

(d) All HealthStart Pediatric Care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational and nutrition services. This may include, but is not limited to: the Women, Infants and Children Program (WIC), the Division of Youth and Family Services, Special Child Health Services Case Management Units and Child Evaluation Centers, the early intervention programs, County Welfare Agencies/Board of Social Services, certified home health agencies, community mental health centers, local and county health departments.

**10:52-3.15 Records; documentation, confidentiality and informed consent for HealthStart Pediatric Care Providers**

(a) HealthStart Pediatric Care providers shall have policies which protect patient confidentiality, provide for informed consent and document comprehensive care services as described in the "New Jersey State Department of Health Guidelines for HealthStart Pediatric Care Providers."

(b) An individual record shall be maintained for each patient.

(c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, Care Plan, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart Pediatric services.

**10:52-3.16 Policy for reimbursement for HealthStart providers**

(a) The HealthStart HCPCS procedure codes listed in this subchapter are governed by the same policies and rules that appear in the HCPCS subchapter of each non-institutional provider services manual (Independent Clinic, Physician and the Nurse Midwifery Services Chapters). The maximum fee allowance schedule and reimbursement requirements for HCPCS HealthStart Maternity Codes (Medical Care and Health Support Services) and HCPCS HealthStart Pediatric Codes are listed under N.J.A.C. 10:66-3(a).

(b) A hospital outpatient department (OPD) which is a HealthStart Provider shall use the present procedure for OPD billing (UB-92 claim form; except for:

1. HealthStart Health Support Services (W9040 through W9043), which shall be billed on the 1500 N.J. claim form, using the Independent Clinic billing number, and
2. HealthStart pediatric continuity of care services (W9070), which shall be billed on the MC-19 form,

Report and Claim for EPSDT/HealthStart Screening and Related Procedures.

**10:52-3.17 HealthStart Maternity Care billing code requirements**

(a) HealthStart Maternity Care billing code requirements shall be as follows:

1. Separate reimbursement shall be available for Maternity Medical Care Services and Maternity Health Support Services.

2. Maternity Medical Care Services shall be billed as a total obstetrical package, when feasible, but may be billed as separate procedures.

3. The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart Maternity Medical or Health Support Service.

4. The modifier "WM" in the HCPCS lists of codes (W9025 through W9030) refers to those services provided by certified nurse midwives who shall include the modifier at the end of each code. HCPCS codes for Health Support Services do not require the "WM" modifier on HCPCS codes W9040 and W9043.

5. Laboratory and other diagnostic procedures and all necessary medical consultations shall be eligible for separate reimbursement.

(b) HealthStart Maternity Medical Care Procedure codes are provided in N.J.A.C. 10:66-3(a) Health Care Financing Administration (HCFA), Common Procedure Coding System (HCPCS), Independent Clinic Services.

**SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES**

**10:52-4.1 Basis of payment; acute general hospitals reimbursed under the Diagnosis Related Groups (DRG) system—inpatient services**

The Division will reimburse acute care general hospitals for inpatient services based upon rates determined under N.J.A.C. 10:52-5 through 9, except for distinct units of acute care general hospitals. For reimbursement methodology for distinct units of acute care general hospitals, see N.J.A.C. 10:52-4.2(c).

**10:52-4.2 Basis of payment; special hospitals (Classification A and B), private psychiatric hospitals and distinct (excluded units) of acute general hospitals—inpatient services**

(a) The Division will reimburse special hospitals (Classification A) (acute and short term special hospitals) and Classification B (Rehabilitation hospitals) for inpatient ser-

VICES (including the interim and final settlement), in accordance with Medicare principles: reimbursement (see 42 CFR 413).

(b) The Division will reimburse special hospitals (Classification C) according to the rules and reimbursement methodology of Chapter 63, Long Term Care Services (N.J.A.C. 10:63).

(c) The Division will reimburse private psychiatric hospitals and distinct units of acute general hospitals for inpatient services (including the interim and final settlement) in accordance with Medicare principles of reimbursement. Distinct units of acute general hospitals are not reimbursed through the Diagnosis Related Groups (DRG) reimbursement system (N.J.A.C. 8:31B) for inpatient services in acute care general hospitals.

