor Diff Neop W Maj O.R. Proc W/O CC	0.8782
408	Myeloprolif Disord Or Poor Diff Neopl W/Other O.R. Proc	1.8385
409	Radiotherapy	1.1226
410	Chemotherapy	1.0711
413	Other Myeloprolif Dis Or Poorly Diff Neopl Diag W CC	2.4597
414	Other Myeloprolif Dis Or Poorly Diff Neopl Diag W/O CC	1.6249
415	O.R. Procedure For Infectious & Parasitic Diseases	2.5884
416	Septicemia Age >17	1.3320
417	Septicemia Age <18	0.6108
418	Postoperative & Post-traumatic Infections	0.9950
419	Fever Of Unknown Origin Age >17 W CC	0.7135
420	Fever Of Unknown Origin Age >17 W/O CC	0.5550
421	Viral Illness Age >17	0.7404
422	Viral Illness & Fever Of Unknown Origin Age <18	0.3746
423	Other Infectious & Parasitic Diseases Diagnoses	0.8433
424	O.R. Procedure W Principal Diagnoses Of Mental Illness	2.5623
425	Acute Adjustment Reaction & Psychosocial Dysfunction	0.8098
426	Depressive Neuroses	0.7229
427	Neuroses Except Depressive	0.8305
428	Disorders Of Personality & Impulse Control	1.0420
429	Organic Disturbances & Mental Retardation	1.2436
430	Psychoses	1.0663
431	Childhood Mental Disorders	0.9722
432	Other Mental Disorder Diagnoses	1.0511
439	Skin Grafts For Injuries	1.9455
440	Wound Debridements For Injuries Except Open Wound	2.1161
441	Hand Procedures For Injuries	0.8758
442	Other O.R. Procedures For Injuries W CC	2.2560
443	Other O.R. Procedures For Injuries W/O CC	1.0332
444	Injuries To Unspec Or Multiple Sites, Age >17 W CC	0.7143
445	Injuries To Unspec Or Multiple Sites, Age >17 W/O CC	0.4827
446	Injuries To Unspecified Or Multiple Sites, Age <18	0.4544
447	Allergic Reactions Age >17	0.4952
448	Allergic Reactions Age <18	0.3939
449	Poisoning & Toxic Effects Of Drugs Age >17 W CC	0.7643
450	Poisoning & Toxic Effects Of Drugs Age >17 W/O CC	0.7643

451	Poisoning & Toxic Effects Of Drugs Age <18	0.4901
452	Complications Of Treatment W CC	0.9207
453	Complications Of Treatment W/O CC	0.5184
454	Other Injury, Poisoning & Toxic Effect Diagnosis W CC	0.9406
455	Other Injury, Poisoning & Toxic Effect Diagnosis W/O CC	0.5334
461	O.R. Proc W Diagnoses Of Other Contact W Health Services	0.6711
462	Rehabilitation	1.4459
463	Signs & Symptoms W CC	0.8114
464	Signs & Symptoms W/O CC	0.5766
465	Aftercare W History Of Malignancy As 2nd Diagnosis	0.6054
466	Aftercare W/O History Of Malignancy As 2nd Diagnosis	0.4308
467	Other Factors Influencing Health Status	0.6701
468	Exten O.R. Procedure Unrelated To Principal Diagnosis	4.9321
469	Principal Diagnosis Invalid As Discharge Diagnosis	0.0000
470	Ungroupable	0.0000
471	Bilateral Or Multiple Major Joint Procs Of Lower Extrem	6.7981
476	Prostatic O.R. Proc Unrelated To Principal Diagnosis	4.3823
477	Non-extensive O.R. Proc Unrelated To Principal Diagnosis	2.6374
478	Other Vascular Procedures W CC	2.0642
479	Other Vascular Procedures W/O CC	1.2054
480	Liver Transplant	10.1100
482	Tracheostomy With Mouth, Larynx Or Pharynx Disorder	3.9199
491	Major Joint & Limb Reattachment Proc Of Upper Extremity	2.4535
493	Laparoscopic Cholecystectomy W/O CDE W CC	1.7116
494	Laparoscopic Cholecystectomy W/O CDE W/O CC	1.0959
530	Craniotomy W Major CC	6.9247
531	Nervous System Procedures Except Craniotomy W Major CC	5.7935
532	Tia, Precerbral Occlusions, Seiz & Headache W MCC	1.3848
533	Oth Nerv Sys Disord Exc Tia, Seiz & Headache W Major CC	2.8289
534	Eye Procedures W Major CC	1.9236
535	Eye Disorders W Major CC	1.9442
536	Ent & Mouth Procs Except Major Head & Neck W Major CC	2.5763
538	Major Chest Procedures W Major CC	4.4477
539	Respiratory Procedures Except Major Chest W Major CC	4.4528
540	Respiratory Infections & Inflammations W Major CC	2.1162
541	Resp Disord Exc Infections,bronchitis,asthma W Major CC	1.6661
543	Circ Disord Exc AMI,endocarditis,chf & Arrhyt W Major CC	1.6273
544	Chf & Cardiac Arrhythmia W Major CC	2.0902
545	Cardiac Valve Or Cardiac Defib Implant Procedure W Major CC	11.4594
546	Coronary Bypass W Major CC	8.7119
547	Other Cardiothoracic Procedure W Major CC	12.0657
548	Cardiac Pacemaker Implant Or Revision W Major CC	6.7797
549	Major Cardiovascular Procedures W Major CC	6.4087
550	Other Vascular Procedures W Major CC	3.6761
551	Esophagitis,gastroent & Uncomplicated Ulcers W Major CC	1.2303
552	Digest Sys Disord Exc Esop,gast & Uncomp Ulcers W Maj CC	1.7468
553	Digest Sys Procs Exc Hern,m Stom Or Bwl Procs W Major CC	3.6484

