

3. Has in effect a hospital utilization review plan applicable to all patients who received medical assistance

under Medicaid (Title XIX) and NJ KidCare (Title XXI); 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 and Senior Services 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:

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

i. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health and Senior Services;

ii. 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

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

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

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

“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, dentist or nurse midwife 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; and/or by a psychiatric hospital or an excluded unit of a general hospital and the institution is licensed or formally approved as a hospital by the New Jersey State Department of Health and Senior Services, or certified by the officially designated authority in the state in which the hospital is located; meets the requirements for participation in Medicare (Title XVI-II) as a hospital; and meets the criteria for participation as stated in N.J.A.C. 10:52-1.3.

“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-92)” means the common billing and reporting form used by the hospital for each Medicaid inpatient.

Amended by R.1997 d.396, effective September 15, 1997.
See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).

Added “Entity”; and amended “Hospital” and “Outpatient hospital services”.

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

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

Deleted “Adjusted admissions” and “Informed Consent”; inserted “DHSS”; in “Early and Periodic Screening, Diagnosis and Treatment (EPSDT)”, substituted references to Medicaid and NJ KidCare—Plan A beneficiaries for references to Medicaid recipients, and inserted “or age 19 for NJ KidCare—Plan A beneficiaries” following “age”; in “Hospital”, inserted a reference to 42 U.S.C. § 1395x(e) in the introductory paragraph; in Hospital (Approved General), inserted references to NJ KidCare in 1 and 3; in “Hospital (Approved Special)”, made internal designation changes; in “Inpatient”, inserted a reference to nurse midwives; in “Outpatient hospital services”, substituted “a psychiatric hospital or an excluded unit of a general hospital and the institution” for “private inpatient psychiatric facility for patients under 21 and over 65 years of age; and the institution that” following “and/or by”, and changed N.J.A.C. reference; and changed “Uniform Bill—Patient Summary (UB-PS or UB-92)” definition to “Uniform Bill—Patient Summary (UB-92)”.

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).

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.

10:52-1.2A (Reserved)

Recodified to N.J.A.C. 10:52-1.3 by R.2000 d.29, effective January 18, 2000.

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

10:52-1.3 Criteria for participation: outpatient hospital services

(a) The Division shall reimburse approved hospitals to provide covered outpatient hospital services, where applicable, in accordance with all the provisions of this chapter. In order to be approved and reimbursed as an outpatient hospital service, effective in accordance with the dates in (c) below, each site that provides an outpatient hospital service for which the hospital bills the Medicaid or NJ KidCare fee-for-service program as an outpatient hospital service shall have been approved by the Division of Medical Assistance and Health Services (known as the “Division”), in accordance with this rule. Such approval shall include sites located in the main inpatient hospital, and both the contiguous and non-contiguous sites.

(b) Each site shall meet all of the following criteria prior to receiving reimbursement from the Medicaid or NJ Kid-Care fee-for-service programs as an outpatient hospital service, effective in accordance with the dates in (c) below:

1. The entity shall be physically located in close proximity to the hospital, and both the entity and the hospital shall service the same patient population (such as from the same service or catchment area);

i. In determining close proximity, the following factors will be considered:

(A) The distance between the entity and the inpatient hospital facility;

(B) The physical location (inner-city, urban, suburban or rural area) of the inpatient hospital facility and the entity; and

(C) The availability of other inpatient hospital facilities providing the same services located closer to the entity than the hospital requesting the outpatient designation.

2. The entity shall be an integral and subordinate part of the hospital, and as such, shall be operated with other departments of that hospital under the common hospital licensure issued by the New Jersey Department of Health and Senior Services, in accordance with N.J.A.C. 8:43G, or under the certification provisions of the appropriate State agency, in accordance with N.J.A.C. 10:52-1.2;

3. The entity shall be included under the accreditation of the hospital as specified by N.J.A.C. 10:52-1.2 and that accrediting body shall have recognized the entity as part of the hospital;

4. The entity shall be operated under common ownership and control (such as common governance) by the hospital, as evidenced by the following:

i. The entity shall be subject to common bylaws and operating decisions of the hospital's governing body;

ii. The hospital shall have final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the entity; and

iii. The entity shall function as a department of the hospital with significant common resource usage of buildings, equipment and service personnel on a daily basis;

5. The entity director shall be under the direct day-to-day supervision of the hospital, as evidenced by the following:

i. The entity director or individual responsible for the day-to-day operations at the entity shall maintain a daily reporting relationship and be accountable to the chief executive officer of the hospital, and report

through that individual to the governing body of the hospital; and

ii. Administrative functions of the entity, such as, but not limited to, records, billing, laundry, housekeeping, and purchasing shall be integrated with those of the hospital;

6. Clinical services of the entity and the hospital shall be integrated as evidenced by the following:

i. Professional staff of the entity shall have clinical privileges in the hospital;

ii. The medical director of the entity, if the entity has a medical director, shall maintain a day-to-day reporting relationship to the chief medical officer or similar official of the hospital;

iii. All medical staff committees or other professional committees at the hospital shall be responsible for all medical activities in the entity;

iv. Medical records for patients treated in the entity shall be integrated into the unified records system of the hospital;

v. Patients treated at the entity shall be considered patients of the hospital and have full access to all hospital services; and

vi. Patient services provided in the entity shall be integrated into corresponding inpatient and/or outpatient services, as appropriate, by the hospital;

7. The entity shall be held out to the public as a part of the hospital, such that patients shall know that they are entering the hospital and shall be billed accordingly; and

8. The entity and the hospital shall be financially integrated as evidenced by the following:

i. The entity and the hospital shall have an agreement for the sharing of income and expenses; and

ii. The entity shall report its costs in the cost report of the hospital using the same accounting system for the same cost reporting period as the hospital's.

(c) In order for a service provided at the site to be reimbursed as an outpatient hospital service, effective on the date indicated in (c)2 and 3 below, the following reporting requirements shall be met for approval by the Division

1. If the location in which the services are provided is located in or contiguous to the main inpatient hospital the Division shall assume that these outpatient hospital services meet the criteria for participation pursuant to (b) above; therefore, the reporting requirements in (c)2 and 3 below shall not be required for these services. However, even though the services are located contiguous to the main inpatient hospital, (d) below shall apply.

2. All hospitals with existing entities as defined in this section, which do not meet the requirements in (c)

above, shall submit a report to the Division no later than October 15, 1997 indicating each location, the type of services provided, and how each entity meets the criteria for participation set forth in (b) above. The Division shall review each hospital's submission and determine whether or not the service provided at the entity is reimbursed appropriately as an outpatient hospital service in accordance with (b) above. A determination of and notification of the approval or denial for reimbursement as an outpatient hospital service shall be issued by the Division.

i. Pending the Division's review process, the entity shall be reimbursed at the interim rate, as specified by N.J.A.C. 10:52-4.3(a).

ii. If the entity is approved to be reimbursed for a specific outpatient hospital service, the service shall continue to be reimbursed as an outpatient hospital service in accordance with N.J.A.C. 10:52-4.3, effective on the date of approval.

iii. If the entity is denied approval for reimbursement of a specific outpatient service, the reimbursement for that service as an outpatient hospital service shall be discontinued 20 days after the date on the determination letter. However, for services provided prior to the date that reimbursement as an outpatient hospital service is discontinued, adjustments shall be made to the cost report for entities that are not considered hospital-based, in accordance with N.J.A.C. 10:52-4.3(a).

3. After September 15, 1997, all hospitals which intend to provide a new outpatient hospital service or existing service at a new location which is not contiguous to the inpatient hospital shall request and obtain approval from the Division before receiving Medicaid/NJ KidCare fee-for service reimbursement as an outpatient hospital service.

i. The hospital shall report to the Division the location of each entity, the type of service provided, and how each entity meets the criteria for participation set forth in (b) above.

ii. The Division shall review each hospital's submission and determine whether or not the service provided by the entity shall be reimbursed as an outpatient hospital service. A determination of and notification of the approval or denial as an outpatient hospital service shall be issued by the Division and include the effective date of the notification of the approval or denial.

4. All information necessary, as specified in (c)3i above, for the Division to determine whether or not the services provided at the entity are approved as outpatient hospital services shall be sent to the following address:

Division of Medical Assistance and Health Services
Provider Enrollment Unit
PO Box 712, Mail Code #9
Trenton, New Jersey, 08625-0712

5. In the event information is not submitted as required by (c)2 and 3 above, the service provided at the entity shall be neither approved nor reimbursed as an outpatient hospital service for services provided on or after September 15, 1997.

(d) Once the Division approves the entity to be reimbursed as an outpatient hospital service, the Division or its settlement agent, as specified in N.J.A.C. 10:52-4.7, shall ensure that the information submitted is in compliance with (b) above. A review may occur at any time at the Division's discretion, including, but not limited to, the time of the audit of the hospital's cost report. If it is determined that the service provided by the entity is not provided consistent with the criteria for participation, as specified in (b) above, the Division shall notify the hospital of its denial of the service and disallow the costs and the related reimbursement for any time that service or entity was not in compliance with these rules.

(e) Close proximity means the minimum distance between a hospital and an entity which will produce unduplicated services sufficient to meet the access and service needs of the population being served. The Division shall grant an exception to the close proximity requirement in (b)1 above on a case-by-case basis, if the exception provides access to the service by the population being served where access to the service has been limited. If an exception is granted for a specific service at an entity and that service changes, or the entity changes location, a hospital shall reapply for an exception. Requests for exceptions for entities existing prior to September 15, 1997 shall be sent to the Division in accordance with (c)2 above. A request for an exception for new entities attempting to be reimbursed as a hospital outpatient service after September 15, 1997 shall be sent to the Division in accordance with (c)3 above.

1. The following are examples of when the Division will grant an exception to the close proximity criterion stated in (b)1 above.

i. When access and/or availability to a particular service within a particular geographic area is limited; or

ii. When the availability of transportation to a particular service within a particular geographical area is limited.

(f) If the services provided at the entity are not approved by the Division as an outpatient hospital service, the entity may apply as a provider of another type of service to the Provider Enrollment Unit of the Division or the fiscal agent, as appropriate, consistent with N.J.A.C. 10:49-3 and 4, and the procedures for enrollment as indicated in the appropriate provider services manuals, such as for clinics, in N.J.A.C. 10:66, Independent Clinic Services, or in N.J.A.C. 10:54, Physician Services.

(g) If the hospital is not satisfied with the Division's determination, all appeals shall meet the requirements of the administrative hearing process in accordance with N.J.A.C. 10:49-10.3.

New Rule, R.1997 d.396, effective September 15, 1997.

See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).

Recodified from N.J.A.C. 10:52-1.2A 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) and (b), inserted references to NJ KidCare fee-for-service programs; and in (c)3, inserted a reference to NJ KidCare fee-for-service reimbursement. Former N.J.A.C. 10:52-1.3, Eligibility; claims procedures, recodified to N.J.A.C. 10:52-1.4.

10:52-1.4 Use of PA-1C for applying for benefits for a hospital patient

(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 children who do not qualify or who do not want an SSI money payment from the Social Security Administration and/or do want to be a Medicaid beneficiary 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 board of social services (CBOSS).

3. A hospital shall submit the form PA-1C to the county board of social services (CBOSS) 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 beneficiary and her newborn shall have the same Medicaid Eligibility Identification 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 CBOSS with a note of explanation (see also N.J.A.C. 10:49-2 in Administration for further information on Medicaid eligibility).

Recodified from N.J.A.C. 10:52-1.3 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 references to beneficiaries for references to recipients and substituted references to CBOSS for references to CWA throughout, and substituted a reference to Medicaid Eligibility Identification Numbers for a reference to HSP (Medicaid) Case Numbers in 3ii. Former N.J.A.C. 10:52-1.4, Eligibility of recipient for hospital services, recodified to N.J.A.C. 10:52-1.5.

10:52-1.5 Eligibility of beneficiary for hospital services

(a) Hospital services shall not be reimbursed by Medicaid or NJ KidCare fee-for-service programs when hospital services were rendered prior to and after period of beneficiary eligibility, as determined in accordance with N.J.A.C. 10:49-2.7; except that, when a Medicaid beneficiary 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 beneficiary shall apply for retroactive eligibility, in accordance with N.J.A.C. 10:49-1.1

Recodified from N.J.A.C. 10:52-1.4 and amended by R.2000 d.29, effective January 18, 2000.

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

Substituted references to beneficiaries for references to recipients throughout; and in (a), inserted a reference to NJ KidCare fee-for-service programs, and changed N.J.A.C. reference. Former N.J.A.C. 10:52-1.5, Covered Services (Inpatient and Outpatient), recodified N.J.A.C. 10:52-1.6.

10:52-1.6 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 or NJ KidCare fee-for-service beneficiary for whom professionally developed criteria and standards of care were used to determine that the beneficiary 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. 10:52-1.14 and Administrative Days in N.J.A.C. 10:52-1.9.)

4. Non-physician services, supplies and equipment supplied by an out-side vendor to Medicaid beneficiaries 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 beneficiary is a patient and shall not be billed directly to the Medicaid or NJ KidCare fiscal agent.

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

(b) The Division shall pay for eligible ancillary services provided during a non-covered period in an acute care hospital for 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 or NJ KidCare-Plan A, B, or C fee-for-service 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 beneficiary age 65 or older; or for any other Medicaid or NJ KidCare beneficiary before attaining the age of 21, except that a Medicaid beneficiary receiving the services immediately before attaining age 21 may continue to receive the services until they are no longer needed or until the beneficiary reaches age 22, whichever occurs first.

(d) Outpatient services include 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:

i. Identified on the UB-92 claim form as a 131 or 136 bill type in accordance with N.J.A.C. 8:31B-3.11(a)1;

ii. The patient shall be discharged before midnight of the day of admission so the admission date and discharge date are the same;

iii. The patient shall have 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. The patient shall have 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 Same day surgery.)

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

(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. 10:52-2.6 and N.J.A.C. 10:60, Home Care Services.

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

Amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

10:52-3.16 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 HCFA 1500 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, EPSDT Referral Report.

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), substituted a reference to HCFA 1500 claim forms for a reference to 1500 N.J. claim forms in 1, and substituted a reference to EPSDT Referral Report for a reference to Report and Claim for EPSDT/Health—Start 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 8, 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).

Amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
Changed N.J.A.C. reference.

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

(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 Medicaid and NJ KidCare program will reimburse special hospitals (Classification C) according to the rules and reimbursement methodology of N.J.A.C. 10:63, Long Term Care Services.

(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 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.

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), substituted a reference to the Medicaid and NJ KidCare program for a reference to the Division; and in (c), deleted N.J.A.C. reference.

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

(a) The Division shall reimburse general hospitals, special hospitals (Classification A), rehabilitation hospitals (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care hospitals for covered outpatient hospital services provided in outpatient hospital departments approved by the Division as meeting the criteria for participation, in accordance with N.J.A.C. 10:52-1.3(b) and 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) private and governmental psychiatric hospitals, and distinct units of acute care 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 and governmental psychiatric hospitals, and distinct units of acute care 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 schedule using the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) procedure codes and the fee schedule contained in the N.J.A.C. 10:52-13. 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. 10:52-13.3); 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 NJ KidCare 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 NJ KidCare fee-for-service 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. 10:52-13.2;

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