CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D–6a(1), 30:4D–7, 7a, b, c, and e; 30:4D–12, P.L. 1992, c.160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 447.251, 253.

Source and Effective Date

R.1995 d.123, effective February 3, 1995.
See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Executive Order No. 66(1978) Expiration Date

Chapter 52, Hospital Services Manual, expires on February 3, 2000.

Chapter Historical Note

Chapter 52, originally Manual for Hospital Services, became effective with Subchapter 1, Coverage, and Subchapter 2, Admission and Billing Procedures, 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 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 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 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.1993 d.327, effective August 17, 1992, but operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a). Pursuant to P.L. 1992, c. 160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 C.F.R. 447.251, 253 and the authority cited above 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. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1995 d.123. See: Source and Effective Date. As a part of R.1995 d.123, Chapter 52 was retitled Hospital Services Manual; existing Subchapters 1 through 4 were repealed, and new Subchapters 1 through 4 were adopted, effective April 17, 1995; and Subchapter 10 was adopted as new rules, effective April 17, 1995. See, also, section annotations.

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APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:52–1.1 Purpose and scope

This chapter of the Hospital Services Manual outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid recipients. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and private psychiatric hospitals, unless specifically indicated otherwise.

Petition for Rulemaking.
See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

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.

"Adjusted admissions" means inpatient admissions increased to reflect outpatient activity, which is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

"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.

"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.

"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 recipients under 21 years of age for the purpose of assessing a recipient'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).

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

"Hospital" means 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. Rehabilitative services for the rehabilitation of injured, disabled, or sick persons; and that

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 identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid provider);

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act);

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

4. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

"Hospital (Approved Private Psychiatric)" means an institution which is approved to participate as a provider in the Division and:

1. Is licensed by the State of New Jersey as a psychiatric (mental-non-governmental) hospital or licensed as a private psychiatric hospital (non-governmental) by the appropriate agency under the laws of the respective state in which the hospital is located;

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a psychiatric hospital;

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX);

4. Meets the special Medicare standards relative to staffing requirements and clinical medical records; and,

5. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

"Hospital (Approved Private Psychiatric) facility that provides inpatient services to children under 21 years of age" means an institution that shall meet the requirements of 1., 2., 3., 4. and 5. above, listed in the definition of "Hospital (Approved Private Psychiatric): or in addition to 1. and 5. above, has facility accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

"Hospital (Approved Special)" means an institution which is approved by the New Jersey State Department of Health as a special hospital (for definition of special hospital, see N.J.A.C. 8:43G–1.3(b)2) and which includes any hospital which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation, where applicable, on an inpatient basis for one or more specific categories of patients; and approved to participate as a provider in the Division if it meets the appropriate standards of participation for one of the following classifications:

(a) Special (Acute care or short term) or Comprehensive Rehabilitation Hospital:

1. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;

2. Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation as a hospital or rehabilitation facility; and/or

3. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a hospital;

4. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

5. Has signed a provider agreement to participate in and abide by the rules of the Division and all applicable Federal regulations.

"Informed Consent" means the voluntary knowing assent from the individual on whom any sterilization is to be performed after he or she has been given (as evidenced by a document executed by such individual) and has been given:

1. A fair explanation of procedures to be followed;

2. A description of attendant discomforts and risks;

3. A description of benefits to be expected;

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4. Previously submitted PA–1C forms shall be updated by the hospital if subsequent facts emerge that alter the original referral.

i. When it is determined that the original referral to the Social Security Administration was incorrect, the hospital shall forward a copy of the original PA–1C to the CWA with a note of explanation (see also N.J.A.C. 10:49–2 in Administration for further information on Medicaid eligibility).

10:52–1.4 Eligibility of recipient for hospital services

(a) Hospital services shall not be reimbursed by Medicaid when hospital services were rendered prior to and after period of recipient eligibility, as determined in accordance with N.J.A.C. 10:49–2.5; except that, when a Medicaid recipient in an acute care general hospital loses eligibility during an inpatient hospital stay, but was eligible on the date of admission, eligibility shall continue for hospital inpatient services for the entire length of that hospital stay.

(b) When a patient is admitted to a hospital and is determined Medicaid eligible subsequent to the date of admission, charges incurred during the ineligible period of the hospital stay shall not be reimbursable, unless coverage is pursued and approved under retroactive eligibility.

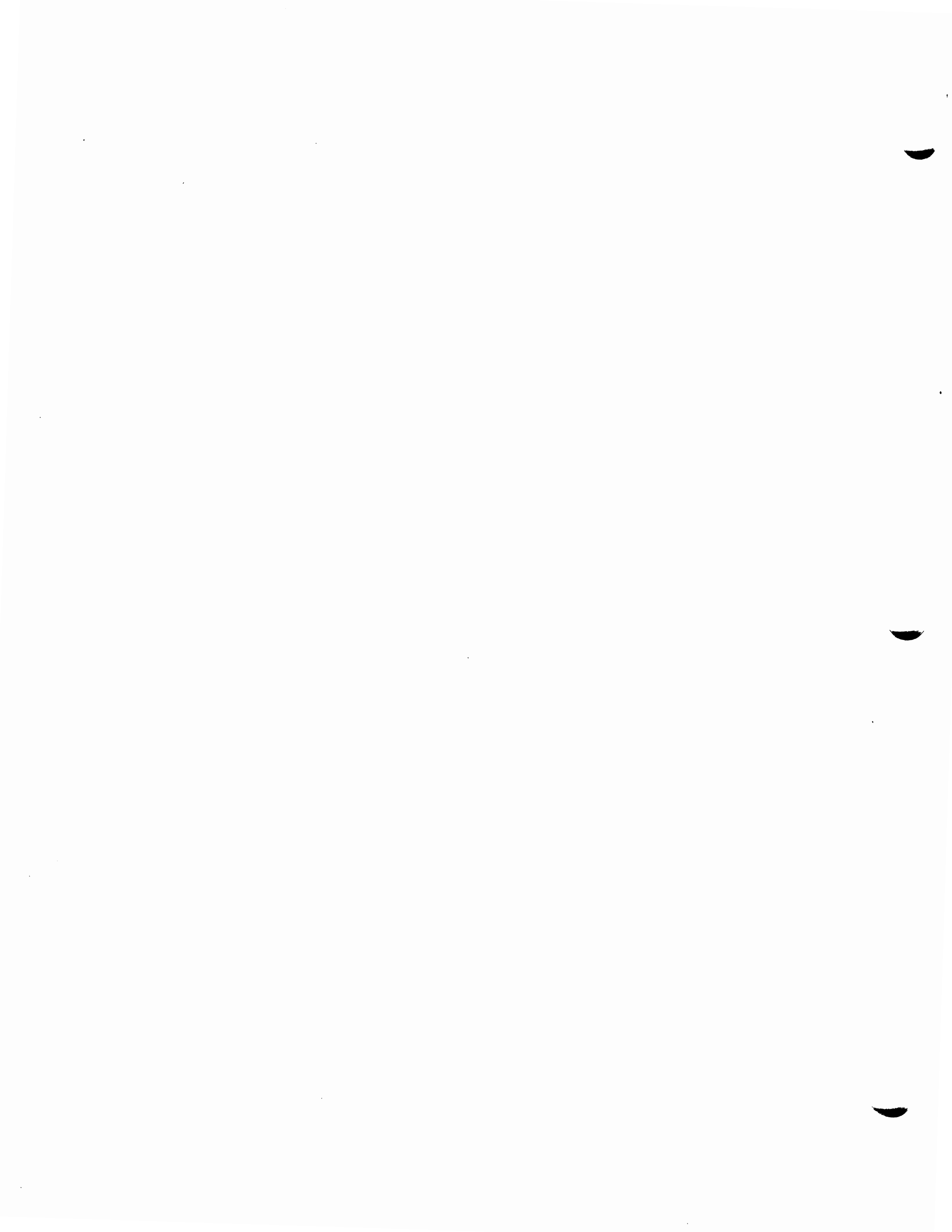
(c) For coverage of services rendered prior to date of application for Medicaid, the recipient shall apply for retroactive eligibility, in accordance with N.J.A.C. 10:49–1.1.

10:52–1.5 Covered Services (Inpatient and Outpatient)

(a) Inpatient services which shall be covered by the Division are those services ordinarily furnished by an approved hospital maintained for the treatment and care of patients and provided to any Medicaid recipient for whom professionally developed criteria and standards of care were used to determine that the recipient warranted an appropriate hospital level of care for a given diagnosis and/or problem.

1. Inpatient psychiatric services in approved beds in a general hospital for patients of any age shall be covered services.

2. Inpatient room and board service shall be provided in a semi-private accommodation. Accommodations other than semi-private require certification of medical necessity or lack of availability of semi-private accommodations.



3. Inpatient services in an acute general hospital rendered the day after acute care is no longer medically necessary shall be covered only under specified conditions. (See Social Necessity Days in N.J.A.C. 10:52–1.11 and Administrative Days in N.J.A.C. 10:52–1.6.)

4. Non-physician services, supplies and equipment supplied by an outside vendor to Medicaid recipients who are receiving inpatient acute care hospital services shall be covered directly under the hospital reimbursement system. Vendor claims for these services are the responsibility of the acute care hospital where the recipient is a patient and shall not be billed directly to the Medicaid fiscal agent.

5. For recipients in the Medically Needy Program, inpatient hospital services shall be available only to pregnant women. For information on how to identify a Medicaid recipient in the Medically Needy Program, refer to N.J.A.C. 10:49–2.3(b)4, Administration.

(b) The Division shall pay for eligible ancillary services provided during a non-covered period in an acute care hospital in the following situations:

1. When the Utilization Review Organization (URO) denies the entire admission for acute level of care; and,

2. When the URO certifies the admission as acute but "carves out" days from the approved continued stay. For eligible ancillary services that were provided during days that were "carved out" or "non-covered" and occurring in an inlier stay, no additional reimbursement by Medicaid shall be made, since the services are already included in the DRG reimbursement rate; and

3. When the URO certifies that only part of the stay is acute.

(c) Medically necessary inpatient psychiatric services provided in an approved private psychiatric hospital shall be covered by the Division for any Medicaid recipient age 65 or older; or for any other Medicaid recipient before attaining the age of 21, except that a recipient receiving the services immediately before attaining age 21 may continue to receive the services until they are no longer needed or until the recipient reaches age 22, whichever occurs first.

(d) Outpatient services that shall be covered by the Division are those medically necessary items or services (preventive, diagnostic, therapeutic, rehabilitative, or palliative) provided to an outpatient, by or under the direction of a physician or dentist, except for the supervision of the certified nurse midwife services, pursuant to the rules of the Division and applicable Federal regulations, including those services listed below:

1. Outpatient psychiatric services in general hospitals and private psychiatric hospitals for patients of all ages;

2. Same Day Surgery shall be covered by the Division when the Medicaid recipient:

i. Is identified on the UB–92 claim form as a 131 or 136 bill type in accordance with N.J.A.C. 8:31B–2.1; and,

ii. Is discharged before midnight of the day of admission so the admission date and discharge date are the same; and,

iii. Had surgery performed in a fully equipped operating room, for example, one routinely equipped and capable of providing general anesthesia, and identified by an operating room charge on the claim; and,

iv. Had a normal discharge, for example was not transferred, did not leave "against medical advice", and was not discharged dead. (See N.J.A.C. 8:31B–3.11 and 8:31G–32—Same day surgery.)

3. Physician services in hospitals (outpatient) (that is, specifically unbundled physicians): A physician practicing in a hospital outpatient department whose reimbursement is not part of the hospital's cost may bill fee-for service if the arrangement with the hospital permits it.

4. Family planning services including medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

5. The Norplant System (NPS) shall be a Medicaid covered service when provided as follows:

i. The NPS is used only in reproductive age women with established regular menstrual cycles;

ii. The Food and Drug Administration (FDA)-approved physician prescribing information is followed; and

iii. Patient education and counseling are provided relating to the NPS, including pre and post insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

iv. The visit relating only to the insertion and removal of the Norplant System (NPS) is not reimbursable on the day of insertion or removal.

v. Only two insertions and two removals of the NPS per recipients are permitted during a five year continuous period.

vi. The hospital shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intra-uterine device.

(e) Transfer from one outpatient facility to another outpatient facility, or a change from an outpatient facility to a private practitioner's care is allowable; however, effort shall be made to avoid duplication of diagnostic tests or services.

(f) For policies and procedures for Ambulatory Surgical Centers, see N.J.A.C. 10:52-2.1 and N.J.A.C. 10:66-5, Independent Clinic Services.

(g) For policies and procedures for hospital-affiliated home health agencies, see N.J.A.C. 10:52-2.5 and N.J.A.C. 10:60, Home Care Services.

(h) For policies and procedures for Medical Day Care Centers (Hospital Affiliated), see N.J.A.C. 10:52-2.6 and N.J.A.C. 10:65, Medical Day Care Services.

(i) For policies and procedures for HealthStart (Comprehensive Maternity and Pediatric Care Services), see N.J.A.C. 10:52-3. For policies and procedures for Early and Periodic Screening Diagnostic and Treatment, see N.J.A.C. 10:52-2.5.

(j) For other policies and procedures related to specific services, both inpatient and outpatient, see N.J.A.C. 10:52-2.

10:52-1.6 Non-Covered Services (Inpatient and Outpatient)

(a) Non-covered services (inpatient and outpatient) that shall not be eligible for payment by the Division are as follows:

1. Hospital admissions of the following description:

i. Admission for any condition for which hospitalization is not medically necessary;

ii. Admission primarily for rest cure, custodial care, convalescent care, or diet therapy for exogenous obesity;

iii. Admission for illnesses which, according to generally accepted professional standards, are not amenable to favorable modification. However, psychiatric services in a general hospital shall be covered for the purpose of determining that such disorders or illness (such as senility) are not amenable to favorable modification;

iv. Admission for diagnostic procedures which may be done on out-of-hospital basis, including but not limited to laboratory tests, electrocardiograms, and diagnostic radiological services;

v. Admission or extension of hospital stay solely for research or teaching studies;

vi. Admission for inpatient services provided in an approved private psychiatric hospital unless:

(1) The Medicaid recipient is age 65 or over; or,

(2) The Medicaid recipient has not attained age 21, except that an individual receiving such services immediately preceding the date on which he or she attained age 21 will continue to be covered until the date the individual no longer requires such services or the date the individual reaches age 22, whichever occurs first; and,

vii. Admission of recipients in the Medically Needy Program, except for pregnant women. For information on how to identify a Medically Needy recipient, see N.J.A.C. 10:49-2.3(b), Administration.

2. Any service or item requiring prior authorization (see N.J.A.C. 10:52-1.7, Prior authorization) which has been performed without prior authorization.

3. Medically unnecessary items and services, as follows:

i. Any service or item which is not medically necessary for the prevention, diagnosis, palliation, rehabilitation, or treatment of a disease, injury or condition;

ii. Inpatient hospital services rendered prior to the day it is medically necessary for the diagnostic services and/or surgical or medical treatment for which the patient is admitted.

iii. Inpatient hospital services rendered after the day it is medically necessary in a general hospital, except when special circumstances, that is, "social necessity", to prevent the discharge or transfer of the patient or when an inpatient is eligible for "administrative days" (see N.J.A.C. 10:52-1.12, Social Necessity and N.J.A.C. 10:52-1.7, Administrative Days).

iv. Inpatient hospital services denied for lack of medical necessity shall not be covered.

4. Private duty nursing services in the hospital inpatient setting;

5. Research or Teaching Studies;

6. Surgery (Elective), as follows:

i. Cosmetic Surgery, except that the Division shall consider authorization of a request from the patient's physician for elective cosmetic surgery, if a significant redeeming medical necessity can be demonstrated; and,

ii. Second Opinion Elective Procedures without meeting the Second Opinion requirement (see N.J.A.C. 10:52-1.11—Second Opinion Program);

7. Transportation, except as in N.J.A.C. 10:52-2.15—Transportation Services (Hospital-based);

8. Fee-for-service billed by a hospital-based physician who is salaried and whose services are reimbursed as part of the hospital's cost;

9. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory, radiological and diagnostic services and surgical procedures:

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose then the hospital shall submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, Mail Code # 14, Trenton, New Jersey 08625–0712;

10. Other services and items not directly related to the care of the patient, such as:

i. Inpatient items and services including guest meals and accommodations, television, telephone, and similar items and services. Personal items shall be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items; and,

ii. Outpatient items and services which are not usually part of the outpatient service; for example, eyeglasses, custom-made limbs and braces, or surgical supplies.

11. Services and items that are billed by, and payable to, another vendor;

12. Services and items furnished by the hospital, for which the hospital does not normally charge;

13. Services and items not medically required for the diagnosis or treatment of a disease, injury or condition; and,

14. Services provided to a patient during the same period for the same condition by both private practitioner and outpatient facility, or by two different facilities, shall not be covered. Payment shall be made for only one service, except in an emergency. (For definition of an emergency, see N.J.A.C. 10:49–6.1, Administration.)

Case Notes

No reimbursement for inpatient services provided while patient awaiting placement in skilled nursing care facility. Monmouth Med. Center v. State, 158 N.J.Super. 241 (App.Div.1978), affirmed 80 N.J. 299 (1979), certiorari denied 444 U.S. 942 (1979).

10:52–1.7 Administrative Days (Nursing Facility Level of Care)—General, Special (Classification A & B) and Private Psychiatric Hospitals

(a) For a patient who is no longer in need of inpatient acute level of care and who is awaiting placement in a nursing facility, payment shall be made for "administrative days" if the general, special, rehabilitation, or the private psychiatric hospital demonstrates that:

1. All other possible health insurance benefits have been utilized;

2. Discharge planning was initiated upon admission of the patient to the hospital, reviewed, and updated regularly. Within one working day of identifying a Medicaid recipient as being at risk for nursing facility placement, the hospital notified the Medicaid District Office and the county welfare agency (CWA). See N.J.A.C. 10:52–1.9 in this chapter—Pre–Admission Screening for Nursing Facility Placement;

3. The care and services provided are medically necessary, that is, the attending physician wrote a discharge order from acute care or made a written entry in the medical record that the patient could be transferred to a nursing facility (NF); and a Pre–Admission Screening Evaluation (PAS) confirmed the necessity for nursing facility services; and

4. Placement could not be made in a NF, as substantiated by documentation of timely and continuous contact (at a minimum, twice a week) with family members, nursing facilities (NFs), and placement agencies.

(b) Upon satisfaction of all the conditions listed under (a)1 through 4 above, payment will be made at the statewide weighted average per diem rate paid to Medicaid participating NFs, as determined on January 1 of each year;

(c) N.J.S.A. 30:4D–6.7 and 6.8 requires every nursing facility in the State to reserve a Medicaid recipient's bed up to 10 days when the recipient is transferred from the nursing facility to a general or private psychiatric hospital. If the discharged Medicaid recipient is unable to return to the nursing facility before the end of the 10 day period, the discharged recipient shall have priority for the next available Medicaid bed in the facility. When the recipient is admitted to the hospital under the bed reserve policy, the hospital shall:

1. Involve the NF in the preparation of the hospital's discharge planning; and,

2. Advise the NF of an anticipated discharge date; and,

3. Keep the NF informed of the patient's progress, particularly if something unexpected happens which causes a revision to the discharge plan; and,

4. Give the NF as much advanced notice as possible to prepare for the return of the patient; and,

5. When the 10 day bed reserve is exceeded and no bed is available in the NF from which the recipient was transferred, the hospital must provide the level of NF care determined by the Medicaid Regional Staff Nurse during the Pre–Admission Screening Evaluation until such time as a bed is available to the Medicaid recipient. (See N.J.A.C. 10:52–1.9.)

(d) For the information of hospital staff assisting in the discharge of a patient to a NF, N.J.S.A. 30:4D–17.3, prohibits, in general, a NF from requiring private pay contracts or donations under certain conditions on behalf of Medicaid recipients. To enforce this prohibition, the law establishes both criminal and civil penalties. (See also N.J.A.C. 10:49–9.7, Administration.)

(e) N.J.S.A. 10:5–12.2 of the New Jersey Civil Rights Act prohibits a NF from discriminating against Medicaid eligible persons and recipients of municipal general assistance by denying them admission when the NF's Medicaid occupancy level is below the Statewide occupancy level.

(f) Provisions for reimbursement of administrative days (nursing facility level of care) do not apply to special hospitals (Classifications A and B).

10:52–1.8 Prior authorization

(a) Prior authorization shall be required for certain dental procedures (see N.J.A.C. 10:56, Dental Services) and partial hospitalization provided in the outpatient department of an acute care hospital beyond exempt time frames (see N.J.A.C. 10:52–2.9(c).)

(b) Other services require adherence to special procedures, such as the requirements of the Second Opinion Program, before certain elective surgical procedures are performed. Specific services are described in the "Policies and Procedures for Providing Specific Services", in N.J.A.C. 10:52–2. Hospital entitlement to Medicaid payment is subject to providing these services in accordance with the policies and procedures as outlined. For general information about prior and retroactive authorization, see N.J.A.C. 10:49–6.1, Administration.

(c) For out-of-State services, see 42 CFR 431.52. Prior authorization as outlined in (d) below shall be required for inpatient and outpatient hospital services provided to a recipient outside the State of New Jersey, except as provided in (e) below. Hospital covered services for a recipient with an HSP (Medicaid) Case Number with the 1st and 2nd digits of 90 or the 3rd and 4th digits of 60, residing out-of-State at the discretion of the New Jersey Department of Human Services, shall not require prior authorization. However, any covered service that requires prior authorization as a prerequisite for payment to New Jersey Medicaid providers also requires prior authorization if it is to be reimbursed by the Division in any other State, except that prior authorization is not required for emergency and interstate transfers.

(d) A request for authorization for reimbursement for out-of-State services shall be directed to the Medicaid District Office (MDO) in the area where the recipient resides except as listed in (d)1 below. For a listing of MDOs, see the Directory at the end of the N.J.A.C. 10:49, Administration.

1. Exception: Prior authorization of out-of-State psychiatric services shall be directed to the psychiatric consultant in the Office of Medical Affairs and Provider Relations of the Division of Medical Assistance and Health Services, in accordance with N.J.A.C. 10:54, Physician Services.

2. For a recipient who resides in New Jersey in other than a hospital and who is to be admitted or referred to an out-of-State hospital for elective inpatient or outpatient services, the physician planning such action shall sign a statement that the medically necessary service is not available at a reasonable distance within the State of New Jersey; and

3. For a recipient who is traveling outside New Jersey and who is to be admitted to an out-of-State hospital for elective surgery, the attending physician shall justify by a signed statement that an attempt to return to a New Jersey hospital would create a significant risk to life or health or would create the need for an unreasonable amount of travel for the recipient.

4. The Division shall notify, in writing, the physician making the request.

i. If authorized, the authorization letter of the Medical Consultant of the Division shall be forwarded to the requesting physician. When arranging for hospital admission, the physician shall forward a copy of the authorization letter to the hospital. When submitting the claim for services to the fiscal agent, the hospital shall attach the authorization letter, or a copy of the letter, to the claim.

(e) Prior authorization shall not be required for emergencies nor for interstate hospital transfers. However, in these instances, the hospital shall attach the attending physician's signed statement to the claim, attesting to the nature of the emergency or, for a hospital interstate transfer, attesting to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey.

(f) For Medicaid recipients who have the diagnosis of Head Injury, for whom it is medically necessary to discharge from a hospital or special hospital to a special program in a NF, or to home care through the Traumatic Brain Injury Waiver Program, the hospital discharge planner and/or social worker shall obtain prior authorization for the placement (for either in-State or out-of-State patients) from the Medicaid District Office in the county where the recipient is residing. For information on the Traumatic Brain Injury Waiver program, see N.J.A.C. 10:60–5.2 and 5.3 and N.J.A.C. 10:49–17.5, Administration.

10:52–1.9 Pre–Admission screening for nursing facility (NF) placement

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

"Pre–Admission Screening" (PAS) means that process by which all Medicaid eligible recipients seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF, receive a comprehensive needs assessment by the Regional Staff Nurse to determine their long term care needs and the most appropriate setting for those needs to be met, pursuant to N.J.S.A. 30:4D–17.10. (P.L. 1988, c.97.)

"Pre–Admission Screening and annual resident review (PASARR)" means that process by which all individuals with mental illness (MI) or mental retardation (MR), regardless of payment source, are screened prior to admission to a NF and annually thereafter in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition.

"PASARR Level I" means the process of identification of individuals diagnosed with a serious mental illness (MI) or mental retardation (MR).

"PASARR Level II" is the process of evaluating and determining whether NF services and specialized services are needed.

"Specialized Services for Mental Illness (MI)" means those services offered when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based on a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24–hour supervision for the individual, specific therapies and activities are prescribed, with the following objectives: a) to diagnose and reduce behavioral symptoms; b) to improve independent functioning; and c) as early as possible, to permit functioning at a level where less than Specialized Services are appropriate. Specialized Services go beyond the range of services which a NF is required to provide.

"Specialized Services for Mental Retardation (MR)" means those services required when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24–hours per day, to teach the individual functional skills. Specialized Services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is required to provide.

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared by the Medicaid Regional Staff Nurse (RSN) during the Pre–Admission Screening (PAS) assessment process. The HSDP reflects the individual's current or potential problems, required care needs, and the Track of Care, and shall be forwarded to the authorized care setting.

"Nursing Facility (NF)" means an institution (or distinct part of an institution) certified for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24–hour basis to Medicaid recipients (children and adults) who, due to medical disorders, developmental disabilities, and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for the care and treatment of mental diseases which require continuous 24–hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

"Regional Staff Nurse (RSN)" means a registered professional nurse employed by the Division who performs health needs assessments as required by this section.

"Track of Care" means designation of the setting and scope of Medicaid services as determined by the PAS process conducted by the RSN following assessment of the Medicaid recipient or potential Medicaid recipient, as follows:

1. "Track I" means long-term NF care;

2. "Track II" means short-term NF care; and,

3. "Track III" means long-term care services in a community setting.

(b) Pre-Admission Screening (PAS) authorization shall be required prior to admission to a Medicaid certified NF of a Medicaid recipient, or an individual who may become a Medicaid recipient within six months following placement in a Medicaid certified NF. The Medicaid Regional Staff Nurse (RSN) will assess each individual's care needs and determine the appropriate setting for the delivery of needed services. The RSN will authorize or deny NF placement based on service requirements at N.J.A.C. 10:63–2 and the feasibility of alternative placement and will designate the track of care, in accordance with N.J.A.C. 10:63–1.11.

(c) PAS authorization is also required for individuals identified as having MI or MR regardless of the payment source. The PASARR assessment and authorization process shall be subsumed within the State's PAS protocols, as required by (d) below.

1. PASARR Level I Identification Screens shall be required for individuals diagnosed as MI, MR, or related conditions.

2. An individual is considered to have mental illness (MI) if he or she has a serious mental illness, such as schizophrenia, mood disorder, paranoia, panic or severe anxiety disorder, or similar condition, diagnosable in the

Diagnostic and Statistical Manual of Mental Disorders (DSMIII–R; 1987 edition) (available from the American Psychiatric Association, 1400 K St. NW, Washington, DC 20005), which leads to a chronic disability and which meets the PASARR requirements for diagnosis, level of impairment, and duration of illness.

i. An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSMIII–R; 1987 edition) and does not have a serious mental illness.

3. An individual is considered to have mental retardation if he or she has a level of retardation (mild, moderate, severe or profound) described in the "American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983)" or a related condition, as defined by, and pursuant to, Section 1905(d) of the Social Security Act (Omnibus Budget Reconciliation Act of 1987—P.L. 100–203); 42 U.S.C. 1396(d), and i below. An individual with a diagnosis of MR or a related condition and a diagnosis of dementia must have the PASARR Level II Specialized Service Screen, prior to admission to a Medicaid certified nursing facility.

i. "Persons with related conditions" means individuals who have severe, chronic disability that meet all of the following conditions:

(1) Persons who have diagnosis of mental retardation (MR) or other developmental disability, such as cerebral palsy, epilepsy, autism, spina bifida, or other neurological impairment;

(2) Persons who have a history or past records that show that the onset of the mental retardation or related conditions occurred prior to age 22; and

(3) The disability is severe and chronic in nature.

4. PASARR Level II Specialized Services Screens shall be conducted for mentally ill or mentally retarded individuals only if the Medicaid RSN's assessment results in authorization of NF placement.

i. Level II Specialized Services Screens require that a psychiatric examination be performed by a Board eligible/certified psychiatrist to determine the need for specialized services, in accordance with (e) below.

ii. Level II Specialized Services Screens for MR individuals will be performed by the Division of Developmental Disabilities (DDD) to determine the need for specialized services, in accordance with (d) below.

5. After an initial PASARR assessment has been completed, the individual transferred from a nursing facility to an acute care general hospital or to a psychiatric hospital with an admitting diagnosis of MI, shall not require a Level II Specialized Services Screen or a PAS nursing facility assessment prior to readmission to a nursing facility. If the individual is transferred to a different facility, the hospital discharge planner shall advise the admitting NF of the individual's former NF placement.

6. For individuals diagnosed with Alzheimer's or related dementias, documentation to support the diagnosis, including the history, physical examination and diagnostic workup shall be provided to the admitting Medicaid certified nursing facility for the individual's clinical record.

7. Hospitals shall not transfer individuals to Medicaid certified NFs until Level II Specialized Service Screens have been conducted and the hospital has received MDO notification that specialized services are not required.

(d) The determination of the necessity for NF services shall be performed through Pre-Admission Screening (PAS), as mandated by N.J.S.A. 30:4D–17.10. The Medicaid Regional Staff Nurse (RSN) shall determine the necessity for nursing facility services for Medicaid recipients, for individuals who may become Medicaid recipients within six months following admission to a Medicaid certified facility, and for individuals identified as meeting PASARR Level I criteria. The MDO having jurisdiction for the area where an acute care hospital is located has the responsibility for completing the PAS assessment, regardless of the recipient's county of residence or anticipated county of discharge.

1. The Medicaid RSN shall:

i. Review the medical, nursing, and social information obtained at the time of assessment, as well as any other supporting data;

ii. Assess the individual's care needs;

iii. Determine the appropriate setting for the delivery of needed services;

iv. Authorize or deny NF placement based on service requirements at N.J.A.C. 10:63–2 and the feasibility of alternative care;

v. Designate the track of care; and

vi. Advise the discharger planner and/or social worker of the appropriate setting for the delivery of needed services and, if appropriate, for the need for the PASARR Level II Specialized Services Screen.

2. The Medicaid RSN shall schedule and perform the assessment process within three working days of the hospital discharge planner and/or social worker's initial contact with the MDO. Individuals who exhibit unstable, severe medical conditions, such as a patient in the Intensive Care or Coronary Care Unit, shall not be referred for PAS until that condition has stabilized.

3. A signed "Release of Information form (MCNH–69 Rev. 11/89)" shall be obtained from the patient. If the patient refuses NF placement, home care services, or participation in the PAS assessment process, the Medicaid RSN shall make every effort to obtain a signed participation declination statement, which shall be included in the patient's MDO case record.

4. NF placement approval: The Medicaid RSN shall verbally advise the hospital discharge planner and/or social worker and patient and/or family of the assessment decision.

i. For a Track I or II determination, the Medicaid RSN shall leave a copy of the HSDP and signed approval letter with the discharge planner/social worker. For individuals requiring Level II Specialized Service Screens, the signed approval letter shall be forwarded only after the determination has been made that no specialized services are required.

ii. For a Track III determination, the Medicaid RSN shall leave a copy of the HSDP and signed approval letter with the discharge planner and/or social worker to forward to the home care provider. The discharge planner and/or social worker shall arrange needed home health services and forward a copy of the HSDP and signed approval letter to the home care agency. A Track III determination shall not be an authorization for NF services.

iii. The original approval letter signed by the Medicaid RSN shall be sent by the MDO to the patient and/or family with copies to the county welfare agency (CWA).

iv. A copy of the HSDP that was left with the hospital discharge planner and/or social worker by the Medicaid RSN, shall be attached to the hospital discharge material and forwarded with the patient to the admitting NF.

(1) If the patient being transferred will be eligible for Medicare benefits, the transfer shall be made to a Medicare participating NF.

5. NF placement denial: The Medicaid RSN shall verbally advise the hospital discharge planner and/or social worker and patient and/or family of the assessment decision. The Medicaid RSN shall leave a signed copy of the NF placement denial letter with the discharge planner/social worker. The original denial letter, signed by the Medicaid RSN, shall be sent to the patient and/or family by the MDO, with copies to the CWA.

(e) The hospital discharge planner and/or social work staff shall be responsible for identifying a Medicaid recipient inpatient or a Medicaid applicant inpatient who may be at risk of NF placement.

1. The identification process shall also include any inpatient in need of NF care who may become a Medicaid recipient within six months after NF admission and individuals meeting PASARR Level I criteria. (See N.J.A.C. 10:52–1.8(c).) These patients shall be referred by the hospital to the MDO and the CWA or the basis of the "At–Risk Criteria for Nursing Facility Placement and Referral to the Medicaid Office for PAS Evaluation" in (f) below. Medicaid recipients already residing in Medicaid participating facilities who are transferred to an acute care hospital and who are returning to either the same or a different NF, shall not require PAS authorization.

i. Within one working day of identifying an inpatient as being at risk for NF placement, the Hospital Discharge Planner and/or Social Worker shall:

(1) Make a telephone or FAX referral to the MDO and the CWA; and,

(2) If not already a Medicaid recipient, generate a Public Assistance Inquiry (PA–1C) to initiate the application process for Medicaid.

(3) Within two working days of the telephone referral to the MDO and CWA, the Hospital Discharge Planning Office shall forward the completed "Hospital Pre–Admission Screening Referral (PAS–5, 2/90)" to the MDO, unless it was "faxed" on the day of the referral.

2. The PASARR Level II Specialized Service Screens shall be performed by a Board eligible or Board certified psychiatrist for final determination, as follows:

i. The hospital discharge planning unit and/or social services department shall immediately arrange through the individual's attending physician, a consultation by a Board eligible or Board certified psychiatrist to complete the "Psychiatric Evaluation (DMH & H, 1994) form. (The "Psychiatric Evaluation" form shall not be completed until such time as the Medicaid RSN has approved Medicaid-certified NF placement.)

ii. Within 48 hours of the psychiatrist's review of the recipient or potential Medicaid recipient, the completed "Psychiatric Evaluation" form shall be sent to the Division of Mental Health and Hospitals, CN–727, Trenton, New Jersey 08625–0727, Attention: PASARR Coordinator.

(1) A supply of the "Psychiatric Evaluation" form may be ordered from the PASARR Coordinator in the Division of Mental Health and Hospitals.

iii. The MDO shall contact the appropriate Regional Office of the Division of Developmental Disabilities (DDD) agency to advise them of the need for a MR Level II Specialized Service Screen. The MR Level II Specialized Service Screen will be completed by the DDD staff within three working days of the MDO contact.

iv. The final determination of the specialized services review by the DMH & H and/or DDD agencies shall be communicated to the Medicaid District Office who, in turn, shall provide the hospital discharge planning unit and/or social services department with the approval or denial decision for placement in a Medicaid NF.

(f) The "At–Risk Criteria for Nursing Facility Placement and Referral to the Medicaid Office for PAS" shall be

utilized by the hospital in determining if a referral for long term care services, either in an NF or in the community, is indicated, as follows:

i. The medical criteria are as follows. Has the patient experienced any of the following:

(1) Catastrophic illness requiring major changes in lifestyle and/or living conditions, that is, multiple sclerosis, stroke, multiple trauma, AIDS, amputation, neurological disease, cancer, birth defect(s), and end stage renal disease.

(2) Debilitation and/or chronic illness causing progressive deterioration of self-care skills, that is, severe chronic disease, spina bifida, progressive pulmonary disease or diabetes.

(3) Multiple hospital admissions within the past six months. (Do not refer patients admitted directly from NFs.)

(4) Previous NFs admissions within the past two years.

(5) Major health needs, that is, tube feedings, special equipment or treatments, rehabilitation/restorative services.

ii. The social criteria are as follows: In addition to the medical criteria, does the patient meet any of the following social situations:

(1) Homeless;

(2) Lives alone and/or has no immediate support system;

(3) Primary caregiver is not able to provide required care services; or

(4) Lack of adequate support systems.

iii. The financial criteria are as follows. Does the patient meet any of the income and asset tests:

(1) Currently eligible for Medicaid;

(2) Monthly income at/or below the current institutional specified at N.J.A.C. 10:71–5.6.

(A) Has no spouse in the community and resources no greater than those specified at N.J.A.C. 10:71–4.4 and 4.5;

(B) Has no spouse in the community and resources at/or below $26,000. (This is an indication that the patient may become Medicaid eligible within the next six months by spending down assets in an NF as private pay); or

(C) Has a spouse in the community with combined countable resources at or below $52,000. (This allows for calculation of the community spouse's resources under Medicare Catastrophic Coverage Act of 1988.)

(3) Monthly income at/or below the current New Jersey Care Special Medicaid programs maximum monthly income limit specified at N.J.A.C. 10:72–4.1 and:

(A) Has no spouse in the community and resources no greater than those specified at N.J.A.C. 10:71–4.4 and 4.5;

(B) Has no spouse in the community and resources at/or below $28,000. (This is an indication that the patient may become Medicaid eligible within the next six months by spending down assets in a NF as private pay; or

(C) Has a spouse in the community with combined countable resources and/or below $56,000. (This allows for calculation of community spouse's resources under the Medicare Catastrophic Coverage Act of 1988.)

(g) The hospital discharge planner and/or social worker shall be responsible for the discharge or placement arrangements of the patient.

1. For each hospital patient referred for PAS, the hospital shall complete and send to the MDO a "Hospital Pre–Admission Screening Discharge form (PAS–6, 2/90)".

i. For any patient discharged to a NF, a Discharge Package (HSDP, discharge paper work, MDO approval letter, hospital transfer sheet, and PASARR documentation including the documentation which supports a diagnosis of Alzheimer's disease or related organic dementia) shall be compiled to accompany the patient to the NF.

(1) If the patient being transferred to a NF is eligible for Medicare benefits, the transfer shall be made to a Medicare participating NF.

ii. For those recipients discharged to community locations, the hospital social worker and/or discharge planner shall be responsible for the implementation of the HSDP by securing home care services.

10:52–1.10 Recordkeeping

Hospitals shall be required to keep legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. This information shall be available upon the request of the Division or its agents.

10:52–1.11 Second opinion program for elective surgical procedures

(a) A second opinion shall be obtained for any elective surgical procedures listed under (b) below. The outcome of the second opinion shall have no bearing on payment. Once the second opinion is rendered, the beneficiary shall retain the right to decide whether or not to proceed with the surgery; however, failure to obtain a second opinion for these procedures shall result in a denial of the hospital claim.

1. If the operating physician determines that the need for surgery is urgent or is an emergency, no second opinion shall be required. "Urgent" or "emergency" includes any situation in which a delay in performing surgery in order to meet the second opinion requirement could result in a significant threat to the patient's health or life.

i. Reimbursement for urgent or emergency surgery shall be made only if a specific statement is attached to the claim form by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. If the Medicaid or NJ KidCare beneficiary is covered by another health insurance carrier (except Medicare) which makes only partial payment on the claim, the fiscal agent shall not make supplementary payment unless the second opinion requirement has been met. However, the fiscal agent shall make payment on the claim if the hospital receives documentation that a second opinion was arranged for and paid for by another health insurance carrier. A copy of this documentation shall be attached to the claim form.

(b) The following elective surgical procedures fall under the Second Opinion Program:

1. Hernia Repair (common abdominal wall type);

i. A second opinion shall be required for any herniorrhaphy involving an adult over 18 years of age.

ii. A second opinion shall not be required for herniorrhaphy involving a child or young adult 18 years of age or under.

2. Hysterectomy (See also N.J.A.C. 10:52–2.13;

3. Laminectomy;

4. Spinal fusion;

i. A second opinion shall not be required for spinal fusion for scoliosis in a child or young adult 18 years of age or under.

(c) A second opinion shall be arranged through the Medicaid Second Opinion Referral Services of the Provider Services Unit at the fiscal agent.

1. A consultation ordered by a physician shall not meet the Program's definition of a second opinion and no "Authorization for Payment" shall be granted based on such a consultation. The only exception to this policy involves second opinions arranged and paid for by other health insurance carriers. (See (a)2 above.)

2. In order to prevent claim denial as a result of a situation in which one of the elective surgical procedures is scheduled and performed before the second opinion requirement is met, it is suggested that the elective surgery not be scheduled until after the second opinion has been rendered.

(d) Neither the physician claim nor hospital claim associated with one of the second opinion procedures shall be paid unless attached to the hard copy is an "Authorization for Payment," or documentation of a second opinion arranged through another health insurance carrier, or a specific statement from the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

1. Reimbursement shall not be made for a second opinion rendered to an individual who is not a Medicaid or NJ KidCare beneficiary. The issuance of a Second Opinion Referral to the beneficiary by the Program's Second Opinion Referral Services of the Provider Services Unit shall not guarantee the individual's eligibility on the date of the second opinion or subsequent surgery. The individual's current Medicaid or NJ KidCare eligibility shall be verified by checking the individual's current New Jersey Validation Form before rendering any service. (See N.J.A.C. 10:49–2.3, Administration—How to Identify a Medicaid or NJ KidCare beneficiary.)

(e) For physician requirements regarding Second Opinion procedures, see N.J.A.C. 10:54, Physician Services.

Amended by R.1998 d.352, effective July 20, 1998.
See: 30 N.J.R. 1258(a), 30 N.J.R. 2653(a).
In (a), substituted "beneficiary" for "recipient" in the introductory paragraph and inserted a reference to NJ KidCare in 2; in (b), rewrote 1, changed the N.J.A.C. reference in 2, and deleted 5; and in (d)1, substituted "beneficiary" for "recipient", deleted references to Medicaid, and inserted references to NJ KidCare throughout.

10:52–1.12 Social Necessity Days

(a) Payment for "Social Necessity Days" shall be made to hospitals for a maximum of 12 calendar days per hospitalization for a Medicaid recipient child admitted with the diagnosis of child abuse or suspected child abuse, if special circumstances (social necessity) prevent the discharge or transfer of the patient and the hospital has taken effective action to initiate discharge or transfer of the patient.

1. For these cases, it is not necessary for the day of admission to be at the acute level of care.

2. Effective action is defined as telephone notification to the County Welfare Agency (CWA), or Division of Youth and Family Services (DYFS) district office, or other responsible officials as may be designated, within 48 hours of the time that the stay is determined to be no longer medically necessary. This telephone contact shall then be confirmed in writing within three working days. A copy of the written notification shall be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).

3. Medicaid reimbursement for social necessity shall be made to hospitals paid in accordance with the DRG rate setting methodology in N.J.A.C. 10:52–5 through 9.

10:52–1.13 Utilization control (inpatient services)

(a) This section provides information on the requirements for utilization control for inpatient services for approved acute general hospitals, special hospitals, and private psychiatric hospitals. EXCEPTION: For inpatient psychiatric hospital services for individuals under the age of 21, refer to N.J.A.C. 10:52–1.14.

(b) For the purposes of this rule, the following words and terms shall have the following meanings:

"Utilization Control" means an approved program instituted, implemented and operated by or under the authorization of a utilization review organization (URO) which effectively safeguards against unnecessary or inappropriate Medicaid services and assesses the quality of those services to Medicaid recipients.

"Utilization Review Organization (URO)" means an organization designated and certified by the New Jersey State Department of Health, that has review authority over hospitals for specific functions for utilization review and quality assurance for all admissions to and continued lengths of stay at general hospitals in New Jersey. The review may be delegated or non-delegated and billed to the hospital under N.J.A.C. 8:31B–3.81.

(c) Under the Social Security Act, Section 1903(g) and (h), the Division is responsible for an effective program to control the utilization of services in hospitals. (See 42 CFR Part 456, Utilization Control, Subchapters B, C, and D). Included under utilization control are: Certification and recertification of the need for inpatient care; medical, psychiatric and social evaluations; a PoC established and periodically reviewed and evaluated by a physician; and a continuous program of utilization review under which the admission of each recipient is reviewed or screened. Hospital entitlement to Medicaid payment for services rendered to a Medicaid recipient for each period of hospitalization is subject to the following requirements:

1. A physician shall certify, for each recipient or applicant, that inpatient services in the acute care or in the private psychiatric hospital are or were needed.

i. The certification shall be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid program authorizes payment.

ii. The certification shall be in writing and signed, or initialed, by a physician. The signature or initials are not acceptable if they are rubber stamped unless the physician has initialed the stamped signature. The physician shall date the certification on the date he or she signs it.

iii. The certification for any Medicaid patient shall be maintained in the recipient's medical record.

iv. Acceptable documentation for certification or recertification may be any of the following:

(1) A statement, signed and dated, by the attending physician, staff physician, and/or consultant physician who has knowledge of the case, attesting that the recipient is in need of hospital care.

(2) Physician's orders which are signed and dated on admission and clearly attest to the need for hospital care.

(3) A medical evaluation which designates the services and which is signed and dated by a physician who has knowledge of the case.

(4) An admission review form signed and dated by an attending or staff physician who has knowledge of the case.

2. A physician shall recertify for each Medicaid recipient or applicant that inpatient services in a hospital are needed.

i. Recertification shall be made at least every 60 days after certification.

ii. The recertification shall be in writing, shall attest to the need for inpatient services, and shall be signed or initialed by a physician who has knowledge of the case.

iii. The physician shall date the recertification on the date that he or she signs it.

iv. The recertification shall demonstrate the need for the level and type of care that the recipient is receiving.

v. The recertification for any Medicaid recipient shall be maintained in the recipient's medical record.

vi. Acceptable documentation for recertification shall include any one of the following:

(1) A signed and dated statement by the physician who has knowledge of the case, attesting that continued care of a particular level or type is needed; or,

(2) Signed and dated orders by the physician who has knowledge of the case that clearly indicated that continued care is needed; or,

(3) Signed and dated progress notes by the physician who has knowledge of the case that clearly indicate that continued care is needed; or,

(4) Signed and dated reports that a physician might use in caring for the recipient that clearly indicate that continued care is needed; or,

(5) An admission certification or recertification form signed and dated by a physician who has knowledge of the case; or

(6) Utilization Review Committee (URC) minutes or form which indicate that the recipient's care was reviewed by a physician who had knowledge of the case and that continued care was needed. The physician's signature, with the date, shall be attached to the URC minutes or forms.

3. Any days billed by the hospital that are not in compliance with the certification/recertification requirements in (b)1 and 2 above shall be considered non-certified days and shall not be reimbursed by the Division.

i. Claims submitted that include non-certified days, (that is, "carved out" days or continued stay denials) as determined by the Division or its agents to affect billing, shall be billed "hard copy" and be accompanied by a certification of stay form.

(d) Before admission of an applicant or recipient to a private psychiatric hospital or before authorization for payment, the attending or staff physician shall make a medical evaluation of each applicant's or recipient's need for care in the hospital; and appropriate personnel shall make a psychiatric and social evaluation.

1. Each medical evaluation shall include the following:

i. Diagnoses;

ii. Summary of present medical findings;

iii. Medical history;

iv. Mental and physical functional capacity;

v. Prognoses; and,

vi. A recommendation by a physician concerning admission to the mental hospital, or continued care in the hospital for individuals who apply for Medicaid while in the private psychiatric hospital.

(e) Plan of Care (PoC): Before the admission of an applicant/recipient to an acute care general, special hospital, or private psychiatric hospital or before authorization for payment, a physician and other personnel in an acute care general and special hospital and the attending or staff physician in a private psychiatric hospital involved in the care of the individual shall establish a written PoC for each Medicaid recipient or applicant.

1. The PoC shall include:

i. Diagnoses, symptoms, complaints, and complications, indicating the need for admission;

ii. A description of the functional level of the individual;

iii. Objectives of the care (in private psychiatric hospitals only);

iv. Any order for diagnostic procedures; medications; treatments; consultations; restorative and rehabilitative services; patient activities; therapies; social services; diet; and, for private psychiatric hospitals only, special procedures for the health and safety of the patient;

v. Plans for continuing care, as appropriate; and, in a private psychiatric hospital, the review and modification of the plan of care; and,

vi. Plans for discharge, as appropriate.

2. Orders and activities shall be developed in accordance with the physician's instructions, (only for acute care general and/or special hospitals).

3. Orders and activities shall be reviewed and revised as appropriate by all personnel involved in the care of an individual (only for acute care general and/or special hospitals).

4. In acute care general and/or special hospitals, a physician and other personnel involved in the Medicaid recipient's case shall review each PoC at least every 60 days.

5. In private psychiatric hospitals, for recipients age 65 or over, the attending or staff physician and other personnel involved in the recipient's care shall review each PoC at least every 90 days; or,

6. Reports of evaluations and PoCs: A written report of each evaluation and plan of care shall be entered in the applicant's or recipient's record, as follows:

i. At the time of admission; or

ii. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

(f) For the Utilization Review (UR) Plan, each hospital shall evaluate the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. The UR includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices. (See 42 CFR 456.10 through 456.145, incorporated herein by reference.)

1. Upon admission of the patient to the hospital, a discharge plan shall be initiated and thereafter reviewed and updated regularly.

2. Any Medicaid recipient or potential Medicaid recipient who is considered for admission to a NF shall receive a pre-admission screening in accordance with N.J.A.C. 10:52–1.9.

3. When an inpatient is to be discharged from the hospital and continuing medical care is required, either in another medical facility (such as a NF, special hospital) or by a community health agency (such as a home health agency), the hospital shall provide the facility or agency with a legible abstract or summary of the patient's care while hospitalized and recommendations for further medical care.

i. This information shall be provided at the time of hospital discharge and shall be signed by the attending physician. The patient information transfer form (adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association) for a transfer from a hospital to a NF, or an equivalent transfer form, shall be used.

10:52–1.14 Utilization control: inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals

(a) This section specifies the unique requirements for certification of the need for inpatient psychiatric services provided to recipients under 21 years of age in private psychiatric hospitals. In accordance with Section 1905(a)16 and (h) of the Social Security Act, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the recipient's condition. This section also includes general requirements; certification of the need for services, which involves "active treatment" as defined in (c) below; requirements for the team certifying the need for services; and, requirements for an individual plan of care. These requirements do not apply to an admission to a psychiatric unit of a general hospital. See N.J.A.C. 10:52–1.12 for requirements on utilization control in an acute care general hospital.

(b) This rule applies only to inpatient psychiatric services in approved private psychiatric hospitals for the treatment of children and youths, before the recipient reaches age 21, or, if the recipient was receiving the services immediately before he reached age 21, before the earlier of the following:

1. The date the recipient no longer requires the services; or,

2. The date the recipient reaches age 22. (See 42 CFR 441.151).

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

1. "Active treatment" means implementation of a professionally developed and supervised PoC, as described in (f) below, that is:

i. Developed and implemented no later than 14 days after admission; and,

ii. Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

2. "Independent team" means a team that is not associated with the facility; for example, none of the members of the team has an employment or consultant relationship with the admitting facility. The independent team shall include a physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry and who has knowledge of the individual's clinical condition and situation.

