# 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Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric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.

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## 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).

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

(b) Hospitals that perform organ transplants (with the exception of bone marrow transplants and corneas) must meet the following requirements for participation in the Medicare and Medicaid programs.

1. Payment for transplant services and organ procurement services rendered to or items dispensed or furnished a donor will be considered a charge on behalf of the Medicaid beneficiary .

(c) Federal organ procurement service requirements are listed in the Social Security Act, Section 1138 as amended by Section 9318(a) of the Omnibus Budget Reconciliation Act of 1986.

1. Organ procurement services, with the exception of bone marrow transplant and cornea procurement services, are covered only when the Organ Procurement Organization (OPO) meets the requirements as outlined in the Section 1138 of the Social Security Act (42 U.S.C. § 1320 (b)–8 Note) and when the OPO is designated and certified by the Secretary of the Department of Health and Senior Services and Human Services as the OPO for that geographical area in which the hospital is located.

(d) The covered organ transplantation procedures shall be performed in an organ transplant center approved or certified by a nationally recognized certifying or approving body, or one designated by the Federal government. In the absence of such a certification or approval of a nationally recognized body, the approval or certification, whichever applies, shall have been obtained from the appropriate body so charged in the State in which the organ transplant center is located.

(e) The candidate for transplantation shall have been accepted for the procedure by the transplant center. Such acceptance shall precede a request for prior authorization from the medical staff in the Office of Health Service Administration, if applicable. All out-of-State hospitalizations for transplantations shall require prior authorization from the MDO of the beneficiary's county of residence (see N.J.A.C. 10:49–6.2, Administration.) Prior authorization shall also be required for hospitalizations for procurement and transplantation services for Medicaid beneficiaries for anatomical sites not explicitly listed in (a) above, or previously considered experimental.

(f) Organ transplantations shall be medically necessary. Transplantations, with the exception of cornea transplantations, shall be performed only to avert a potentially life-threatening situation for the patient.

1. If all factors pertinent to decision-making concerning the site of performance of a transplant procedure are essentially equal, preference shall be given to a New Jersey transplant center. However, Medicaid policy of equitable access also applies (see 42 CFR 431.52(c)).

(g) Hospital inpatient services for an out-of-State organ procurement and transplantation shall require approval by the Medicaid District Office and shall be reimbursed according to the policies in the section on the Basis of Payment—Out-of-State Hospital Services in N.J.A.C. 10:52–4.4.

(h) For organ transplants for Medicaid or NJ KidCare beneficiaries enrolled with a managed care organization, the managed care organization shall be responsible for all costs, except for the costs of the hospital. Included in the hospital costs are the costs of procuring the organ. The hospital should bill the Fiscal Agent for these costs as part of the inpatient hospital claim.

Recodified from 10:52–2.8 and amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
In (b)1 and (e), substituted references to beneficiaries for references to recipients throughout; in (e), substituted a reference to the Office of Health Service Administration for a reference to the Office of Medical Affairs and Provider Relations; and added (h). Former N.J.A.C. 10:52–2.9, Psychiatric services; partial hospitalization, recodified to N.J.A.C. 10:52–2.10.

### 10:52–2.10 Psychiatric services; partial hospitalization

(a) Partial hospitalization (PH) means a psychiatric service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. A PH program shall provide, as listed below, a full system of services necessary to meet the comprehensive needs of the individual Medicaid or NJ KidCare fee-for-service beneficiary. These services shall include:

1. Assessment and evaluation;
2. Service procurement;
3. Therapy;
4. Information and referral;
5. Counseling;
6. Daily living education;
7. Community organization;
8. Pre-vocational therapy;
9. Recreational therapy; and,
10. Health-related services.

(b) Pre-vocational therapy, recreational therapy, and health related services, as required in (a) above, may be provided directly or arranged by partial hospitalization staff through other programs' elements or agencies. To avoid duplication of payment, these services shall not be billed separately from the claim submitted for partial hospitalization reimbursement.

