
SUBCHAPTER 1. GENERAL PROVISIONS

10:52-1.1 Purpose and scope

(a) This chapter outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid and NJ FamilyCare fee-for service beneficiaries. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and psychiatric hospitals, unless specifically indicated otherwise.

(b) Unless otherwise stated, the rules of this chapter apply to Medicaid and NJ FamilyCare fee-for-service beneficiaries and to Medicaid and NJ FamilyCare fee-for-service services which are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services which are to be provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO in accordance with the Division's rules for MCOs at N.J.A.C. 10:74, the MCO's policies and procedures, and the MCO's provider contract with the State, and all amendments thereto.

Petition for Rulemaking.
See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).
Amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
In (a), substituted a reference to Medicaid and NJ KidCare fee-for service beneficiaries for a reference to Medicaid recipients, and substituted a reference to psychiatric hospitals for a reference to private psychiatric hospitals; and added (b).

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), substituted "FamilyCare" for "KidCare"; rewrote (b).

10:52-1.2 Definitions

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

"Adult acute partial hospital" or "APH" means an intensive and time-limited acute psychiatric service for beneficiaries 18 years of age or older who are experiencing, or are at risk for, rapid decompensation. This mental health service is intended to minimize the need for hospitalization.

"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.

"Centers for Medicare & Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program.

"Current Cost Base" means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period for the purposes of rate setting.

"DHSS" means the State Department of Health and Senior Services.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications, and consumption of a similar amount of resources.

"Disproportionate share hospital" means a hospital designated as such by the Commissioner of the Department of Human Services, in accordance with N.J.A.C. 10:52-13.

"Division" means the New Jersey Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

"Division of Disability Services (DDS)" means the agency located within the Department which is designated as the agency responsible for information and referral for all individuals with disabilities.

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid and NJ FamilyCare-Children's Program-Plan A beneficiaries under 21 years of age for the purpose of assessing a beneficiary's health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

"Entity," as used in N.J.A.C. 10:52-1.3, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

"Equalization Factor" means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs in setting Statewide standard costs per case.

"Financial Elements" means the reasonable cost of items approved as reimbursable under Medicaid (see N.J.A.C. 10:52-5.9).

"Group outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders which involves a group of usually four to 12 beneficiaries who have similar problems and treatment needs. The group meets regularly with a therapist who uses the interaction of the group members to relieve distressful symptoms and modify beneficiaries' behavior.

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

"Hospital" means, pursuant to section 1861(e) of the Social Security Act (42 U.S.C. § 1395x(e)), an institution which meets the following requirements:

1. Is primarily engaged in providing 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 rehabilitation services for the rehabilitation of injured, disabled, or sick persons or is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons;

2. Maintains clinical records on all patients;

3. Has by-laws in effect with respect to its staff of physicians;

4. Requires every patient to be under the care of a physician;

5. 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;

6. 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;

7. 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;

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

9. For the purposes of N.J.A.C. 10:52-1.3 only, is where the main inpatient hospital services are located.

"Hospital (Approved General)" means an institution which is approved to participate as a provider in the Division if it:

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid/NJ FamilyCare 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 received medical assistance under Medicaid (Title XIX) and NJ FamilyCare-Children's Program (Title XXI); and

4. Has signed a provider agreement to participate in and abide by Federal and State laws and 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 Federal and State laws and 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 is approved to participate as a provider in the Division if it meets the appropriate standards of participation for either a Special (Acute care or short term) or a Comprehensive Rehabilitation Hospital and:

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

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 Federal and State laws and regulations.

"Individual outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders that is tailored for a beneficiary and is administered one on one, in sessions which last between 30 minutes and one hour and which are provided on a regular basis for a defined period of time.

"Inliers" means inpatient cases which 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.

"Medical social worker" means an individual who is licensed or certified in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G and meets the Medicare certification requirements for education (See 42 U.S.C. § 1395x).

"Medication management" means medication services to evaluate, prescribe or administer and monitor a beneficiary's use of psychotropic medications provided by, or under the supervision of, a licensed physician or APN.

"Medication monitoring" means medication services provided to monitor a beneficiary's use of psychotropic medications under the supervision of a licensed physician or APN.

"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 XVIII) as a hospital; and meets the criteria for participation as stated in N.J.A.C. 10:52-1.3.