554	Hernia Procedures W Major CC	2.7706
555	Pancrea,liv & Oth Bil Trt Proc Exc Liv Trplnt W Major CC	5.3172
556	Cholecystectomy & Other Hepatobiliary Procs W Major CC	2.3765
557	Hepatobiliary & Pancreas Disorders W Major CC	2.2492
558	Maj Musculoskel Procs Exc Bilat Or Mult Maj Jnt W Maj CC	4.6850
559	Non-major Musculoskeletal Procedures W Major CC	3.7296
560	Musculo Disord Exc Osteo,sep Arth & Conn Tiss W Major CC	1.2230
561	Osteomyel,septic Arthritis & Conn Tiss Disord W Major CC	2.1390
562	Major Skin & Breast Disorders W Major CC	3.2216
563	Other Skin Disorders W Major CC	1.0980
564	Skin & Breast Procedures W Major CC	2.7628
565	Endoc, Nutrit & Metab Proc Exc Low Limb W Amput W Maj CC	5.2531
566	Endoc, Nutrit & Metab Disor Exc Eat Disord Or Cf W Maj CC	1.7345
567	Kid & Urin Tract Procs Exc Kidney Transplant W Major CC	4.4894
568	Renal Failure W Major CC	2.8869
569	Kid & Urin Tract Disord Exc Renal Failure W Major CC	1.3308
570	Male Reproductive Disorders W Major CC	1.8396
571	Male Reproductive Procedures W Major CC	3.3913
572	Female Reproductive Disorders W Major CC	2.1188
573	Non-radical Female Reproductive Procedures W Major CC	3.0549
574	Blood,blood Form Organs & Immunolog Disord W Major CC	1.7149
575	Blood,blood Form Organs & Immunolog Procs W Major CC	5.8966
576	Acute Leukemia W Major CC	8.9417
577	Myeloprol Disord & Poorly Differ Neoplasms W Major CC	2.9596
578	Lymphoma & Non-acute Leukemia W Major CC	3.6695
579	Procs For Lymph,leukemia,myeloprolif Disord W Major CC	8.7256
580	Syst Infect & Parasitic Disord Exc Septicemia W Major CC	1.9618
581	Systemic Infect & Parasitic Disord Procedures W Major CC	5.1776
582	Injuries Except Multiple Trauma W Major CC	1.7100
583	Procs For Injuries Except Multiple Trauma W Major CC	3.9692
584	Septicemia W Major CC	2.4470
585	Maj Stomach,esop,duod,small & Lrg Bowel Proc W Major CC	6.3726
586	Ent & Mouth Disorders, Age > 17 With Major CC	1.9914
587	Ent & Mouth Disorders, Age < 18 With Major CC	1.1098
588	Bronchitis And Asthma Age> 17 W Major CC	1.0037
589	Bronchitis And Asthma Age< 17 W Major CC	0.6935
602	Neonate, Birthwt <750g, Discharged Alive	21.9229
603	Neonate, Birthwt <750g,died	9.9688
604	Neonate, Birthwt 750-999g, Discharged Alive	16.7650
605	Neonate, Birthwt 750-999, Died	15.6277
606	Neonate, Bwt 1000-1499g, W Sig ORProc, Disch Alive	27.6407
607	Neonate, Bwt 1000-1499g, W/O Signif Or Proc, Disch Alive	7.0681
608	Neonate, Birthwt 1000-1499g, Died	9.4511
609	Neonate, Bwt 1500-1999g, W Sig ORProc, W Mult Maj Prob	14.7394
610	Neonate, Bwt 1500-1999g, W Sig ORProc, W/O Mul Maj Prob	3.3572
611	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W Mul Maj Prob	5.1749
612	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W Major Prob	3.8296