3. "Interdisciplinary team", as described in federal regulations in 42 CFR 441.156, is comprised of those employed by, or those who provide services to Medicaid recipients in the facility or program, and include, as a minimum either a Board eligible or Board certified psychiatrist; or a physician and a clinical psychologist who has a doctoral degree; or a physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a Master's degree in clinical psychology or who has been certified by the State psychological association; and one of the following:

i. A psychiatric social worker;

ii. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;

iii. A psychologist who has a Master's degree in clinical psychology or who has been certified by the State or by the State psychological association; or,

iv. An occupational therapist who is licensed by the State in which the individual is practicing, if applicable, and who has specialized training or one year experience in treating mentally ill individuals.

4. "Plan of care (PoC)" means a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary.

(d) Certification of the need for services (see 42 CFR 441.152) shall be made by a team, either independent or interdisciplinary, as specified in (e) below. The team shall certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipients;

2. Proper treatment of the recipient's psychiatric condition, requires services on an inpatient basis under the direction of a physician are needed; and,

3. Services can reasonably be expected to improve the recipient's condition, or prevent further regression, so that inpatient services would no longer be needed.

(e) The certification of the need for services, as stated under (d) above, shall be made by teams, in accordance with Federal regulations, 42 CFR 441.153 and specified as follows:

1. Certification for the admission of a recipient: For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team, as described under (c) above.

2. Certification for inpatient applying for Medicaid: For an individual who applies for Medicaid while in the facility or program, the certification must be made by an interdisciplinary team responsible for the plan of care, as described under (c) above.

3. Certification—Emergency Admission: For emergency admission of a recipient, the certification must be made by the interdisciplinary team responsible for the plan of care, in accordance with Federal regulation, 42 CFR 441.156, and as described under (f)1 below.

(f) The individual PoC is as follows. Within 14 days of admission to a private psychiatric hospital, or before authorization for payment, the attending physician or staff physician must establish a written PoC for each applicant or recipient to improve the recipient's condition to the extent that inpatient care no longer is necessary, in accordance with (e) above. (See 42 CFR 456.180 and 456.181.)

1. The Plan of Care (PoC) shall:

i. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's clinical condition and situation, and reflects the need for inpatient psychiatric care;

ii. Be developed by a team of professionals as described in (g) below in consultation with the recipient, the recipient's parents, legal guardians, or others in whose care he or she will be released after discharge;

iii. State treatment objectives;

iv. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and,

v. Include, at an appropriate time, post discharge plans and coordination of inpatient services with partial discharge plan and related community services to ensure continuity of care with the recipient's family, school, and community, upon discharge.

2. The plan shall be reviewed every 30 days by the team to:

i. Determine that services being provided are or were required on an inpatient basis; and,

ii. Recommend changes in the plan as indicated by the recipient's overall adjustments as an inpatient.

(g) Functions of the interdisciplinary team developing the individual PoC are as follows:

1. The individual PoC as described under 42 CFR 441.156, shall be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the psychiatric hospital.

2. Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of the following:

i. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

ii. Assessing the potential resources of the recipient's family;

iii. Setting treatment objectives; and,

iv. Prescribing therapeutic modalities to achieve the plan's objectives.

10:52–1.15 Utilization control; outpatient psychiatric services

(a) The following policies and procedures in this rule were developed to help ensure the appropriate utilization of outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a PoC, performance of periodic reviews for evaluation purposes, and supportive documentation for services rendered. Outpatient psychiatric services include the initial evaluation; individual psychotherapy; group psychotherapy; family therapy; family conference; partial hospitalization (see N.J.A.C. 10:52–2.9); psychological testing; and medication management.

(b) The policy for intake evaluation shall be as follows:

1. An intake evaluation shall be performed within 14 days or by the third outpatient visit, whichever is later, for each Medicaid recipient being considered for continued treatment, and shall consist of a written assessment that:

i. Evaluates the recipient's mental condition; and,

ii. Determines whether treatment in the program is appropriate, based on the patient's diagnosis; and,

iii. Includes certification (signed statement) by the evaluation team that the program is appropriate to meet the patient's treatment needs; and,

iv. Is made part of the patient's records.

(c) The policy for the evaluation team shall be as follows:

1. The evaluation team for the intake process shall include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified, in accordance with 42 CFR 153).

(d) The policy for the Plan of Care (PoC) shall be as follows:

1. A written individualized PoC shall be developed by the evaluation team for each patient who receives continued treatment. The PoC shall be included in the pa-

tient's records and shall be designed to improve the patient's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The PoC shall consist of the following:

i. A written description of the treatment objectives which include the treatment regimen, the specific medical and remedial services, therapies, and activities that will be used to meet the objectives;

ii. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;

iii. A description designation of the type of personnel that will be furnishing the services; and,

iv. A projected schedule for completing reevaluations of the patient's condition and updating the PoC.

(e) Documentation for outpatient psychiatric services shall be as follows:

1. For psychiatric services, the outpatient department shall develop and maintain written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. Such documentation shall include, at a minimum, the following:

i. The specific services rendered, such as individual psychotherapy or family therapy;

ii. The date and the actual time services were rendered;

iii. The duration of services provided, such as 1 hour or ½ hour;

iv. The signature of the practitioner who rendered the services;

v. The setting in which services were rendered; and,

vi. A notation of unusual occurrences or significant deviations from the treatment described in the PoC.

2. Clinical progress, complications, and treatment which affect prognosis and/or progress shall be documented in the patient's medical record at least once a week for partial hospitalization, and at each patient contact or visit for other psychiatric services. Any other information important to the clinical picture, therapy, and prognosis shall also be documented.

i. The individual services provided under partial hospitalization shall be documented on a daily basis. More substantive documentation, including progress notes, and any other information important to the clinical picture shall be made at least once a week.

3. For services requiring prior authorization, such as partial hospitalization (see N.J.A.C. 10:52–2.10), a departure from the PoC requires a new request for prior authorization when a change in the patient's clinical condition necessitates an increase in the frequency and intensity of services, or change in the type of services which will exceed the services authorized.

(f) The policy for periodic reviews shall be as follows:

1. The evaluation team should periodically review the patient's PoC on a regular basis (at least every 90 days) to determine:

i. The patient's progress toward the treatment objectives;

ii. The appropriateness of the services being furnished; and

iii. The need for the patient's continued participation in the program.

2. The periodic reviews should be documented in detail in the patient's records and made available upon request of the Division and/or its agents.

SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

10:52–2.1 Ambulatory Surgical Center (ASC)

(a) An Ambulatory Surgical Center (ASC) shall be defined as follows:

1. Any distinct entity that operates for the purpose of providing surgical services to patients not requiring hospitalization; and,

2. Has an agreement with the Health Care Financing Administration (HCFA) to participate in the Medicare program; and,

3. Meets specific conditions for coverage set forth in Federal regulations in 42 CFR 416.2, Part B.

(b) An ASC may be operated by a hospital, that is under common ownership or control of a hospital.

1. An ASC operated by a hospital shall be a separately identifiable entity physically, administratively, and financially independent and distinct from other operations of the hospital. For policies and procedures concerning an ASC, see N.J.A.C. 10:66–2, Independent Clinic Services.

i. To apply as a provider of ASC services, contact the Chief, Provider Enrollment, Division of Medical Assistance and Health Services, CN–712, Mail Code # 9, Trenton, New Jersey 08625–0712.