"Partial hospital" or "PH" means an individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

"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.

"State fiscal year" means the State of New Jersey's fiscal year, which begins July 1 and ends the following June 30.

"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)".
Amended by R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).
Added "Disproportionate share hospital".
Amended by R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).
Rewrote the section.
Amended by R.2007 d.59, effective February 5, 2007.
See: 38 N.J.R. 4359(a), 39 N.J.R. 456(a).
Added definitions "Adult acute partial hospital", "Group outpatient hospital psychiatric services", "Individual outpatient hospital psychiatric services", "Medication management", "Medication monitoring" and "Partial hospital".

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 FamilyCare fee-for-service program as an outpatient hospital service shall have been approved by 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 FamilyCare 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.

ii. Pursuant to P.L. 2001, c.393, specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services shall not be subject to the close proximity criterion contained in (b)1 above. However, such pediatric facilities shall be subject to all other criteria set forth in (b)2 through 8 below.

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)1 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 FamilyCare 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
Office of Hospital Reimbursement
PO Box 712, Mail Code #44
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.

6. The Offsite Location (entity) Certification Form (FD-392) can be requested from the above address.

5. If a hospital is not satisfied with the Division's determination, the hospital may request an administrative hearing pursuant to N.J.A.C. 10:49-10. If the hospital elects to request an administrative hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision, adopting, modifying or rejecting the Administrative Law Judge's initial decision. Thereafter, review may be sought in the Appellate Division.

(c) Prior authorization shall be required for patients with prognoses that necessitate lengths of stay in excess of 30 days. Reimbursable patient days shall be subject to utilization review requirements as specified in N.J.A.C. 10:52-1.15.

(d) The Medicaid and NJ FamilyCare program will reimburse special hospitals (Classification C) according to the rules and reimbursement methodology of N.J.A.C. 8:85, Long Term Care Services.

(e) 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.

(f) 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.
Amended by R.2002 d.376, effective November 18, 2002.
See: 34 N.J.R. 2247(a), 34 N.J.R. 2549(b), 34 N.J.R. 3980(b).
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).
In (a), substituted "2001" for "2002" preceding ", c.393"; in (d), substituted "FamilyCare" for "KidCare" preceding "program" and amended the 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 413.1; 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 413.1. 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.

i. Hospitals shall notify the Division of any changes made to the hospital's charge structure or cost-to-charge ratios. Notice shall be given 30 days prior to implementation of the change, in writing, addressed to:

Office of Hospital Reimbursement
Division of Medical Assistance and Health Services
PO Box 712 Mail Code #44
Trenton, NJ 08625-0712

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 including the fiscal year ending June 30, 2001, 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 (CMS-2552). This reduction shall be calculated when the Medicare Cost Report (CMS-2552) is finalized and if the report is amended. Effective for fiscal years ending on or after July 1, 2001, the Division shall reduce hospital outpatient capital cost by 10 percent and the reasonable cost of hospital outpatient services (net of the outpatient capital cost) by 5.8 percent. The 5.8 percent reduction will be calculated during the interim and final settlement process of the Medicare cost report (CMS-2552) and if the report is amended. The 10 percent outpatient capital cost reduction will be calculated at final settlement and if the cost 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, Medicare deductible and coinsurance amounts and all outpatient psychiatric services for individuals 22 years of age and over 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 Healthcare Common Procedure Coding System (HCPCS) procedure codes and the fee schedule contained in the N.J.A.C. 10:52-10. 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) shall be 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 GOOO1 and 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 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 FamilyCare 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. 10:52-10.1;

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) shall be reimbursed at 100 percent of the composite rate and shall include 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 pediatric continuity of care services shall be reimbursed on a fee-for-service basis in the hospital outpatient department. All other HealthStart maternity and pediatric care services shall be reimbursed based on the cost-to-charge ratio. See N.J.A.C. 10:52-3.16.

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 or NJ FamilyCare fee-for-service 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 shall not be subject to the cost-to-charge ratio and are reimbursed at 100 percent of the amounts.

8. All outpatient psychiatric services provided to individuals 22 years of age and over shall be paid at the lower of charges or prospective unit rates.

i. Separate unit rates shall be reimbursed for the following service categories as defined in N.J.A.C. 10:52 and 10:52A:

(1) Adult acute partial hospital services shall be billed on an hourly basis using revenue code 913. At least two hours per day of services shall be billed, but not more than five hours. The hourly unit rate is $65.00. When revenue code 913 is billed, no other outpatient psychiatric revenue code can be billed on the same date of service.

(2) Partial hospital services shall be billed on an hourly basis using revenue code 912. At least two hours per day shall be billed, but not more than five hours. The hourly unit rate is $35.00. When revenue code 912 is billed, no other outpatient psychiatric revenue code can be billed on the same date of service.

(3) Individual outpatient hospital psychiatric services shall be billed on a unit basis of 30 minutes using revenue code 914. The daily billing limit is two units per day. The half hour unit rate is $40.00.

(4) Initial evaluations shall be billed on a unit basis of 30 minutes using revenue code 918. The daily billing limit is four units per day. The half hour unit rate is $50.00.

(5) Group outpatient hospital psychiatric services shall be billed on an hourly basis using revenue code 915. The billing limit is three hours per week. The hourly unit rate is $30.00.

(6) Medication monitoring and medication management shall be billed on a unit basis of 15 minutes using revenue code 919. The daily billing limit shall be two units per day. The 15 minutes unit rate is $34.00.

ii. Costs related to all outpatient psychiatric services for individuals 22 years of age and over shall be excluded from outpatient cost settlements. Hospitals shall maintain a separate cost center on the Medicare cost report for all outpatient psychiatric services, regardless of the age of the individuals treated. Hospitals shall report all psychiatric outpatient costs, charges and statistics in this separate cost center.

(c) Emergency room visits for treatment of conditions that are not the responsibility of an HMO or for Medicaid or NJ FamilyCare fee-for-service beneficiaries who are not admitted as inpatients shall be coded by the hospital as requiring primary care or non-primary care.

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 beneficiary for the reason that such beneficiary does not require services on an emergency basis.

4. The cost of emergency room services for a Medicaid/NJ FamilyCare fee-for-service beneficiary for the treatment of a condition that is not the responsibility of an HMO when the beneficiary is admitted as an inpatient shall be allocated to the inpatient rates and shall not be reimbursed through the outpatient hospital's 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).
Amended by R.1997 d.396, effective September 15, 1997.
See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).
Rewrote (a).
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 governmental psychiatric hospitals for references to psychiatric hospitals and inserted references to distinct units of acute care hospitals throughout, and changed N.J.A.C. reference in the introductory paragraph; in (b)1, substituted a reference to fee-for-service schedules for a reference to fee-for-service in the introductory paragraph, changed N.J.A.C. reference in i, and substituted a reference to Medicaid NJ KidCare for a reference to Medicaid in ii(1); in (b)2i, substituted a reference to Medicaid NJ KidCare fee-for-service reimbursement for a reference to Medicaid reimbursement, and changed N.J.A.C. reference; in (b)6i, inserted a reference to NJ KidCare fee-for-service; and rewrote (c).
Amended by R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).
Rewrote the section.
Amended by R.2007 d.59, effective February 5, 2007.
See: 38 N.J.R. 4359(a), 39 N.J.R. 456(a).
In the introductory paragraph of (b), deleted "and the" preceding "Medicare" and substituted "and all outpatient psychiatric services for individuals 22 years of age and over" for a comma following "amounts"; and added (b)8.

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

(a) The Division shall 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 or NJ FamilyCare beneficiaries if the hospital meets the requirements of the Division and the services are prior authorized pursuant to N.J.A.C. 10:52-1.10. Reimbursement of inpatient hospital services is outlined in (b) through (c) below, and for outpatient services is outlined in (d) below. See (e) below for the procedure for rate appeals for out-of-State hospitals.

(b) Reimbursement for inpatient hospital services for an out-of-State hospital participating in the New Jersey Medicaid or NJ FamilyCare program shall be 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. Reimbursement shall be at 100 percent of the claim-specific reimbursement

methodology approved by the State Medicaid agency in the state in which the hospital is located except as specified in (b)2 and (c) below. The Division shall not reimburse out-of-State hospitals for disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located.

2. 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 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.

10:52-4.5 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.

10:52-4.6 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.

10:52-4.7 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: