TO:

DATE:

SUBJECT:

Attached is a summary of your hospital's XXXX Uncompensated Care Verification (X Quarter), performed on behalf of the New Jersey Department of Health (Department) by Myers and Stauffer LC, agent and contractor for Charity Care Claims.

Adjustments in the attached results [($0.00) and zero (0) accounts] will be made against submitted claims that may be used in future Charity Care Subsidy calculations.

Please have the appropriate hospital representative sign and date the designated line below to acknowledge receipt of this document and of the verification results included herein. Additionally, please indicate whether you agree or disagree with the results as explained and reported.

Please note the results are preliminary and will not be finalized until our review process has been completed. Any corrections or revisions occurring as a result of the review process will be communicated to you by Thursday, March XX, XXXX approximately fifteen (15) calendar days from the verification date; any changes to the preliminary results will be provided to you and require new signatures. All revisions will be accompanied by explanations and no changes will be made without your knowledge.

If you disagree with the verification results, you must request in writing a Department review of the results within fifteen (15) calendar days of receipt of the report as dated and signed below, detailing the reason(s) for the disagreement, as specified by N.J.A.C. 10:52-11.15(h). The Department will review the contractor's findings and your hospital's objections and make a determination regarding your hospital's final adjustment, if any, within thirty (30) days of receipt of your request for review.

Checking the box indicating agreement, or failure to check either box, indicates receipt of Myers and Stauffer LC's findings. Checking the box indicating disagreement will not be considered a request for a Department review.

☐ I agree with the attached findings.

☐ I disagree with the proposed findings, intend to pursue the appeal process as specified by NJAC 10:52-11.15(h), and will submit a written request for a Department review within fifteen (15) calendar days of the signatures below.

Signature of Provider Representative

Date

Title of Provider Representative

Signature of Department Representative

Date

Title of Department Representative

SUMMARY OF RESULTS

HOSPITAL NAME: _____

HOSPITAL NUMBER: _____

LISTING TOTALS	*STATE LISTING ACCOUNTS*	*ADJUSTMENTS TO STATE LISTING* *VOIDED ACCOUNTS*	*LISTING ACCOUNTS*	*ADJUSTED ACCOUNTS*
INPATIENT				
OUTPATIENT				
TOTAL				

	STATE LISTING CHARGES	*ADJUSTMENTS TO STATE LISTING* *VOIDED CHARGES*	*LISTING CHARGES*	*ADJUSTED CHARGES*
INPATIENT				
OUTPATIENT				
TOTAL				

TESTING RESULTS (file weight)		**ORIGINAL**	**ADDITIONAL**	**TOTAL**
1. SAMPLE SIZE	*weighted accounts*			
2. SUBSAMPLE SIZE	*weighted accounts*			
3. TESTED ACCOUNTS	*weighted accounts*			
4. FAILED ACCOUNTS (COMPLIANCE)		-	-	-
5. FAILED RATE (COMPLIANCE)	**(line 4 / line 3)**	*0.000%*	*0.000%*	*0.000%*
6. ALTERNATIVE DOCUMENTATION ACCOUNTS		-	-	-
7. ALTERNATIVE DOCUMENTATION FAILED RATE	**(line 6 / line 3)**	*0.000%*	*0.000%*	*0.000%*
8. PASSED VOIDED CLAIMS		-	-	-

TESTING RESULTS (file count)		**ORIGINAL**	**ADDITIONAL**	**TOTAL**
9. SAMPLE SIZE	*physical files*			
10. SUBSAMPLE SIZE	*physical files*			
11. TESTED ACCOUNTS	*physical files*			
12. FAILED ACCOUNTS (COMPLIANCE)		-	-	-
13. FAILED RATE (COMPLIANCE)	**(line 12 / line 11)**	*0.000%*	*0.000%*	*0.000%*
14. ALTERNATIVE DOCUMENTATION ACCOUNTS		-	-	-
15. ALTERNATIVE DOCUMENTATION FAILED RATE	**(line 14 / line 11)**	*0.000%*	*0.000%*	*0.000%*
16. PASSED VOIDED CLAIMS		-	-	-

This is to acknowledge receipt of the above results concerning Xth, Quarter XXXX Charity Care Claims, as explained at the conclusion of testing during the Exit Conference held.

DATE	*SIGNATURE OF DEPARTMENT REPRESENTATIVE*	*TITLE*
DATE	*SIGNATURE OF PROVIDER REPRESENTATIVE*	*TITLE*

CHARITY CARE FILE COUNT SIGN OFF

17. Total number of Charity Care Files requested prior to the verification: *FILE COUNT:*
18. Total number of Charity Care Files available at the start of the verification: *FILES PROVIDED:*
19. Total number of Additional Charity Care Files requested the morning of the verification: *FILE COUNT:*
20. Total number of Additional Charity Care Files provided the day of the verification: *FILES PROVIDED:*

Explain reasons for missing files (if applicable):

DATE	*SIGNATURE OF PROVIDER REPRESENTATIVE*	*TITLE*

CHARITY CARE SAMPLING METHODOLOGY

Xth QUARTER XXXX CHARITY CARE VERIFICATION

PURPOSE

To ensure that the provider's methods for administering the Charity Care program are compliant and in accordance with Department Criteria as set forth by the NJAC while verifying charges written-off by the provider are appropriate and accurate

SOURCE

Patient Charity Care Applications and documentation supporting the application provided by the hospital, Charity Care Regulations as set forth by the NJAC, and Charity Care Account and Charge Listings provided by the State

SCOPE

Myers and Stauffer, LC systematically sampled the hospital's net charity care claims listing, less provider-identified voided claims, for the quarter. The sampling method utilized a random starting point and a fixed, periodic interval to select a weighted sample of accounts for verification. An account is determined to have a weight greater than one when the charges attributed to that account exceed the sampling interval, or gap between each sample selection, causing the particular account to be selected more than once. All files sampled were assigned weights based on the cumulative occurrences the file was selected.

The duplicative files selected in instances the account weight was greater than one were removed from the claims listing to arrive at the sample count of unique files. The sample count is the listing provided to the hospital prior to the verification. Every third weighted account from the weighted sample initially selected was identified to arrive at a subsample of weighted accounts to be tested. During the course of the verification, if 10% or greater of the weighted subsample failed for compliance or more than 10% were identified as alternative documentation accounts testing would be expanded to every weighted account within the sample of files requested.

The morning of the verification an additional request of 25 files or 25% of the subsample weight, whichever greater, each with a weight of one, was given to the provider and tested to assess whether the provider is properly and consistently maintaining all charity care files and not only those files selected in advance. All files tested were verified to ensure that the charity care application and the documentation supporting the application was in accordance with charity care guidelines and regulations as set forth by the Department.

CONCLUSION

Testing the provider's files included verification of gross charges and third party liability; all charges written-off as Charity Care are appropriate unless otherwise noted. The verification results are summarized in the table below.

NJ State Established Charity Care Failure Thresholds	
Alternative Documentation	> 10%
Compliance	≥ 10%

Charity Care Claims Testing

Subsample

	Failed Files		Percentage Failed		*Only Applicable to Weighted Failed Accounts*		
Area Tested	Weighted Accounts	Associated Dollar Value	Weighted Accounts	Associated Dollar Value	Threshold	Threshold Exceeded?	Expand To Full Sample?
Alternative Documentation	0	$ -	0.000%	0.000%	> 10%	No	No
Compliance	0	$ -	0.000%	0.000%	≥ 10%	No	No

Additional Onsite Sample

	Failed Files		Percentage Failed	
Area Tested	Weighted Accounts	Associated Dollar Value	Weighted Accounts	Associated Dollar Value
Alternative Documentation	0	$ -	0.000%	0.000%
Compliance	0	$ -	0.000%	0.000%

PSSC FAILED CASE DETAILS

Xth QUARTER XXXX CHARITY CARE VERIFICATION

We did not identify any noncompliant accounts; an explanation to the provider was not necessary.				
#	**Patient Name**	**Amount**	**Wt.**	**Reason**
None				

PSSC FAILED CASE DETAILS

Xth QUARTER XXXX CHARITY CARE VERIFICATION

We did not identify any alternative documentation accounts; an explanation to the provider was not necessary.				
#	**Patient Name**	**Amount**	**Wt.**	**Reason**
None				

PSSC FAILED CASE DETAILS

Xth QUARTER XXXX CHARITY CARE VERIFICATION

No accounts required listing adjustments; an explanation to the provider was not necessary.					
#	**Patient Name**	**Adjustment**	**Balance**	**Wt.**	**Reason**
None					

PSSC FAILED CASE DETAILS

Xth QUARTER XXXX CHARITY CARE VERIFICATION

No accounts were identified as having been previously voided; an explanation to the provider was not necessary.					
#	Patient Name	Amount	TPL Reported	Wt.	Reason
None					

EXIT CONFERENCE MEMORANDUM

Xth QUARTER XXXX CHARITY CARE CLAIMS VERIFICATION

HOSPITAL INFORMATION

EXIT CONFERENCE INFORMATION

Date _____

Time _____

Location _____

_____

MYERS AND STAUFFER LC REPRESENTATIVES IN ATTENDANCE

Name	Title

PROVIDER REPRESENTATIVES IN ATTENDANCE

Name	Title

CONTACT WITH STATE

SUMMARY OF FAILURE COUNTS AND DOLLAR VALUE

Provider Number: _____

		No. of Weighted Accounts	Dollars
1. FAILED ACCOUNTS (COMPLIANCE)		-	$ -
2. ALTERNATIVE DOCUMENTATION ACCOUNTS		-	$ -
3. LISTING ADJUSTMENTS		No. of Weighted Accounts	Dollars
(Accounts Removed from listing)	**Type I**	-	$ -
(Accounts Partially Adjusted)	**Type II**	-	$ -
(Accounts with Non-Allowable Charges Removed)	**Type III**	-	$ -
		-	$ -
4. VOIDED CLAIMS THAT WERE PASSED DURING TESTING		-	$ -

XXXX CHARITY CARE VERIFICATION - Xth QUARTER CLAIMS LISTING

Source: X Charity Care Claims Sample for the XXXX, Xth Qtr, generated in accordance with the methodology set forth by the Department's "Charity Care Claims Handbook" per the Charity Care Charges, net of Voids, submitted during the quarter To test the claims selected per the attributes
Purpose: indicated below
Conclusion: See below for the 'Summary of Verification Results' Section, located beneath the detailed claims testing per the 'Subsample' and 'Additional Onsite Sample' Sections

																			Complete(d) during Testing				NOT EXPANDED		**Reportable Accounts**				**Step Number**[3]								
ID #	Provider Number	PT Last Name	PT First Name	Middle Initial	Sample Wt	Sub-Sample Wt	ACCT Number	ICN Number	Write-off Date	Claim Charge	Claim Charge - Doc	TPL Paid	TPL Doc	CC %	IP/OP	Service / Discharge Date	Trans Type	PT Date of Birth	PT Age at DOS	*DRG / Type of Service*	*Date per 1st CC App*	*Date CC App Expires*	*App Type*[1]	*PT signed CC App?*	*PT has other Insurance?*[2]	***Alt Doc***	***Compliance***	***Listing Adjustment***	***Passed Void***	*Pat ID*	*NJ Res*	*Income*	*Assets*	*PT assessed for XIX Eligibility and Referral made (as necessary)?*[4]	Priced Amount	*Listing Adj Amount Type 1*	*Listing Adj Amount Type 2*	*Listing Adj Amount Type 3*	*Additional Testing Comments on File*	*WP Ref*
Subsample																																						

ID #	Provider Number	PT Last Name	PT First Name	Middle Initial	Sample Wt	Sub-Sample Wt	ACCT Number	ICN Number	Write-off Date	Claim Charge	Claim Charge - Doc	TPL Paid	TPL Doc	CC %	IP/OP	Service / Discharge Date	Trans Type	PT Date of Birth	PT Age at DOS	*DRG / Type of Service*	*Date per 1st CC App*	*Date CC App Expires*	*App Type*[1]	*PT signed CC App?*	*PT has other Insurance?*[2]	***Alt Doc***	***Compliance***	***Listing Adjustment***	***Passed Void***	*Pat ID*	*NJ Res*	*Income*	*Assets*	*PT assessed for XIX Eligibility and Referral made (as necessary)?*[4]	Priced Amount	*Listing Adj Amount Type 1*	*Listing Adj Amount Type 2*	*Listing Adj Amount Type 3*	*Additional Testing Comments on File*	*WP Ref*
												Total weighted accounts																														
												Sub-sample weighted accounts																														

	Count	Wght		Value ($)	Claims (%)	Value (%)
(full)						
(sub)	*0*	*0*	$	-	0.000%	0.000%
(add'l)	*0*	*0*	$	-	0.000%	0.000%
All	0	0	**$**	**-**	0.000%	0.000%

All	**0**	**0**	**$**				-
All IP	*0*	*0*	$				-
All OP	*0*	*0*	$				-
	0	**0**	**$**				**-**

Total requested accounts	
Total reviewed accounts	