613	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W Minor Prob	3.1562
614	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W/Other Prob	1.5722
615	Neonate, Bwt 2000-2499g, W Sig ORProc, W Mul Major Prob	14.1787
616	Neonate, Bwt 2000-2499g, W Sig ORProc, W/O Mul Maj Prob	3.2295
617	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W Mul Maj Prob	2.7421
618	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W Major Prob	1.6039
619	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W Minor Prob	0.9931
620	Neonate,bwt 2000-2499g,w/o Sig ORProc, W Norm Newb Diag	0.3201
621	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W/Other Prob	0.8898
622	Neonate, Bwt >2499g, W Sig ORProc, W Mult Major Prob	8.9415
623	Neonate, Bwt >2499g, W Sig ORProc, W/O Mult Major Prob	2.1306
624	Neonate, Birthwt >2499g, W Minor Abdom Proc	1.1216
626	Neonate, Bwt >2499g, W/O Sig ORProc, W Mult Major Prob	1.7723
627	Neonate, Bwt >2499g, W/O Signif Or Proc, W Major Prob	0.8778
628	Neonate, Bwt >2499g, W/O Signif Or Proc, W Minor Prob	0.3906
629	Neonate, Bwt >2499g, W/O Sign Or Proc, W Norm Newb Diag	0.2486
630	Neonate, Bwt >2499g, W/O Sig ORProc, W/Other Prob	0.4692
631	BPD And Other Chron Resp Diseas Arising Perinatal Period	1.3731
633	Mult,other And Unspec Congenital Anomalies W CC	2.2852
634	Mult,other And Unspec Congenital Anomalies W/O CC	2.2852
635	Neonatal Aftercare For Weight Gain	1.3924
636	Infant Aftercare For Weight Gain, Age>28 Days & <1 Year	1.9727
637	Neonate, Died W/in One Day Of Birth, Born Here	0.2682
638	Neonate, Died W/in One Day Of Birth, Not Born Here	0.9414
639	Neonate, Transferred <5 Days Of Birth, Born Here	0.2531
640	Neonate, Transferred <5 Days Of Birth, Not Born Here	0.2822
641	Extracorporeal Membrane Oxygenation, Bwt >2499 Grams	13.4550
650	High Risk Cesarean Section W CC	1.3912
651	High Risk Cesarean Section W/O CC	0.9996
652	High Risk Vaginal Delivery W Sterilization And/or D7C	1.2167
700	Tracheostomy For HIV Infection	19.0652
701	HIV W/O.R. Procedure & Ventilation Or Nutrition Support	10.4605
702	HIV W/O.R. Procedure W Multiple Major Related Infections	8.4742
703	HIV W/O.R. Procedure W Major Related Diagnosis	3.8141
704	HIV W/O.R. Procedure W/O Major Related Diagnosis	3.2017
705	HIV W Multiple Major Related Infections W TB	6.9240
706	HIV W Multiple Major Related Infections W/O TB	3.4419
707	HIV W Ventilator Or Nutritional Support	3.7718
708	HIV W Major Related Diagnosis, Discharge AMA	1.2738
709	HIV W Major Related Diag W Mult Major Or Sign Diag W TB	4.1577
710	HIV W Major Related Diag W Mult Maj OR Sign Diag W/O TB	2.0843
711	HIV W Major Relat Diag W/O Mult Maj OR Signif Diag W TB	2.7215
712	HIV W Maj Relat Diag W/O Mult Maj OR Signif Diag W/O TB	1.5821
713	HIV W Significant Related Diagnosis, Discharged AMA	0.8933
714	HIV W Significant Related Diagnosis	1.2861
715	HIV W/Other Related Diagnoses	0.6051
716	HIV W/O Other Related Diagnoses	0.5892

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730	Craniotomy For Multiple Significant Trauma	7.4960
731	Spine, Hip, Femur Or Limb Proc For Mult Signif Trauma	6.1765
732	Other O.R. Procedures For Multiple Significant Trauma	3.6514
733	Head, Chest & Lower Limb Diagnoses Of Mult Signif Trauma	1.7576
734	Other Diagnoses Of Multiple Significant Trauma	1.7323
737	Ventricular Shunt Revision	1.9126
738	Craniotomy, Age <18 W CC	4.5824
739	Craniotomy, Age <18 W/O CC	2.4000
740	Cystic Fibrosis	2.1574
743	Opioid Abuse Or Dependence Left Against Medical Advice	0.2114
744	Opioid Abuse Or Dependence W CC	0.5347
745	Opioid Abuse Or Dependence W/O CC	0.3608
746	Cocaine Or Other Drug Abuse Or Dependence Left AMA	0.3263
747	Cocaine Or Other Drug Abuse Or Dependence W CC	0.7014
748	Cocaine Or Other Drug Abuse Or Dependence W/O CC	0.7014
749	Alcohol Abuse Or Dependence Left AMA	0.3018
750	Alcohol Abuse Or Dependence W CC	0.8665
751	Alcohol Abuse Or Dependence W/O CC	0.5300
752	Lead Poisoning	0.6685
753	Compulsive Nutrition Disorder Rehabilitation	2.4205
754	Tertiary Aftercare, Age =>	1.0005
755	Spinal Fusion W CC	3.1777
756	Spinal Fusion W/O CC	3.1777
757	Back & Neck Procedures Except Spinal Fusion W CC	1.6469
758	Back & Neck Procedures Except Spinal Fusion W/O CC	1.2315
759	Multiple Channel Cochlear Implants	8.9849
760	Hemophilia Factors Viii And Ix	1.6503
761	Traumatic Stupor & Coma, Coma >1 Hr	0.8201
762	Concussion,intracran Inj W Coma <1 Hr Or No Coma Age <18	0.4464
763	Traumatic Stupor & Coma, Coma <1 Hr Age <18	0.9120
764	Concuss,intracran Inj W Coma<1 Hr Or No Coma Age>17 W CC	0.8332
765	Concuss,intracran Inj W Coma<1 Hr /no Coma Age>17 W/O CC	0.5454
766	Traumatic Stupor & Coma, Coma <1 Hr Age >17 W CC	1.4348
767	Traumatic Stupor & Coma, Coma <1 Hr Age >17 W/O CC	0.7802
768	Seizure & Headache Age <18 W CC	0.5792
769	Seizure & Headache Age <18 W/O CC	0.5792
770	Respiratory Infections & Inflammations Age <18 W CC	1.7841
771	Respiratory Infections & Inflammations Age <18 W/O CC	1.1278
772	Simple Pneumonia & Pleurisy Age <18 W CC	0.6024
773	Simple Pneumonia & Pleurisy Age <18 W/O CC	0.4401
774	Bronchitis & Asthma Age <18 W CC	0.6228
775	Bronchitis & Asthma Age <18 W/O CC	0.4319
776	Esophagitis,gastroent & Misc Digest Disord Age <18 W CC	0.4797
777	Esophagit,gastroent & Misc Digest Disord Age <18 W/O CC	0.3215
778	Other Digestive System Diagnoses Age <18 W CC	0.6202
779	Other Digestive System Diagnoses Age <18 W/O CC	0.4600
780	Acute Leukemia W/O Major O.R. Procedure Age <18 W CC	5.2075