(d) Therapeutic leave days (days spent outside the facility) are not reimbursed to hospitals by the Division.

**10:52-4.3 Basis of payment; all general and special (Classification A), rehabilitation (Classification B), and private psychiatric hospitals—outpatient services**

(a) The Division reimburses providers for covered services in the outpatient department of general hospitals, special hospitals (Classification A), rehabilitation hospitals (Classification B) and private psychiatric hospitals consistent with the following conditions and reimbursement methodology:

1. Establishment of a final rate of reimbursement: The final rate of reimbursement is based on the lower of cost or charges as defined by Medicare principles of reimbursement at 42 CFR 447.321; and,

2. Establishment of an interim rate of reimbursement: The charge for an outpatient service is subject to a reduction based on the application of a cost-to-charge ratio determined for each individual hospital by the Division, in accordance with Medicare principles of reimbursement at 42 CFR 447.321. This cost-to-charge ratio is used to assure that reimbursement for outpatient services does not exceed the rate based on Medicare principles of reimbursement.

3. Effective for services rendered on or after July 1, 1991, and until further notice, the Division is reducing the interim reimbursement rates for covered outpatient services subject to the cost-to-charge ratio in general, special (Classification A), rehabilitation (Classification B) and private psychiatric hospitals by 4.4 percent. The final settlement for covered outpatient services subject to the cost-to-charge ratio is the lower of costs or charges minus 4.4 percent.

(b) Certain outpatient services, that is, most laboratory services, all renal dialysis services, all dental services, some HealthStart services, and the Medicare deductible and coinsurance amounts, are excluded from a reduction based on the cost-to-charge reimbursement methodology and have their own reimbursement methodology as follows:

1. Most outpatient laboratory services are reimbursed on the basis of a fee-for-service using the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) procedure codes and the fee schedule contained in N.J.A.C. 10:52-9.3 through 9.5. If the hospital charge is less than the amount on the fee allowance, reimbursement is based upon the actual billed charge. In addition, there are situations which have unique billing arrangements, as follows:

i. Specimen collection, that is a routine venipuncture for collection of specimen(s) or a catheterization for collection of urine specimen(s) are reimbursed at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day. (See HCPCS G0001, P9610, P9615 in N.J.A.C. 10:52-10.3); and,

ii. Profiles and panels shall be reimbursed as follows:

(1) Profiles are comprised of those components of a test or series of tests performed as groups or combinations (profiles) which are performed on automated multichannel equipment and are finished identifiable laboratory study(ies). Examples are: The components of an SMA (Sequential Multichannel Automated Analysis) 12/60 or other automated laboratory study. Complete blood counts (CBC) with inclusion of Hemoglobin, Hematocrit, Red Blood Cell (RBC) Counts, Red Blood Cell (RBC) indices, White Blood Cell (WBC) Counts, and Differentials, MCHs, MCVs and MCHCs, are calculations, and not billable services. If the components of a profile or panel are billed separately, reimbursement for the components of the profile shall not exceed the Medicaid fee schedule for the profile itself.

(2) Panels are laboratory tests that are associated with other organ or disease oriented areas, such as organ "panels". Examples are hepatic function panels and lipid panels. The tests listed with each panel identifies the defined components of that panel. (See also (b)2iii below.)

2. Some outpatient laboratory services which use laboratory HCPCS procedure codes that are reimbursed based on actual billed charges, are subject to the cost-to-charge ratio. These include procedure codes such as:

i. Those valid for Medicaid reimbursement but not listed on the Medicare Laboratory HCPCS Procedure Code File (see 42 U.S.C. § 1395L). They are designated as "subject to cost-to-charge" or S.C.C. in N.J.A.C. 10:52-9.2;

ii. For those HCPCS codes submitted for payment on the same claim with charges for blood products (if no blood product is provided and/or billed on the same claim, the codes are reimbursed according to the fee allowance schedule); and

iii. For some codes associated with other laboratory services such as for organ or disease oriented panels; clinical pathology consultations; unlisted chemistry or toxicology procedures; certain bone marrow testing; certain specific or unlisted hematology procedures; certain immunology testing; unlisted microbiology procedures; and certain procedures under anatomic pathology.

3. All renal dialysis services for end-stage renal disease (ESRD) are reimbursed at 100 percent of the composite rate and includes any add-on charge to the composite rate approved by Medicare.

i. Renal dialysis services provided on an emergency basis in a hospital center not approved to provide renal dialysis services for ESRD are reimbursed actual billed charges, subject to the cost-to-charge ratio.

4. All dental services are reimbursed in accordance with the Division Dental Fee Schedule. This fee-for-service schedule is consistent with the Division's fees paid to the private practitioners and independent dental clinics. For information about dental services in the Outpatient Department, see N.J.A.C. 10:52-2.3.

5. All HealthStart Maternity Health Support Services and HealthStart Pediatric Continuity of Care services are reimbursed on a fee-for-service basis in the hospital outpatient department. All other HealthStart Maternity and Pediatric Care Services are reimbursed based on the cost-to-charge ratio. (For policies and procedures for HealthStart Services, see N.J.A.C. 10:52-3.10.)

6. Early Periodic Screening, Diagnosis, and Treatment services are reimbursed in the hospital outpatient department according to the specific reimbursement methodology. (See also N.J.A.C. 10:52-2.4.)

i. The physician who is allowed by the hospital to bill Medicaid separately from the hospital costs (unbundled) for EPSDT services, shall bill on the EPSDT form.

7. All deductible and coinsurance amounts for Medicare crossover claims are not subject to the cost-to-charge ratio and are reimbursed at 100 percent of the amounts.

(c) Emergency room visits for Medicaid recipients not admitted as inpatients are coded by the hospital as needing primary care or non-primary care. (See N.J.A.C. 8:31B-3.23(e)).

1. Primary care is defined as those categories described in the Physicians' Current Procedural Terminology (CPT) as either minimal, brief, or limited service.

2. Non-primary care shall be defined as those categories described in the Physicians' Current Procedural Terminology (CPT), 1994, as amended and supplemented, as either intermediate, extended, or comprehensive service.

3. Hospitals shall not refuse to provide emergency room services to any Medicaid recipient for the reason that such recipient does not require services on an emergency basis.

NOTE: The cost of emergency room services for a Medicaid recipient admitted as an inpatient is allocated to the inpatient rates and is not reimbursed through the outpatient hospital reimbursement methodology, as stated above.

#### 10:52-4.4 Basis of payment; out-of-State hospital services

(a) The Division will reimburse an out-of-State approved hospital (see N.J.A.C. 10:52-1.2—Definitions) for providing inpatient and outpatient hospital services to New Jersey Medicaid recipients if the hospital meets the requirements of the Division and the services are prior authorized pursuant to N.J.A.C. 10:52-1.6(b). Reimbursement of inpatient hospital services is outlined in (b) through (d) below; and for outpatient services, is outlined in (e) below.

(b) Reimbursement of inpatient hospital services for hospitals participating in the Medicaid program is based on the following criteria:

1. All rates in effect at the time the service is rendered shall be considered final rates by the State.

i. In Diagnosis Related Group (DRG) hospitals, interim reimbursement is 100 percent of the DRG rate approved for the provider by the State Medicaid Agency in the state in which the hospital is located and in effect at the time the service is rendered.

ii. In non-Diagnosis Related Group (DRG) hospitals, reimbursement is 95 percent of the any reimbursement methodology (per diem, charges or case rate) approved by the State Medicaid agency of the state in which the hospital is located.

3. An out-of-State hospital should provide official documentation of the Medicaid rate that has been established by the State Medicaid agency in the state in which the hospital is located.

i. An example of acceptable documentation is a copy of the letter sent by the State Medicaid Agency to the hospital specifying the Medicaid rate. The purpose of this information is to facilitate claims processing.

(c) In the event an out-of-State hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with the State Medicaid agency, the hospital must enter into a negotiated rate with the Division at the time of enrollment for inpatient hospital services. The rate that is established between the hospital and the Division may be reviewed periodically thereafter.

1. Reimbursement for out-of-State inpatient hospital services for organ transplantation and procurement provided to a Medicaid recipient who has been determined to be in need of, and approved for, a kidney, heart, heart-lung, liver, bone marrow transplant, or other selected medically necessary organ transplants, except for those transplants categorized as experimental because of a life-threatening situation, shall be at a rate negotiated between the New Jersey Medicaid program and the hospital performing the organ transplant. Cornea transplants, although not life-threatening, shall be reimbursed as any other out-of-State transplant service.

(d) Reimbursement for outpatient hospital services in an out-of-State approved hospital is based on the rate of reasonable covered charges (subject to a percentage reduction based upon the cost-to-charge ratio) approved by the State Medicaid Agency in the state in which the hospital is located if the hospital participates in the State's Medicaid program, or if the hospital does not participate in the State's Medicaid program, the rate negotiated by the Division with the hospital.

#### 10:52-4.5 Medicaid reimbursement for third-party claims

On claims for hospital services rendered to Medicaid recipients who are also covered by another form of health insurance, the Division shall pay the difference between the insurer's payment amount and that of Medicaid for covered services. (See N.J.A.C. 10:49-7.3, Administration.)

#### 10:52-4.6 Medicare/Medicaid claims

(a) Some patients may be covered under both Medicare and Medicaid. When the Medicaid recipient is covered under both programs, Item 57 on the hospital claim form shall be completed showing the Medicaid Program Case and Person Number.

(b) Reimbursement of the deductible and coinsurance for inpatient and outpatient services for Medicaid recipients having both Medicare and Medicaid coverage shall be limited to the unsatisfied deductible and coinsurance.

(c) Where benefits have been exhausted under Medicare, the charges to be billed to the Medicaid program must be itemized for the Medicare non-covered services and the HSP (Medicaid) Case Number, including Person Number, must be shown on the hospital claim form.

(d) Where prior authorization is required for Medicaid program purposes, it shall be obtained and shall be submitted with the UB-92 claim form.

#### 10:52-4.7 Medicaid settlement

(a) In the capacity of the New Jersey Medicaid Settlement Agent for hospital for all New Jersey acute care general (excluding inpatient services), special, rehabilitation, private psychiatric and county governmental psychiatric hospitals and all hospital-based home health agencies, Blue Cross and Blue Shield of New Jersey, Inc. (BCBSNJ) shall determine their amount of disbursements, recoupments, and/or changes in per diem amounts and outpatient percentages, as applicable. BCBSNJ shall inform the hospital and the Division of Medical Assistance and Health Services (Division) of the results of their review. If the BCBSNJ's review is accepted, DMAHS, through its fiscal agent for claims processing, shall perform the following processes:

1. For disbursements, payment shall be made to the hospital for the full amount due within 20 working days from the date of BCBSNJ's letter.

2. The fiscal agent shall begin recoupment for the full amount of the overpayment 30 days after the date the Division receives BCBSNJ's overpayment notification by withholding the Medicaid payments to the hospital.

3. If the withholding of the New Jersey Medicaid payment is not acceptable to the hospital, the hospital must submit, prior to the end of the 30-day period, a proposed repayment schedule to the Division. For a repayment schedule in excess of three months, documentation (as specified in Medicare Bulletin No. 0452) shall be submitted. If an approvable repayment schedule is not received by the Division, the withholding of Medicaid payments shall be implemented to begin recoupment.

4. The proposed repayment plans should be submitted directly to the following address:

Bureau of Institutional and Provider Reimbursement  
Division of Medical Assistance and Health Services  
CN 712, Mail Code # 25  
Trenton, New Jersey 08625-0712  
Attention: Health Care Facilities Analyst

5. Interest shall be charged at the maximum legal rate as of the date of the repayment agreement or 30 days from the date of the BCBSNJ letter to the Division, whichever is sooner.