(c) The requirements of the PH program shall include the following:

1. PH shall serve ambulatory, non-residential patients who spend only a part of a 24–hour period (a minimum of three hours of participation in active programming for a half day program exclusive of meals and a minimum of five hours of active participation in active programming for a full day program exclusive of meals) in the hospital.

i. Day, evening, or night care (night care shall include overnight stay) shall require prior authorization from the Division after the first 30 calendar days from the first date of treatment. Prior authorization from the Division shall not be required for the first 30 calendar days beginning from the first date of treatment.

2. A PH program shall be available daily for five days a week, with additional planned activities each week, during evening and/or weekend hours, as needed. Individual clients need not attend every day but as needed.

3. The staff of the PH program shall include a director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field, with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the PH program on a regularly scheduled basis. Other staff deemed necessary to implement a PH program shall include qualified mental health professionals, para-professionals, and volunteers.

(d) Prior authorization for PH from the Division shall be required after the first 30 calendar days from the date of the initial treatment. Each prior authorization for PH shall be granted for a maximum period of six months. Additional authorizations may be requested.

1. A detailed explanation and a new prior authorization request for PH is required when a departure from the plan of care is made because a change in the patient's clinical condition necessitates an increase in the frequency, duration, and intensity of services, or a change in the type of services which will exceed the services authorized.

2. When prior authorization is required, the request shall be submitted on the "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD–07)" and the "Request for Prior Authorization: Supplemental Information (FD–07A)" forms to the Medical Assistance Customer Center that serves the county in which the services are rendered.

3. The staff of the PH program shall include a director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field, with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the PH program, on a regularly scheduled basis. Other staff deemed necessary to implement a PH program shall include qualified mental health professionals, para-professionals, and volunteers.

4. The notification of the disposition (approved, modified, denied, or suspended) of the prior authorization request will be made by the Division's fiscal agent. When submitting a claim for reimbursement, the prior authorization number shall be provided on the UB–92 hospital claim form, in order for the claim to be paid by Medicaid/NJ KidCare.

5. The Division shall not reimburse a hospital for partial hospitalization and medical day care center services provided to the same beneficiary on the same day.

6. The Division also shall not reimburse a hospital for any mental health service (including medication management) in addition to partial hospitalization services provided to the same beneficiary on the same day.

Recodified from 10:52–2.9 and 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 in the introductory paragraph; and in (d), substituted a reference to the Division's fiscal agent for a reference to the Medicaid fiscal agent and added a reference to NJ KidCare in 4, and substituted references to beneficiaries for references to recipients in 5 and 6. Former N.J.A.C. 10:52–2.10, Rehabilitative services; hospital outpatient department, recodified to N.J.A.C. 10:52–2.11.
Special amendment, R.2002 d.82, effective February 15, 2002 (to expire December 21, 2004).
See: 34 N.J.R. 1279(a).
Rewrote (c)1i; in (d), inserted ", except as provided in (e) below"; added (e).
Special amendment, R.2002 d.191, effective May 24, 2002 (to expire December 21, 2004).
See: 34 N.J.R. 2149(a).
In (c), rewrote 1i; in (d), substituted "30" for "90" and deleted ", except as provided in (e) below"; deleted (e).
Amended by R.2003 d.182, effective May 5, 2003.
See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).
Rewrote (d)2.

### 10:52–2.11 Rehabilitative services; hospital outpatient department

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

1. "Rehabilitative services" means physical therapy, occupational therapy, speech pathology and audiology services, and the use of such supplies and equipment as are necessary in the pro-vision of such services.

2. "Occupational therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a Medicaid or NJ KidCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist. These services include necessary supplies and equipment.

3. "Occupational therapist" means an individual who is:

i. Registered by the American Occupational Therapy Association (AOTA); or,

ii. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association. If treatment and/or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure, if applicable, and shall also meet all applicable Federal requirements.