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781	Acute Leukemia W/O Major O.R. Procedure Age <18 W/O CC	1.8332
782	Acute Leukemia W/O Major O.R. Procedure Age >17 W CC	7.0876
783	Acute Leukemia W/O Major O.R. Procedure Age >17 W/O CC	1.8376
784	Acquired Hemolytic Anemia Or Sickle Cell Crisis Age <18	0.5964
785	Other Red Blood Cell Disorders Age <18	0.4326
786	Major Head & Neck Procedures For Malignancy	4.1069
787	Laparoscopic Cholecystectomy W CDE	1.8547
789	Major Joint & Limb Reattach Proc Low Ext, Exc Hip, For Comp	3.7541
790	Wnd Debrid & Skn Grft For Open Wound,ms Conn Tis, Exc Hnd	0.8638
791	Wound Debridements For Open Wound Injuries	1.3700
792	Craniotomy For Mult Sig Trauma W Non-traumatic Major CC	12.1776
793	Proc For Mul Sig Trauma Exc Craniot W Non-traum Major CC	6.2368
794	Diag For Multiple Signif Trauma W Non-traumatic Major CC	2.0561
795	Lung Transplant	36.1282
796	Lower Extremity Revascularization W CC	3.5366
797	Lower Extremity Revascularization W/O CC	1.5879
798	Tuberculosis With Operating Room Procedure	4.5582
799	Tuberculosis Left Against Medical Advice	2.0008
800	Tuberculosis W CC	1.2661
801	Tuberculosis W/O CC	1.2661
802	Pneumocystosis	2.3819
803	Allogeneic Bone Marrow Transplant	20.8772
804	Autologous Bone Marrow Transplant	5.4177
805	Simultaneous Kidney And Pancreas Transplant	21.4888
806	Combined Anterior/posterior Spinal Fusion W CC	6.8196
807	Combined Anterior/posterior Spinal Fusion W/O CC	3.9928
808	Percuataneous Cardiovasc Proc W AMI, Hf Or Shock	2.3186
809	Other Cardiothoracic Procedures W PDX Cong Anomaly	6.2120
810	Intracranial Hemorrhage	1.8148
811	Heart Assist System Implant	8.3172
812	Malfunction, Reaction & Comp Of Cardiac Or Vasc Dev Or Proc	0.9698
813	Nonbacterial Gastroenteritis & Abdominal Pain Age >17 W CC	0.6785
814	Nonbacterial Gastroenteritis & Abdominal Pain Age >17 W/O CC	0.6338
815	Nonbacterial Gastroenteritis & Abdominal Pain Age <18 W CC	0.3979
816	Nonbacterial Gastroenteritis & Abdominal Pain Age <8 W/O CC	0.2835
817	Hip Replacement For Complications	1.8842
818	Hip Replacements Except For Complications	2.3865
819	Create, Revise Or Remove Renal Access Device	1.5259
820	Malfunctions, Reactions & Comp Of Gu Device/Graft/Transplant	0.7523
821	Extensive 3rd Degree Burns W Skin Graft	20.2280
822	Extensive 3rd Degree Burns W/O Skin Graft	11.7845
823	Full Thick Burn W Skin Graft Or Inhal Inj W CC Or Sig Trauma	4.8899
824	Full Thick Burn W Skin Graft Or Inhal Inj W/O CC Or Sig Trauma	4.1930
825	Full Thick Burn W/O Skin Graft Or Inhal Inj W CC Or Sig Trauma	2.7417
826	Full Thick Burn W/O Skin Graft Or Inhal Inj W/O CC Or Sig Tr	1.7317
827	Non-extensive Burns W Inhal Inj, CC Or Significant Trauma	1.4931
828	Non-extensive Burns W/O Inhal Inj, CC Or Sig. Trauma	1.4931

829	Pancreas Transplant	21.4888
832	Transient Ischemia	0.7890
833	Intracranial Vascular Procedures W PDX Hemorrhage	4.8433
836	Spinal Procedures W CC	2.3586
837	Spinal Procedures W/O CC	2.1181
838	Extracranial Procedures W CC	1.9032
839	Extracranial Procedures W/O CC	1.0715
849	Cardiac Defib Implant W Cardiac Cath W AMI/HF/Shock	5.6694
850	Cardiac Defib Implant W Cardiac Cath W/O AMI/HF/Shock	5.6694
851	Cardiac Defibrillator W/O Cardiac Catheter	5.4784
852	Percutaneous Cardiovas Proc W Non-drug Eluting Stent W/O AMI	1.9772
853	Percutaneous Cardiovas Proc W Drug Eluting Stent W AMI	2.4087
854	Percutaneous Cardiovas Proc W Drug Eluting Stent W/O AMI	1.7132
864	Cervical Spinal Fusion W CC	2.8409
865	Cervical Spinal Fusion W/O CC	1.4101
866	Local Incsn & Rem Of Int Fix Devices Exc Hip & Femur W CC	2.3017
867	Local Incsn & Rem Of Int Fix Devices Exc Hip & Femur W/O CC	1.2991
874	Lymphoma & Leukemia W Major O.R. Procedure W CC	3.8098
875	Lymphoma & Leukemia W Major O.R. Procedure W/O CC	1.8455
876	Chemo W Acute Leuk As SDX Or W Use Of High Dose Chemo Agent	0.9738
877	Ecmo Or Trach W MV 96+ Hrs Or PDX Exc Face, Mouth & Neck W M	21.6449
878	Trach W MV 96+ Hrs Or PDX Exc Face, Mouth & Neck W/O Maj OR	13.4781
879	Craniotomy W Implant Of Chemo Agent Or Acute Complex CNS PDX	9.2432
880	Acute Ischemic Stoke W Use Of Thrombolytic Agent	3.6136
881	Respiratory System Diagnosis W MV 96+ Hrs	5.6576
882	Respiratory System Diagnosis W MV < 96 Hrs	1.9020
883	Laproscopic Appendectomy	0.8467
884	Spinal Fusion Exc Cerv W Curvature Of The Spine Or Malignanc	4.3258
885	Other Antepartum Diagnoses W O.R. Procedure	0.6596
886	Other Antepartum Diagnoses W/O O.R. Procedure	0.5273

(b) In subsequent rate years, the resulting DRG weights from the recalibration process will be accessible on the New Jersey Medicaid Management Information System website http://www.njmmis.com.

5. Statewide base rate

(a) The Division determined a single Statewide base rate, referred to as the "Statewide base rate," for all general acute care hospitals as described in Section 6.

(b) The Statewide base rate is used in conjunction with increases to the Statewide base rate referred to as add-on amounts, DRG relative weights and other components defined in this subchapter which were developed for the New Jersey DRG reimbursement system to determine the total payment for each discharge.

(c) Except for the initial rate year and in rate years in which rebasing occurs, the Statewide base rate will not change except for inflation increases as described in Section 6(c).

6. Determination of the Statewide base rate

(a) The Division established an initial Statewide base rate, which applies to all hospitals. Those hospitals meeting the criteria for add-on amounts in accordance with Section 7 have rates higher than the Statewide base rate. The initial Statewide base rate is established as follows:

1. For the initial rate year, the Division used the actual payments made for claims paid during calendar year 2006. Total payments include all DRG and outlier payments. Payments for hospital-based physicians were removed since hospital-based physician groups will bill for these services separately beginning (the effective date of this new rule). These historical 2006 payments were inflated to the rate year by applying the excluded hospital inflation factor, also referred to as the economic factor recognized under the Center for Medicare and Medicaid Services (CMS) Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248 (TEFRA) target limitations, which is published annually in the Federal Register by CMS. These adjusted payments were used to establish the total budgeted amount for inpatient acute hospital services for the rate year.

2. The amount calculated in (a) above is reduced to account for the following DRG system payments: add-on amounts under Section 7, outlier payments, payments for alternate levels of care and the effect on payments where Medicaid is not the primary payer (that is, Medicare claims partially paid by Medicaid and third party liability

claims). A reduction in payments was also made to remove an amount for utilization review services that were previously paid for by hospitals, which will become a State obligation, effective (the effective date of this new rule).

i. If the Division does not have a contractor for hospital utilization review services by (the effective date of this rule), hospitals will receive separate payments equal to the aggregate amount of utilization review removed before establishing the Statewide base rate. Each hospital will receive a utilization review payment based on its proportional amount of Medicaid fee-for-service discharges from the most recent available 24 months of Medicaid paid claims data. The allocation of utilization review payments will account for closed hospitals in accordance with the method set forth in Section 7(d).

(b) The Statewide base rate is increased by the hospital specific add-on amounts to determine a final rate for each hospital. The final rate for new hospitals and hospitals that had no Medicaid discharges in the base year are set at the Statewide base rate.

(c) The Statewide base rate will be updated annually by the excluded hospital inflation factor, also referred to as the economic factor recognized under the CMS TEFRA target limitations, which is published in the Federal Register by CMS.

(d) The initial Statewide base rate calculated in this section is $4,479. The Statewide base rate will not be changed, except for annual inflation as noted in (c) above, unless rebasing occurs as described in (e) below.

(e) Rebasing, which is setting the Statewide base rate using a more current year's claim payment data, will be done at the discretion of the Division with the approval of the Commissioner of DHS. Rebasing may or may not include recalibrating the DRG weights as described in Section 3(g).

7. Criteria to qualify for add-on amounts to the Statewide base rate

(a) Each rate year, the Division will determine if each general acute hospital participating in the New Jersey Medicaid program is eligible for add-on amounts. The Division determined hospital eligibility for add-on amounts in the initial rate year as described in (c) below and eligibility and add-ons will be calculated each rate year thereafter using the most recent year for which there is 24 months of Medicaid paid claims data. However, if the initial rate year is a partial year, add-on amounts will remain the same for the second rate year.

(b) Each hospital will receive written notification of its final rate annually, which includes any add-on amounts for which the hospital qualifies. 2006 cost report and claim data was used to set the rates and will be used to determine add-on amounts in the initial rate year. Effective (the effective date of this new rule), the eligibility of hospitals for add-on amounts will be determined based on the methodology in (c) below.

