

**CHAPTER 52**

**HOSPITAL SERVICES MANUAL**

**Authority**

N.J.S.A. 30:4D-7 and 12.

**Source and Effective Date**

R.2000 d.29, effective December 21, 1999.  
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 52, Hospital Services Manual, expires on December 21, 2004.

**Chapter Historical Note**

Chapter 52, Manual for Hospital Services, was adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c).

Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, Coverage, was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b).

Pursuant to Executive Order No. 66(1978), Subchapter 2, Admissions and Billing Procedures, was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1992 d.327, effective August 17, 1992, operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a).

Subchapter 5, Procedural and Methodological Regulations, Subchapter 6, Financial Reporting Principles and Concepts, Subchapter 7, Diagnosis Related Groups (DRG), Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993, to expire May 10, 1993. See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 1582(a), 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Hospital Services Manual, was readopted as R.1995 d.123, effective February 3, 1995, and Subchapter 1, Coverage, Subchapter 2, Admission and Billing Procedures, Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric Services, Subchapter 4, Basis of Payment for Hospital Services, and Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, were adopted as new rules by R.1995 d.123, effective April 17, 1995. See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Subchapter 10, Charity Care, was adopted as R.1995 d.258, effective May 15, 1995. See: 27 N.J.R. 656(a), 27 N.J.R. 1995(a).

Subchapter 12, Graduate Medical Education and Indirect Medical Education, was adopted as R.1997 d.43, effective January 21, 1997. See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was adopted as R.1997 d.520, effective January 5, 1998. See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Hospital Services Manual, was readopted as R.2000 d.29, effective December 21, 1999, and Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, was recodified as Subchapter 13, Eligibility for and Basis of Payment for Disproportionate Share Hospitals, Subchapter 10, Charity Care, was recodified as Subchapter 11, Charity Care, Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was recodified as Subchapter 12, Charity Care Component of the Disproportionate Share Hospital Subsidies, Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, was recodified as Subchapter 10, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, and Subchapter 12, Graduate Medical Education and Indirect Medical Education, was recodified as Subchapter 8, Graduate Medical Education and Indirect Medical Education, by R.2000 d.29, effective January 18, 2000. See: Source and Effective Date. See, also, section annotations.

**CHAPTER TABLE OF CONTENTS**

**SUBCHAPTER 1. GENERAL PROVISIONS**

- 10:52-1.1 Purpose and scope
- 10:52-1.2 Definitions
- 10:52-1.2A (Reserved)
- 10:52-1.3 Criteria for participation: outpatient hospital services
- 10:52-1.4 Use of PA-1C for applying for benefits for a hospital patient
- 10:52-1.5 Eligibility of beneficiary for hospital services
- 10:52-1.6 Covered services (inpatient and outpatient)
- 10:52-1.7 Offset of disproportionate share hospital payments
- 10:52-1.8 Non-covered services (inpatient and outpatient)
- 10:52-1.9 Administrative days (nursing facility level of care)—general, special (Classification A & B) and private psychiatric hospitals
- 10:52-1.10 Prior authorization
- 10:52-1.11 Pre-admission screening for nursing facility (NF) placement
- 10:52-1.12 Recordkeeping
- 10:52-1.13 Second opinion program for elective surgical procedures
- 10:52-1.14 Social Necessity Days
- 10:52-1.15 Utilization control (inpatient services)
- 10:52-1.16 Utilization control: inpatient psychiatric services for beneficiaries under 21 years of age in private psychiatric hospitals
- 10:52-1.17 Utilization control; outpatient psychiatric services
- 10:52-1.18 Advance directives

**SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES**

- 10:52-2.1 Ambulatory Surgical Center (ASC)
- 10:52-2.2 Blood and blood products
- 10:52-2.3 Dental services
- 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- 10:52-2.5 Family planning services
- 10:52-2.6 Home health agencies; hospital-based
- 10:52-2.7 Medical day care centers; hospital affiliated
- 10:52-2.8 Narcotic and drug abuse treatment centers; free-standing
- 10:52-2.9 Organ procurement and transplantation services
- 10:52-2.10 Psychiatric services; partial hospitalization
- 10:52-2.10A Psychiatric services; partial hospitalization prevocational programs
- 10:52-2.11 Rehabilitative services; hospital outpatient department
- 10:52-2.12 Renal dialysis services for end-stage renal disease (ESRD)
- 10:52-2.13 Sterilization
- 10:52-2.14 Hysterectomy

- 10:52-2.15 Termination of pregnancy
- 10:52-2.16 Transportation services; hospital-based

**SUBCHAPTER 3. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES**

- 10:52-3.1 Purpose
- 10:52-3.2 Scope of services
- 10:52-3.3 HealthStart provider participation criteria
- 10:52-3.4 Termination of HealthStart certificate
- 10:52-3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate
- 10:52-3.6 Access to services
- 10:52-3.7 Plan of Care (PoC)
- 10:52-3.8 Maternity Medical Care services
- 10:52-3.9 HealthStart health support services
- 10:52-3.10 Professional staff requirements for HealthStart Comprehensive Maternity Care services
- 10:52-3.11 Records; documentation, confidentiality and informed consent requirements for HealthStart Comprehensive Maternity Care providers
- 10:52-3.12 Standards for HealthStart Pediatric Care Certificate.
- 10:52-3.13 Professional requirements for HealthStart Pediatric Care providers
- 10:52-3.14 Preventive care services provided by HealthStart Pediatric Care providers
- 10:52-3.15 Records; documentation, confidentiality and informed consent for HealthStart Pediatric Care Providers
- 10:52-3.16 Reimbursement for HealthStart providers
- 10:52-3.17 HealthStart Maternity Care billing code requirements

**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
- 10:52-4.2 Basis of payment; special hospitals (Classification A and B), private and governmental psychiatric hospitals and distinct (excluded units) of acute general hospitals—inpatient services
- 10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care hospitals—outpatient services
- 10:52-4.4 Basis of payment and appeal procedure; out-of-State hospital services
- 10:52-4.5 Reimbursement for third-party claims
- 10:52-4.6 Medicare/Medicaid or Medicare/NJ KidCare claims
- 10:52-4.7 Personal contribution to care requirements for NJ KidCare—Plan C and copayments for NJ KidCare—Plan D
- 10:52-4.8 Settlement for Medicaid/NJ KidCare fee-for-service services

**SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS**

- 10:52-5.1 Derivation of Preliminary Cost Base
- 10:52-5.2 Uniform Reporting: Current costs
- 10:52-5.3 Costs per case
- 10:52-5.4 Development of standards
- 10:52-5.5 Current Cost Base
- 10:52-5.6 Financial elements reporting/audit adjustments
- 10:52-5.7 Identification of direct and indirect costs related to Medicaid/NJ KidCare patient care
- 10:52-5.8 Patient care cost findings; direct costs per case, physician and nonphysician
- 10:52-5.9 Reasonable cost of services related to patient care
- 10:52-5.10 Standard costs per case
- 10:52-5.11 Reasonable direct cost per case
- 10:52-5.12 Net income from other sources
- 10:52-5.13 Update Factors
- 10:52-5.14 Capital facilities
- 10:52-5.15 Division adjustments and approvals
- 10:52-5.16 Derivation from Preliminary Cost Base
- 10:52-5.17 Schedule of rates—effective date

- 10:52-5.18 (Reserved)
- through
- 10:52-5.21

**SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS**

- 10:52-6.1 Reporting period
- 10:52-6.2 Objective evidence
- 10:52-6.3 Consistency
- 10:52-6.4 Full disclosure
- 10:52-6.5 Materiality
- 10:52-6.6 Basis of Valuation
- 10:52-6.7 Accrual accounting
- 10:52-6.8 Accounting for minor moveable equipment
- 10:52-6.9 Accounting for capital facilities costs
- 10:52-6.10 Timing differences
- 10:52-6.11 Self-insurance
- 10:52-6.12 Related organizations
- 10:52-6.13 Financial elements (generally)
- 10:52-6.14 Services related to Medicaid/NJ KidCare fee-for-service patient care
- 10:52-6.15 Direct patient care
- 10:52-6.16 Paid taxes
- 10:52-6.17 Educational, research and training program
- 10:52-6.18 Capital facilities
- 10:52-6.19 Major moveable equipment
- 10:52-6.20 Natural classifications of expense
- 10:52-6.21 Medical and Surgical Supplies
- 10:52-6.22 Non-Medical and Non-Surgical Supplies
- 10:52-6.23 Purchased Services
- 10:52-6.24 Major Moveable Equipment
- 10:52-6.25 Reports of costs and revenues
- 10:52-6.26 Excluded health care services
- 10:52-6.27 Education and research
- 10:52-6.28 Sales and services not related to patient care
- 10:52-6.29 Patient convenience items
- 10:52-6.30 Administrative items
- 10:52-6.31 Non-operating revenues (net of expenses)
- 10:52-6.32 Reporting of costs and revenues
- 10:52-6.33 Medical-Surgical Acute Care Units (MSA)
- 10:52-6.34 Obstetric Acute Care Unit (OBS)
- 10:52-6.35 Pediatric Acute Care Units (PED)
- 10:52-6.36 Psychiatric Acute Care Units (PSA)
- 10:52-6.37 Burn Care Units (BCU)
- 10:52-6.38 Intensive Care Units (ICU)
- 10:52-6.39 Coronary Care Units (CCU)
- 10:52-6.40 Neonatal Intensive Care Units (NNI)
- 10:52-6.41 Newborn Nursery (NBN)
- 10:52-6.42 Emergency Services (EMR)
- 10:52-6.43 Anesthesiology Services (ANS)
- 10:52-6.44 Cardiac Catheterization (CCA)
- 10:52-6.45 Delivery and Labor Rooms (DEL)
- 10:52-6.46 Dialysis (DIA)
- 10:52-6.47 Drugs Sold to Patients (DRU)
- 10:52-6.48 Electrocardiology (EKG)
- 10:52-6.49 Laboratory (LAB)
- 10:52-6.50 Medical and Surgical Supplies Sold (MSS)
- 10:52-6.51 Neurology, Diagnostic (NEU)
- 10:52-6.52 Nuclear Medicine (NMD)
- 10:52-6.53 Occupational and Recreational Therapy (OCC)
- 10:52-6.54 Operating and Recovery Rooms (ORR)
- 10:52-6.55 Organ Acquisition (ORG)
- 10:52-6.56 Physical Therapy (PHT)
- 10:52-6.57 Psychiatric/Psychological Services (PSY)
- 10:52-6.58 Radiology, Diagnostic (RAD)
- 10:52-6.59 Respiratory Therapy (RSP)
- 10:52-6.60 Speech-Language Pathology and Audiology (SPA)
- 10:52-6.61 Therapeutic Radiology (THR)
- 10:52-6.62 Central Supply Services (CSS)
- 10:52-6.63 Dietary (DTY)
- 10:52-6.64 Housekeeping (HKP)
- 10:52-6.65 Laundry and Linen (L&L)
- 10:52-6.66 Medical Records (MRD)

- 10:52-6.67 Pharmacy (PHM)
- 10:52-6.68 Social Services (SOC)
- 10:52-6.69 Research (RSH)
- 10:52-6.70 Nursing and Allied Health Education (EDU)
- 10:52-6.71 Graduate Medical Education (GME)
- 10:52-6.72 General Administrative Services (GAM)
- 10:52-6.73 Inpatient Administrative Services (IAM)
- 10:52-6.74 Malpractice Insurance (MAL)
- 10:52-6.75 Employee Health Insurance (EHI)
- 10:52-6.76 Repairs and Maintenance (RPM)
- 10:52-6.77 Utilities Cost (UTC)
- 10:52-6.78 (Reserved)
- 10:52-6.79 through

#### SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

- 10:52-7.1 Diagnosis Related Groups (DRG)
- 10:52-7.2 Calculation of Payment Rates
- 10:52-7.3 List of Diagnosis Related Groups

#### SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

- 10:52-8.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed
- 10:52-8.2 Distribution of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement
- 10:52-8.3 Establishment of GME and IME interim method of reimbursement
- 10:52-8.4 Establishment of GME and IME final method of reimbursement
- 10:52-8.5 Hospital fee-for-service reimbursement for Graduate Medical Education (GME) effective on or after July 6, 1998
- 10:52-8.6 Distribution of Graduate Medical Education (GME) effective on or after July 6, 1998

#### SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

- 10:52-9.1 Review and appeal of rates

#### SUBCHAPTER 10. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

- 10:52-10.1 Introduction
- 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory
- 10:52-10.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT)
- 10:52-10.4 Pathology and Laboratory HCPCS Codes—Qualifiers
- 10:52-10.5 Pathology and Laboratory HCPCS Codes—Modifiers

#### SUBCHAPTER 11. CHARITY CARE

- 10:52-11.1 Charity care audit functions
- 10:52-11.2 Sampling methodology
- 10:52-11.3 Charity care write off amount
- 10:52-11.4 Differing documentation requirements if patient admitted through emergency room
- 10:52-11.5 Charity care screening and documentation requirements
- 10:52-11.6 Identification
- 10:52-11.7 New Jersey residency
- 10:52-11.8 Income eligibility criteria and documentation
- 10:52-11.9 Proof of income
- 10:52-11.10 Assets eligibility criteria
- 10:52-11.11 Limit on accounts with alternative documentation
- 10:52-11.12 Additional information to be supplied to facility by applicant
- 10:52-11.13 Application and determination
- 10:52-11.14 Collection procedures and prohibited action
- 10:52-11.15 Adjustment methodology

- 10:52-11.16 Charity care applications of patients admitted through emergency room
- 10:52-11.17 Charity care applications of patients admitted through the emergency room between January 1, 1999, and July 17, 2000

#### SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

- 10:52-12.1 Definitions
- 10:52-12.2 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund
- 10:52-12.3 Basis of pricing for charity care claims

#### SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

- 10:52-13.1 Disproportionate share adjustment—general eligibility
- 10:52-13.2 Disproportionate share hospital (DSH) payment—general
- 10:52-13.3 Eligibility and disproportionate share hospital payments for hospitals operating under N.J.S.A. 18A:64G-1
- 10:52-13.4 Eligibility for disproportionate share hospital payments from the Charity Care Component of the Health Care Subsidy Fund
- 10:52-13.5 Eligibility for and payment of Hospital Relief Subsidy Fund DSH
- 10:52-13.6 Eligibility and payment for DSH funding from the Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients
- 10:52-13.7 Calculation and distribution of Disproportionate Share Hospital (DSH) payments as a result of a hospital closure: purpose and procedure

#### APPENDIX. FISCAL AGENT BILLING SUPPLEMENT

#### SUBCHAPTER 1. GENERAL PROVISIONS

##### 10:52-1.1 Purpose and scope

(a) This chapter outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid and NJ KidCare fee-for service beneficiaries. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and psychiatric hospitals, unless specifically indicated otherwise.

(b) Unless otherwise stated, the rules of this chapter apply to Medicaid and NJ KidCare—Plan A, B and C fee-for-service beneficiaries and to Medicaid and NJ KidCare—Plan A, B, C and D fee-for-service services which are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services which are to be provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO.

Petition for Rulemaking.  
See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).  
Amended by R.2000 d.29, effective January 18, 2000.  
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (a), substituted a reference to Medicaid and NJ KidCare fee-for service beneficiaries for a reference to Medicaid recipients, and substituted a reference to psychiatric hospitals for a reference to private psychiatric hospitals; and added (b).

### 10:52-1.2 Definitions

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

“Base year” means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

“Bundled drug service” means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost of the drug, the drug product and ancillary services, such as, but not limited to, case management and laboratory services.

“Current Cost Base” means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period for the purposes of rate setting.

“DHSS” means the State Department of Health and Senior Services.

“Diagnosis Related Groups (DRGs)” means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications, and consumption of a similar amount of resources.

“Disproportionate share hospital” means a hospital designated as such by the Commissioner of the Department of Human Services, in accordance with N.J.A.C. 10:52-13.

“Division” means the New Jersey Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid and NJ KidCare-Plan A beneficiaries under 21 years of age or age 19 for NJ KidCare-Plan A for the purpose of assessing a beneficiary’s health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

“Entity,” as used in N.J.A.C. 10:52-1.2A, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

“Equalization Factor” means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs in setting Statewide standard costs per case.

“Financial Elements” means the reasonable cost of items approved as reimbursable under Medicaid (see N.J.A.C. 10:52-5.10).

“Group” means the logic that assigns cases into the appropriate Diagnosis Related Groups in accordance with the clinical and statistical information supplied.

“Hospital” means, pursuant to section 1861(e) of the Social Security Act (42 U.S.C. § 1395x(e)), an institution which is primarily engaged in providing the following services to inpatients, by or under the supervision of physicians:

1. Diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or,
2. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; and
3. Maintains clinical records on all patients;
4. Has by-laws in effect with respect to its staff of physicians;
5. Requires every patient to be under the care of a physician;
6. Provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a registered professional nurse or licensed practical nurse on duty at all times;
7. Has in effect a hospital utilization review plan that meets the requirement of the law (Sec. 1861(K) of the Social Security Act); and has in place a discharge planning process that meets the requirements of the law (Sec. 1861(ee)) of the Social Security Act;
8. Is licensed as a hospital in the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located, or approved by the agency of the state or locality responsible for licensing hospitals meeting the standards established for such licensing;
9. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of health and safety of individuals who furnished services in the institution; and
10. For the purposes of N.J.A.C. 10:52-1.2A only, is where the main inpatient hospital services are located.

“Hospital (Approved General)” means an institution which is approved to participate as a provider in the Division if it:

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifi-

able part of a multi-service institution is licensed, only the section licensed is considered a Medicaid/NJ KidCare provider);