

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 As a part of R.1995 d.123, Chapter 52 was retitled Hospital Services Manual; existing Subchapters 1 through 4 were repealed, and new Subchapters 1 through 4 were adopted, effective April 17, 1995; and Subchapter 10 was adopted as new rules, effective April 17, 1995.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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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.

“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.

“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.

“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; and

9. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

“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;

4. An explanation concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure;

5. An offer to answer any inquiries concerning the procedures; and

6. An instruction that the individual is free to withhold or withdraw his or her consent to the procedure at any time prior to the sterilization without prejudicing his or her future care without loss of other project or program benefits to which the patient might otherwise be entitled;

7. The documentation referred to in this subsection must meet all applicable State and Federal requirements, and should be bilingual as necessary. (See N.J.A.C. 10:52-2.12 Sterilization).

“Inliers” means inpatient cases who display common or typical patterns of resource use that are assigned to DRGs and have a length of stay within the high and low trim points.

“Inpatient” means a patient who has been admitted to an approved hospital as an inpatient on the recommendation of a physician or dentist and receives room, board, and professional services in the hospital for a 24 hour period or longer, even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the hospital for 24 hours.

“Inpatient Hospital Services” means services that:

1. Are ordinarily furnished in a hospital for the care and treatment of inpatients;
2. Are furnished under the direction of a physician or dentist, except, as specified in 42 CFR 440.165 of the Social Security Act, for services provided by a certified nurse midwife;
3. Are furnished in an institution that:
 - i. Is maintained primarily for the care and treatment of patients with disorders including obstetrical services and services to the normal newborn;
 - ii. Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
 - iii. Except in the case of medical supervision of nurse-midwife services, as specified in 42 CFR 440.165 of the Social Security Act, or private inpatient psychiatric facilities for children under 21 years of age, meets the requirements for participation in Medicare as a hospital; and,
 - iv. Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30 of the Social Security Act, unless a waiver has been granted by the U.S. Secretary of Health and Human Services.

“Labor Market Area” means counties and municipalities in the State that are grouped in accordance with similar labor costs.

“Neonate” means a newborn less than 29 days of age.

“Nontherapeutic sterilization” means any procedure or operation, the purpose of which is to render an individual permanently incapable of reproducing and which is not either a necessary part of the treatment of an existing illness or injury, or medically indicated as an accompaniment of an operation on the female genitourinary tract. For the purpose of this definition, mental incapacity is not considered an illness or injury.

“Outliers” means patients who display atypical characteristics relative to other patients in a DRG and have lengths of stay either above or below the established trim points.

“Outpatient” means a patient registered in the outpatient department of a hospital or in a distinct part of that hospital who is expected to receive and who does receive professional services for less than a 24 hour period, regardless of the hour of admission; or whether or not a bed is used; or whether or not the patient remains in the hospital past midnight.

“Outpatient hospital services” means medically necessary items or services (preventive, diagnostic, rehabilitative, therapeutic, or palliative) provided to an outpatient by or under the direction of a physician or dentist, except for the medical supervision of nurse midwife services, or private inpatient psychiatric facility under 21 years of age, by an institution that is licensed or formally approved as a hospital by the New Jersey State Department of Health or by the officially designated authority in the state in which the hospital is located and meets the requirements for participation in Medicare (Title XVIII) as a hospital.

“Patient” means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

“Physician” means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

“Physician services” means those services provided within the scope of practice of a doctor of medicine (M.D.) or osteopathy (D.O.) as defined by the laws of New Jersey, or if in practice in another state by the laws of that state, and which services are performed by or under the direction and/or personal supervision of the physician. (See also N.J.A.C. 10:54-1.2.)

“Preliminary Cost Base (PCB)” means the estimated revenue a hospital may collect based on an approved schedule of rates which includes DRG rate amounts and indirect costs not included in the all-inclusive rate. Those indirect costs will either be the dollar amount specified or the estimated amount determined by a specific percentage adjustment to the rate.

“Rate year” means the year in which current reimbursement takes place.

“Trim points” means the high and low length of stay cutoff points assigned to each DRG.

“Uniform Bill—Patient Summary (UB-PS or UB-92)” means the common billing and reporting form used by the hospital for each Medicaid inpatient.

Case Notes

Consent; bilateral salpingectomy and hysterectomy; purposes of Medicaid Reimbursement. *Centra State Medical Center v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 65.

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).

10:52-1.3 Eligibility; claim procedures

(a) A hospital shall adhere to the following procedure for completing the form, the “Public Assistance Inquiry (PA-1C)” to inform the appropriate agency that an individual intends to file a Medicaid application:

1. For those aged, blind or disabled persons with limited income and resources who appear to be eligible for Supplemental Security Income (SSI)/Medicaid, a hospital shall complete the form PA-1C and send it to the Social Security Administration (SSA) District Office serving their locale to initiate the eligibility process. The date of the inquiry shall protect the application date provided that the individual follows through with filing of an application.

2. For the aged, blind and/or disabled individuals, and/or pregnant women and/or certain children who do not qualify for or who do not want an SSI money payment from the Social Security Administration and/or do want to be a Medicaid recipient through “Medicaid Only” or New Jersey Care ... Special Medicaid Programs, a hospital shall complete the form PA-1C and send it to the appropriate county welfare agency (CWA).

3. A hospital shall submit the form PA-1C to the County Welfare Agency (CWA) immediately after the birth of a newborn of a mother who is or may become eligible for Medicaid. (Information on the newborn shall be included in item 1, 2, 4, 11a and 15 only. The mother’s signature shall be included in Item 23.)

i. There shall be no requirement for joint hospitalization of a mother and newborn as the sole condition for which claims for services to the newborn may be submitted using the mother’s Person Number.

ii. A mother who is a Medicaid recipient and her newborn shall have the same HSP (Medicaid) Case Number when they are a part of the same household, but each shall be assigned his or her own Person Number.

iii. A hospital shall be permitted to submit a claim for services to a newborn for 60 days from the date of the birth through the end of the month in which the 60th day occurs or until the newborn is assigned his or her own Person Number, whichever happens first.

iv. After the extended time frame of 60 days from the date of birth through the end of the month in which the 60th day occurs or upon the assignment of the newborn’s Person Number, the newborn’s personal data shall be used on the claim form as soon as it is available to the hospital. The mother’s personal data shall not be used on the claim form after this time frame or after the newborn’s Person Number is available to the hospital.

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.

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

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

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

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

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

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

10:52-3.16 Policy for reimbursement for HealthStart providers

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

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

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

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

10:52-3.17 HealthStart Maternity Care billing code requirements

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

1. Separate reimbursement shall be available for Maternity Medical Care Services and Maternity Health Support Services.
2. Maternity Medical Care Services shall be billed as a total obstetrical package, when feasible, but may be billed as separate procedures.
3. The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart Maternity Medical or Health Support Service.
4. The modifier "WM" in the HCPCS lists of codes (W9025 through W9030) refers to those services provided by certified nurse midwives who shall include the modifier at the end of each code. HCPCS codes for Health Support Services do not require the "WM" modifier on HCPCS codes W9040 and W9043.
5. Laboratory and other diagnostic procedures and all necessary medical consultations shall be eligible for separate reimbursement.

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

SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

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

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

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

(a) The Division will reimburse special hospitals (Classification A) (acute and short term special hospitals) and Classification B (Rehabilitation hospitals) for inpatient services (including the interim and final settlement), in accordance with Medicare principles: reimbursement (see 42 CFR 413).

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

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

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

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

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

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

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

3. Effective for services rendered on or after July 1, 1991 through October 6, 1996, the Division is reducing the interim reimbursement rates for covered outpatient services subject to the cost-to-charge ratio in general, special (Classification A), rehabilitation (Classification B) and private psychiatric hospitals by 4.4 percent. The final settlement for covered outpatient services subject to the cost-to-charge ratio is the lower of costs or charges minus 4.4 percent. Effective for services rendered on and after October 7, 1996, and until further notice, the Division shall reduce hospital outpatient capital cost by 10 percent and reasonable cost of hospital outpatient services (net of the outpatient capital cost) by 5.8 percent as reported in the Medicare Cost Report (HCFA-2552). This reduction shall be calculated when the Medicare Cost Report (HCFA-2552) is finalized and if the report is amended. The reduction shall apply to general, special (Classification A), rehabilitation (Classification B) and private psychiatric hospitals.

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

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

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

ii. Profiles and panels shall be reimbursed as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Emergency room visits for Medicaid recipients not admitted as inpatients are coded by the hospital as needing

primary care or non-primary care. (See N.J.A.C. 8:31B-3.23(e)).

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

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

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

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

Amended by R.1996 d.479, effective October 7, 1996.
See: 28 N.J.R. 3221(b), 28 N.J.R. 4479(b).

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

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

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

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

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

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

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

i. An example of acceptable documentation is a copy of the letter sent by the State Medicaid Agency to

the hospital specifying the Medicaid rate. The purpose of this information is to facilitate claims processing.

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

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

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

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

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

10:52-4.6 Medicare/Medicaid claims

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

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

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

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

10:52-4.7 Medicaid settlement

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

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

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

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

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

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

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