(c) Add-on amounts were developed to provide additional payments for high volumes of inpatient services to Medicaid and other low income patients. These add-on amounts increase the Statewide base rate for qualifying hospitals as a percentage add-on to the Statewide base rate. These add-on amounts are based on high volume Medicaid inpatient services or low income access.

1. High volume Medicaid inpatient services, referred to as critical services, are comprised of two categories; the first category is maternity and neonates, and the second category is mental health and substance abuse. The data used to determine eligibility as a critical service provider is patient days from the Medicaid fee-for-service claims for all DRGs in Major Diagnostic Categories (MDCs) 14, 15 (maternity and neonates), 19 and 20 (mental health and substance abuse), as specified in the All Patient Diagnosis Related Groups Patient Classification System Definitions Manual published by 3M Health Information Systems. The methodology determines eligibility for add-on amounts separately for each of the two categories, ranks patient day volume from high to low, and deems eligible those hospitals with patient days in the top 25 percent (referred to as the first quartile) of the total number of hospitals. Hospitals ranked in the first quartile for either category qualify for a 10 percent add-on to the Statewide base rate, and those hospitals that ranked in the first quartile of both categories qualify for a 15 percent add-on to the Statewide base rate.

2. High volume low income utilization, referred to as critical access, is expressed as a percentage and is defined as the sum of Medicaid fee-for-service days, Medicaid managed care days and charity care days, divided by total patient days. The data sources are Medicaid fee-for-service and charity care claims adjudicated by the New Jersey Medicaid fiscal agent and Medicaid HMO and total patient days as reported on the Medicare cost reports. Each hospital's low income utilization percentage is ranked from high to low, and hospitals in the first quartile are classified as critical access hospitals. Critical access hospitals qualify for a 10 percent add-on to the Statewide base rate. However, those hospitals with the highest low income utilization

percentages for the top 10 percent of the total number of hospitals qualify for an additional five percent, which equals a 15 percent add-on to the Statewide base rate.

3. The Medicaid claims data used to calculate the add-on amounts as defined in (c)1 and 2 above, will be the most recent data available for which the Division has 24 months of Medicaid paid claims data as of July 1 of the year prior to the rate year. For each year the add-on amounts are calculated, the Medicaid claims will have DRGs assigned using the version of the AP-DRGs Grouper that was used to pay the claims in that year.

4. The total number of hospitals referenced in (c)1 and 2 above is all hospitals that are open at the beginning of the rate year. The total number of hospitals is used in the hospital counts in the calculation of add-on amounts under (c)1 above, regardless of whether or not the hospitals have data in the relevant MDCs. The number of hospitals as calculated in (c)1 and 2 above are rounded to the nearest whole number.

(d) Regarding the treatment of closed hospitals, the calculation of add-on amounts will be determined as follows:

1. Hospitals expected to be closed by December 31 of the year prior to the rate year will be excluded from the add-on calculations. Only those hospitals with a Certificate of Need for closure approved by the Department of Health and Senior Services (DHSS) and a closure date set by DHSS of December 31 or earlier will be excluded from the add-on calculations. The Division will only use hospital closure information available up to October 1 of the year prior to the rate year for add-on calculations; and

2. The add-on amounts will be calculated only once prior to the beginning of each rate year. If hospital closures occur before the December 31 prior to the rate year without prior notification as described in (d)1 above, the Division will not recalculate the add-on amounts. Hospital closures during the rate year will not result in a recalculation of the add-on amounts.

8. DRG daily rates

(a) The Division will calculate DRG daily rates for each DRG for each hospital. These rates are used for calculating reimbursement in cases involving transfers, same-day discharges and for cases in which Medicaid eligibility began or ended during the inpatient stay.

(b) The DRG daily rate is calculated for each DRG as follows: the hospital's final rate multiplied by the DRG weight divided by the geometric mean length of stay. The geometric mean length of stay is rounded to the nearest whole number.

9. Hospital specific Medicaid cost-to-charge ratios

(a) For the initial rate year and every year thereafter, the Division will calculate hospital-specific initial inpatient cost-to-charge ratios (CCR) using the most recent available submitted Medicare cost report data.

(b) The hospital-specific CCRs are calculated using total cost, total inpatient charges and total charges by cost center from the most recent available submitted Medicare cost report Worksheet C. Inpatient costs are estimated by developing the percent of inpatient charges to total charges for each cost center and multiplying that percentage times the total costs in that cost center; total inpatient costs are the sum of the inpatient costs for all cost centers. The inpatient CCR is calculated by dividing total inpatient costs by total inpatient charges.

(c) The hospital-specific CCRs are used to estimate the cost of claims for determining whether the hospital's inpatient claims exceed the cost outlier threshold in accordance with Section 11 and also to calculate the cost outlier payments.

(d) The Division will monitor charges and payments from current claims on an ongoing basis and adjust the CCRs and payments as needed during the rate year to ensure appropriate payments. Adjustment of payments would include repricing Medicaid claims for the rate year.

(e) Hospitals shall notify the Division of any changes made to the hospital's charge structure or cost-to-charge ratios. Notice shall be given 30 days prior to implementation of the change, in writing, addressed to:

Office of Reimbursement

Division of Medical Assistance and Health Services

Mail Code #44

P.O. Box 712

Trenton, NJ 08625-0712

(f) In cases in which a hospital failed to notify the Division of changes in the hospital's charge structure, 30 days prior to implementation, the hospital shall pay for all costs associated with reprocessing its claims, as well as the recovery of the related overpayments and interest related to those overpayments. Reprocessing shall apply to both Medicaid and charity care claims. Repeated occurrences of the failure to timely notify the Division of hospital changes in the hospital's charge structure will be forwarded to the State's Medicaid Inspector General for review and possible referral to the Office of the Attorney General's Division of Criminal Justice for legal action.

10. Standard DRG payment calculation

The standard DRG payment is the hospital's final rate multiplied by the DRG weight.

11. Cost outlier payment calculation

(a) A cost outlier is defined as an inpatient stay with an estimated cost, which exceeds the greater of the State designated cost outlier threshold or the cost outlier statistical limit for a certain DRG. The cost outlier calculation is set forth in (e) below.

(b) The cost outlier statistical limit is the statistical limit for each DRG, defined as the sum of the Statewide average cost per stay for that DRG, and 1.96 times the standard deviation of the Statewide average cost per stay for that DRG.

(c) The cost outlier threshold is the fixed dollar amount cost outlier limit established by the Division, which applies to all DRGs. Applying this threshold in the cost outlier calculation assures that no cost outlier payments will be made for any DRG with a cost outlier statistical limit less than the threshold amount. The dollar amount of the cost outlier threshold is $25,000.

(d) The marginal cost percentage is the State-designated percentage used to determine the proportion of estimated cost that will be reimbursed as a cost outlier payment as

described in (e) below. The State-designated marginal cost percentage, which is 75%, applies to all DRGs and all hospitals.

(e) To calculate the estimated cost of a claim, the hospital's cost-to-charge ratio (CCR) is multiplied by the total covered charges on the claim. If the estimated cost amount exceeds the higher of the statistical cost outlier limit for the assigned DRG or the State-designated cost outlier threshold amount, the hospital will receive a cost outlier payment. The amount of the estimated cost in excess of the applicable cost outlier threshold or cost outlier statistical limit is multiplied by the marginal cost percentage. The resulting amount is the cost outlier payment.

(f) The cost outlier payment is made to the hospital in addition to the standard DRG payment amount.

(g) For claims with alternate level of care days, charges used to calculate cost outlier payments do not include routine per diem charges for alternate level of care days.

(h) The hospital specific CCRs used to develop the final rates were calculated using 2003 audited Medicare cost report data and 2003 claims data. Specifically, the 2003 CCRs were derived from the process used to convert charges to cost for calculating the DRG weights, as described in Section 3. In the initial rate year, the hospital specific CCRs

used to calculate cost outlier payments were calculated using the most recent available submitted Medicare cost report data, subject to review and adjustment by the Division if necessary.

12. Day outlier payment calculation for alternate level of care days

(a) The day outlier calculation only applies to claims in which there are alternate level of care days (for example, skilled nursing facility, intermediate care facility). This calculation is only used to determine qualification for payment of nursing facility days for those claims with days at an alternate level of care awaiting placement in a non-acute facility.

(b) For a total length of stay on the claim, which is higher than the day outlier limit for the assigned DRG, a day outlier payment will be made to the hospital for only those days that both exceed the day outlier limit and are classified as days awaiting placement in an alternative level of care.

(c) The day outlier payment is the number of alternate level of care days from the formula in (b) above multiplied by the statewide average nursing facility per diem rate calculated annually pursuant to Attachment 4.19-D of the State Plan by the Facility Rate Setting program of the Division of Senior Benefits and Utilization Management in the Department of Health and Senior Services.

(d) The day outlier limit is calculated for each DRG as follows: the geometric mean length of stay of the DRG plus 1.96 standard deviations of the geometric mean length of stay of the DRG, excluding any alternate level of care days. The day outlier limit is rounded to the nearest whole number.

(e) The day outlier payment is made to the hospital in addition to the standard DRG payment amount.

13. Simultaneous cost outlier and day outlier payments

If a covered hospital inpatient stay is determined to be eligible for both a cost outlier and a day outlier payment, the total reimbursement will be the sum of the standard DRG payment, the cost outlier payment and the day outlier payment.

14. Payment for transfers

(a) When a patient is transferred during a covered general acute care hospital inpatient stay from one hospital to another hospital, the reimbursement to the general acute care hospitals involved in the transfer(s) will be calculated as follows:

1. The reimbursement to each transferring general hospital will be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital will be no greater than the standard DRG payment, except where the transferring hospital is eligible for an outlier payment;

2. The receiving acute care general hospital will be reimbursed the standard DRG payment. If the claim qualifies as an outlier, the receiving hospital will be eligible for outlier payments based solely on the stay at the receiving hospital; and

3. Transfer cases, both transferring and receiving, that are cost or day outliers shall be subject to the Division's utilization review to determine whether the outlier payment is medically necessary.

15. Payment for same day discharges

In cases where the patient has been admitted and is discharged on the same day, reimbursement will be paid at the DRG daily rate.

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 first three digits in accordance with the International Classification of Diseases, 9th 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.

i. The letter from the QIO or PA shall also include the beneficiary's name, Medicaid identification number, dates of service for the paid and denied claims and the hospital's Medicaid provider number.

ii. The discharge summary shall be provided for both the paid and denied claims. For stays less than 48 hours, progress notes may be used in lieu of discharge summaries.

3. The Division's fiscal agent will forward appeals that meet the requirements in (b)1 and 2 above to the Division's Office of the Medical Director. Each admission will be evaluated by New Jersey licensed physicians on a case-by-case basis to determine whether the admission and readmission to the same hospital should be combined.

(c) The requirements in (a) and (b) above apply to New York hospitals for readmissions within 30 days and apply to Pennsylvania hospitals for readmissions within 31 days. New York and Pennsylvania appeal requests shall be mailed to:

Division of Medical Assistance and Health Services

Attention: Hospital Discharge/Readmit Appeals

Mail Code #44

P.O. Box 712

Building 7, Room 302

Trenton, NJ 08625-0712

17. Appeal of the hospital's Medicaid final rate

(a) For the purposes of submitting and adjudicating calculation error and rate appeals, a hospital may designate an individual or firm to represent it. This designation shall be in writing, signed by the chief executive officer of the hospital, and shall contain the representative's name, address and telephone number. This written notification shall be sent to the Division's Office of Reimbursement.

(b) Each hospital, within 15 working days of receipt of its Medicaid inpatient rate package including its final rate and applicable add-on amounts, shall notify the Division of any calculation errors in its final rate. For years after the initial year that rates are set under this system, and for which no recalibration or rebasing has occurred, only calculation errors that relate to adjustments that have been made to the rates since the previously announced schedule of rates shall be permitted. For subsequent years, calculation error appeals will be limited to the mathematical accuracy or data used for recalibration, rebasing or both. Calculation errors are defined as mathematical errors in the calculations, or data not matching the actual source documents used to calculate the DRG weights and rates as specified in this subchapter. Hospitals shall not use the calculation error appeal process to revise data used to calculate the DRG weights and rates. Calculation error appeals that challenge the methodology used to calculate DRG weights and rates shall not be adjudicated as calculation error appeals, but hospitals are permitted to file such

appeals as rate appeals delineated in (c) below. If upon review it is determined by the Division that the error would constitute at least a one percent change in the hospital's final rate, a revised final rate will be issued to the hospital within 10 working days. If the discrepancy meets the one percent requirement above and a revised Schedule of Rates is not issued by the Division within 10 working days, notification time frames to appeal calculation errors noted above will not become effective until the hospital receives a revised Schedule of Rates. The Division will issue a written decision regarding all calculation error appeal issues timely submitted in accordance with (d) below.

(c) Any hospital which seeks an adjustment to its final rate shall submit a rate appeal request.

1. A hospital shall notify the Division in writing of its intent to submit a rate appeal. The notice of appeal shall be submitted to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, Mail Code #44, PO Box 712, Trenton, New Jersey 08625-0712 within 20 calendar days of receipt by the hospital of its Medicaid inpatient final rate, including applicable add-on amounts.

2. A hospital shall identify its rate appeal issues and submit supporting documentation in writing to the Division within 80 calendar days of receipt by the hospital of its Medicaid inpatient final rate, including applicable add-on amounts.

3. In order to be considered a valid rate appeal, the hospital's submission shall meet the following requirements:

i. A detailed description of the rate appeal issue shall be provided, including, but not limited to, the basis of the issue, such as whether certain portions of the Division's rate setting methodology are being challenged; and

ii. Detailed calculations showing the financial impact of the rate appeal issue on the hospital's final rate and its estimated impact on the hospital's Medicaid inpatient reimbursement for the rate year.

4. If the Division finds the rate appeal issue to have merit, a financial review shall be undertaken by the Division to determine whether the hospital is efficiently operated in order to qualify for a rate adjustment. The financial review shall include, but not be limited to, the following:

i. Financial ratios;

ii. Efficiency indexes;

iii. Occupancy and length of stay;

iv. Debt structure;

v. Changes in cost, revenue and services;

vi. Analysis of the hospital's audited financial statements, including all related entities; and

vii. Comparison to appropriate state and national norms.

(d) The Division shall review the documentation and determine if an adjustment is warranted.

(e) The Division shall issue a written determination with an explanation as to each calculation error appeal, or request for a rate adjustment. If a hospital is not satisfied with the Division's determination, the hospital may request an Office of Administrative Law hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an OAL hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying, rejecting or remanding the Administrative Law Judge's initial decision. Thereafter, review may be had in the Appellate Division of New Jersey Superior Court.

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

Inpatient Reimbursement for General Acute Care Hospitals

18. HOSPITAL CAPITAL PROJECT PAYMENT ADJUSTMENT

(a) Any qualifying general acute care hospital that has completed a capital facilities construction project with an approved certificate of need from the New Jersey Department of Health and Senior Services, which meet the both conditions in (a)1 below will be eligible for increased payments for capital project funding related to its Medicaid and NJ Family Care-Plan A managed care utilization.

1. The conditions required in (a) above are:

   i. The approval is for a single capital project in excess of $20 million, which is for replacement beds, which reduce the number of hospital beds available in the State as of September 15, 1997; and

   ii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low income revenue percentage shall be based on the sum of the Medicaid revenue as reported on Forms E-5 and E-6, line 1, column E, plus the Charity Care revenue as reported on Forms E-5 and E-6, line 1, column J, divided by the sum of the total revenue as reported on Forms E-5 and E-6, line 1, column M.

2. Payments to eligible hospitals shall begin upon project completion and facility operation.

3. The hospital-specific capital project funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid and NJ FamilyCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

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

Inpatient Reimbursement for General Acute Care Hospitals

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