

CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

Source and Effective Date

R.2011 d.010, effective December 6, 2010.
See: 42 N.J.R. 1656(a), 43 N.J.R. 43(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 52, Hospital Services Manual, expires on December 6, 2017. See: 43 N.J.R. 1203(a).

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, Manual for Hospital Services, was readopted as R.1995 d.123, effective February 3, 1995. As a part of R.1995 d.123, Chapter 52 was renamed Hospital Services Manual, 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Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric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, 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: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Chapter 52, Hospital Services Manual, was readopted as R.2005 d.214, effective June 9, 2005. See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

Subchapter 14, Methodology for Establishing DRG Payment Rates for Inpatient Services at General Acute Care Hospitals Based on DRG Weights and a Statewide Base Rate, was adopted as new rules by R.2009 d.249, effective August 3, 2009. See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

Chapter 52, Hospital Services Manual, was readopted as R.2011 d.010, effective December 6, 2010. As a part of R.2011 d.010, Subchapter 10, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, was renamed Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, effective January 3, 2011. See: Source and Effective Date. See, also, section annotations.

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1. Reimbursement for out-of-State inpatient hospital services for organ transplantation and procurement provided to a Medicaid or NJ FamilyCare beneficiary 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/NJ FamilyCare program and the hospital performing the organ transplant.

2. 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.

(e) In addition to the provisions of N.J.A.C. 10:52-9.1(c) and (d), the following rate appeal procedure shall be followed for a rate appeal filed by an out-of-State hospital:

1. If an out-of-State hospital wishes to file an appeal concerning issues related to the rate of reimbursement, the appeal shall be filed by the hospital, in writing, to the following address within 20 calendar days after the filing of a rate appeal by the hospital to the State Medicaid agency in the state in which the hospital is located.

Division of Medical Assistance and Health
Services
Office of Administrative and Financial Services
PO Box 712, Mail Code #44
Trenton, New Jersey 08625-0712

2. The following limitations shall apply to the rate appeal procedure in (e)1 above.

i. The hospital shall submit with its rate appeal to the Division all appropriate documentation demonstrating that an appeal was filed with the State Medicaid agency in the state in which the hospital is located and the date that the appeal was filed.

ii. If the hospital did not file a timely appeal in the state in which it is located, the payment made by the New Jersey Medicaid or NJ FamilyCare program shall be considered the final payment.

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 "NJ KidCare beneficiaries" for "recipients", changed N.J.A.C. references, and added a new last sentence; rewrote (b); and added a new (e).

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) and (e), changed N.J.A.C. references; and in (c), substituted a reference to Medicaid and NJ KidCare beneficiaries for a reference to Medicaid recipients and substituted a reference to the Medicaid/NJ KidCare program for a reference to the Medicaid program in 1.

Amended by R.2005 d.214, effective July 5, 2005.

See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

In (a), amended the N.J.A.C. reference; in (c), designated the former last sentence of 1 as 2; substituted "FamilyCare" for "KidCare" throughout.

Recodified from N.J.A.C. 10:52-4.4 by R.2009 d.249, effective August 3, 2009.

See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

Former N.J.A.C. 10:52-4.5, Reimbursement for third-party claims, recodified to N.J.A.C. 10:52-4.6.

10:52-4.6 Reimbursement for third-party claims

On claims for hospital services rendered to Medicaid or NJ FamilyCare beneficiaries for services provided that are not the responsibility of an HMO and 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/NJ FamilyCare for covered services. (See N.J.A.C. 10:49-7.3.)

Amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Rewrote the section.

Amended by R.2005 d.214, effective July 5, 2005.

See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

Substituted "FamilyCare" for "KidCare" throughout.

Recodified from N.J.A.C. 10:52-4.5 by R.2009 d.249, effective August 3, 2009.

See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

Former N.J.A.C. 10:52-4.6, Medicare/Medicaid or Medicare/NJ FamilyCare claims, recodified to N.J.A.C. 10:52-4.7.

10:52-4.7 Medicare/Medicaid or Medicare/NJ FamilyCare claims

(a) Some patients may be covered under both Medicare and Medicaid or Medicare and NJ FamilyCare. When the Medicaid or NJ FamilyCare beneficiary is covered under both programs, Item 57 on the hospital claim form shall be completed showing the Medicaid or NJ FamilyCare Eligibility Identification Number.

(b) Reimbursement of the deductible and coinsurance for inpatient and outpatient services for Medicaid or NJ FamilyCare beneficiaries 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/NJ FamilyCare Program must be itemized for the Medicare non-covered services and the Medicaid or NJ FamilyCare Eligibility Identification Number, including Person Number, must be shown on the hospital claim form.

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

Amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Rewrote the section.

Amended by R.2005 d.214, effective July 5, 2005.

See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

Substituted "FamilyCare" for "KidCare" throughout.

Recodified from N.J.A.C. 10:52-4.6 by R.2009 d.249, effective August 3, 2009.

See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

Former N.J.A.C. 10:52-4.7, Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D, recodified to N.J.A.C. 10:52-4.8.

10:52-4.8 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D fee-for-service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services are \$5.00 a visit for outpatient clinic visits and \$10.00 for an emergency room visit that does not result in an inpatient hospital stay.

(c) Hospitals are required to collect the personal contribution to care for the above mentioned NJ FamilyCare-Plan C services if the NJ FamilyCare Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ FamilyCare form which indicates that the beneficiary has reached their cost share limit and no further personal contributions to care are required, until further notice. Personal contribution to care charges cannot be waived.

(d) Under NJ FamilyCare-Plan D, copayments in the amounts indicated below shall be collected by the hospital for the services as follows:

1. A \$5.00 copayment per visit shall be required for the following services:

- i. Outpatient rehabilitation services, including physical therapy, occupational therapy and speech therapy;
- ii. Hospital outpatient department visits and diagnostic testing;

(1) For prenatal care, the \$5.00 copayment shall apply only to the first visit;

2. A \$25.00 copayment per visit shall be required for outpatient mental health visits; and

3. A \$35.00 copayment per visit shall be required for outpatient emergency services including services provided in an outpatient hospital department or an urgent care facility.

- i. No copayment shall be required if the beneficiary was referred to the emergency room by his or her pri-

mary care provider for services that should have been rendered in the primary care physician's office or if the beneficiary is admitted into the hospital.

4. No copayment shall be charged for the following services:

- i. Outpatient surgery;
- ii. Inpatient hospital services;
- iii. Inpatient mental health services;
- iv. Inpatient substance abuse detoxification services; or
- v. Skilled nursing facility services.

(e) Hospitals shall collect the copayment specified in (d) above except for those situations outlined in (f) below. Copayments shall not be waived.

(f) Hospitals shall not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, including well child visits and age-appropriate immunizations; for lead screenings and treatment, or for preventive dental services provided to children under the age of 12.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:52-4.7, Medicaid settlement, recodified to N.J.A.C. 10:52-4.8.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

In (a), added reference to copayments for NJ KidCare-Plan D; added (d) through (f).

Amended by R.2005 d.214, effective July 5, 2005.

See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

Substituted "FamilyCare" for "KidCare" throughout.

Recodified from N.J.A.C. 10:52-4.7 by R.2009 d.249, effective August 3, 2009.

See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

Former N.J.A.C. 10:52-4.8, Settlement for Medicaid/NJ FamilyCare fee-for-service services, recodified to N.J.A.C. 10:52-4.9.

10:52-4.9 Settlement for Medicaid/NJ FamilyCare fee-for-service services

(a) The New Jersey Medicaid settlement agent for New Jersey acute care general (excluding inpatient services), special, rehabilitation, and private psychiatric and county governmental psychiatric hospitals shall determine the amount of disbursements, recoupments, and/or changes in per diem amounts and outpatient percentages, as applicable. The settlement agent shall inform the hospital and the Division of Medical Assistance and Health Services (Division/DMAHS) of the results of their review. If the settlement agent's review is accepted, DMAHS, through its fiscal agent for claims processing, shall perform the following processes: