

CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D-6a(1), 30:4D-7, 7a, b, c, and e; 30:4D-12, P.L. 1992, c.160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 447.251, 253.

Source and Effective Date

R.1995 d.123, effective February 3, 1995.
See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Executive Order No. 66(1978) Expiration Date

Chapter 52, Hospital Services Manual, expires on February 3, 2000.

Chapter Historical Note

Chapter 52, originally Manual for Hospital Services, became effective with Subchapter 1, Coverage, and Subchapter 2, Admission and Billing Procedures, adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c). Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1 was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b). Pursuant to Executive Order No. 66(1978), Subchapter 2 was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a). Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1993 d.327, effective August 17, 1992, but operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a). Pursuant to P.L. 1992, c. 160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 C.F.R. 447.251, 253 and the authority cited above Subchapter 5, Procedural and Methodological Regulations; Subchapter 6, Financial Reporting Principles and Concepts; Subchapter 7, Diagnosis Related Groups (DRG); Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993 (to expire May 10, 1993). See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1995 d.123. See: Source and Effective Date. As a part of R.1995 d.123, Chapter 52 was retitled Hospital Services Manual; existing Subchapters 1 through 4 were repealed, and new Subchapters 1 through 4 were adopted, effective April 17, 1995; and Subchapter 10 was adopted as new rules, effective April 17, 1995. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:52-1.1 Purpose and scope
- 10:52-1.2 Definitions
- 10:52-1.2A Criteria for participation: outpatient hospital services
- 10:52-1.3 Eligibility; claim procedures
- 10:52-1.4 Eligibility of recipient for hospital services
- 10:52-1.5 Covered Services (Inpatient and Outpatient)
- 10:52-1.6 Disproportionate share of adjustments
- 10:52-1.7 Non-Covered Services (Inpatient and Outpatient)

- 10:52-1.8 Administrative Days (Nursing Facility Level of Care)—General, Special (Classification A & B) and Private Psychiatric Hospitals
- 10:52-1.9 Prior authorization
- 10:52-1.10 Pre-Admission screening for nursing facility (NF) placement
- 10:52-1.11 Recordkeeping
- 10:52-1.12 Second opinion program for elective surgical procedures
- 10:52-1.13 Social Necessity Days
- 10:52-1.14 Utilization control (inpatient services)
- 10:52-1.15 Utilization control; inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals
- 10:52-1.16 Utilization control; outpatient psychiatric services

SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

- 10:52-2.1 Ambulatory Surgical Center (ASC)
- 10:52-2.2 Blood and blood products
- 10:52-2.3 Dental services
- 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- 10:52-2.5 Home health agencies; hospital-based
- 10:52-2.6 Medical day care centers; hospital affiliated
- 10:52-2.7 Narcotic and drug abuse treatment centers; free-standing
- 10:52-2.8 Organ procurement and transplantation services
- 10:52-2.9 Psychiatric services; partial hospitalization
- 10:52-2.10 Rehabilitative services; hospital outpatient department
- 10:52-2.11 Renal dialysis services for end-stage renal disease (ESRD)
- 10:52-2.12 Sterilization
- 10:52-2.13 Hysterectomy
- 10:52-2.14 Termination of pregnancy
- 10:52-2.15 Transportation services; hospital-based

SUBCHAPTER 3. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES

- 10:52-3.1 Purpose
- 10:52-3.2 Scope of services
- 10:52-3.3 HealthStart provider participation criteria
- 10:52-3.4 Termination of HealthStart certificate
- 10:52-3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate
- 10:52-3.6 Access to services
- 10:52-3.7 Plan of Care (PoC)
- 10:52-3.8 Maternity Medical Care services
- 10:52-3.9 HealthStart Health Support services
- 10:52-3.10 Professional staff requirements for HealthStart Comprehensive Maternity Care services
- 10:52-3.11 Records; documentation, confidentiality and informed consent requirements for HealthStart Comprehensive Maternity Care providers
- 10:52-3.12 Standards for HealthStart Pediatric Care Certificate
- 10:52-3.13 Professional requirements for HealthStart Pediatric Care providers
- 10:52-3.14 Preventive care services provided by HealthStart Pediatric Care providers
- 10:52-3.15 Records; documentation, confidentiality and informed consent for HealthStart Pediatric Care Providers
- 10:52-3.16 Policy for reimbursement for HealthStart providers
- 10:52-3.17 HealthStart Maternity Care billing code requirements

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

- 10:52-4.3 Basis of payment; all general and special (Classification A), rehabilitation (Classification B), and private psychiatric hospitals—outpatient services
 10:52-4.4 Basis of payment; out-of-State hospital services
 10:52-4.5 Medicaid reimbursement for third-party claims
 10:52-4.6 Medicare/Medicaid claims
 10:52-4.7 Personal contribution to care requirements for NJ KidCare-Plan C
 10:52-4.8 Medicaid settlement

SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

- 10:52-5.1 Derivation of Preliminary Cost Base
 10:52-5.2 Uniform Reporting: Current costs
 10:52-5.3 Costs per case
 10:52-5.4 Development of standards
 10:52-5.5 (Reserved)
 10:52-5.6 Schedule of Rates
 10:52-5.7 Extraordinary expense
 10:52-5.8 (Reserved)
 10:52-5.9 Current Cost Base
 10:52-5.10 Financial elements reporting/audit adjustments
 10:52-5.11 Identification of direct and indirect costs related to Medicaid patient care
 10:52-5.12 Patient care cost findings; direct costs per case, physician and nonphysician
 10:52-5.13 Reasonable cost of services related to patient care
 10:52-5.14 Standard costs per case
 10:52-5.15 Reasonable direct cost per case
 10:52-5.16 Net income from other sources
 10:52-5.17 Update Factors
 10:52-5.18 Capital facilities
 10:52-5.19 Division adjustments and approvals
 10:52-5.20 Derivation from Preliminary Cost Base
 10:52-5.21 Schedule of rates—effective date

SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

- 10:52-6.1 Reporting period
 10:52-6.2 Objective evidence
 10:52-6.3 Consistency
 10:52-6.4 Full disclosure
 10:52-6.5 Materiality
 10:52-6.6 Basis of Valuation
 10:52-6.7 Accrual accounting
 10:52-6.8 Accounting for minor moveable equipment
 10:52-6.9 Accounting for capital facilities costs
 10:52-6.10 Timing differences
 10:52-6.11 Self-insurance
 10:52-6.12 Related organizations
 10:52-6.13 Financial elements (generally)
 10:52-6.14 Services related to Medicaid patient care
 10:52-6.15 Medicaid direct patient care
 10:52-6.16 Paid taxes
 10:52-6.17 Educational, research and training program
 10:52-6.18 Capital facilities
 10:52-6.19 Major moveable equipment
 10:52-6.20 through 10:52-6.21 (Reserved)
 10:52-6.22 Natural Classifications of Expense
 10:52-6.23 Medical and Surgical Supplies
 10:52-6.24 Non-Medical and Non-Surgical Supplies
 10:52-6.25 Purchased Services
 10:52-6.26 Major Moveable Equipment
 10:52-6.27 Reports of costs and revenues
 10:52-6.28 Excluded Health Care Services
 10:52-6.29 Education and Research
 10:52-6.30 Sales and services not related to patient care
 10:52-6.31 Patient convenience items
 10:52-6.32 Administrative items
 10:52-6.33 Non-operating revenues (net of expenses)
 10:52-6.34 Reporting of costs and revenues
 10:52-6.35 Medical-Surgical Acute Care Units (MSA)
 10:52-6.36 Obstetric Acute Care Unit (OBS)

- 10:52-6.37 Pediatric Acute Care Units (PED)
 10:52-6.38 Psychiatric Acute Care Units (PSA)
 10:52-6.39 Burn Care Units (BCU)
 10:52-6.40 Intensive Care Units (ICU)
 10:52-6.41 Coronary Care Units (CCU)
 10:52-6.42 Neonatal Intensive Care Units (NNI)
 10:52-6.43 Newborn Nursery (NBN)
 10:52-6.44 Emergency Services (EMR)
 10:52-6.45 Anesthesiology Services (ANS)
 10:52-6.46 Cardiac Catheterization (CCA)
 10:52-6.47 Delivery and Labor Rooms (DEL)
 10:52-6.48 Dialysis (DIA)
 10:52-6.49 Drugs Sold to Patients (DRU)
 10:52-6.50 Electrocardiology (EKG)
 10:52-6.51 Laboratory (LAB)
 10:52-6.52 Medical and Surgical Supplies Sold (MSS)
 10:52-6.53 Neurology, Diagnostic (NEU)
 10:52-6.54 Nuclear Medicine (NMD)
 10:52-6.55 Occupational and Recreational Therapy (OCC)
 10:52-6.56 Operating and Recovery Rooms (ORR)
 10:52-6.57 Organ Acquisition (ORG)
 10:52-6.58 Physical Therapy (PHT)
 10:52-6.59 Psychiatric/Psychological Services (PSY)
 10:52-6.60 Radiology, Diagnostic (RAD)
 10:52-6.61 Respiratory Therapy (RSP)
 10:52-6.62 Speech-Language Pathology and Audiology (SPA)
 10:52-6.63 Therapeutic Radiology (THR)
 10:52-6.64 Central Supply Services (CSS)
 10:52-6.65 Dietary (DTY)
 10:52-6.66 Housekeeping (HKP)
 10:52-6.67 Laundry and Linen (L&L)
 10:52-6.68 Medical Records (MRD)
 10:52-6.69 Pharmacy (PHM)
 10:52-6.70 Social Services (SOC)
 10:52-6.71 Research (RSH)
 10:52-6.72 Nursing and Allied Health Education (EDU)
 10:52-6.73 Graduate Medical Education (GME)
 10:52-6.74 General Administrative Services (GAM)
 10:52-6.75 Inpatient Administrative Services (IAM)
 10:52-6.76 Malpractice Insurance (MAL)
 10:52-6.77 Employee Health Insurance (EHI)
 10:52-6.78 Repairs and Maintenance (RPM)
 10:52-6.79 Utilities Cost (UTC)

SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

- 10:52-7.1 Diagnosis Related Groups (DRG)
 10:52-7.2 Calculation of Payment Rates
 10:52-7.3 List of Diagnosis Related Groups

SUBCHAPTER 8. BASIS OF SPECIFIC PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

- 10:52-8.1 Disproportionate share adjustment
 10:52-8.2 Method of payment
 10:52-8.3 Calculation and distribution of disproportionate share hospital (DSH) payments as a result of hospital closure; purpose and procedure

SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

- 10:52-9.1 Review and appeal of rates

SUBCHAPTER 10. CHARITY CARE

- 10:52-10.1 Charity care audit functions
 10:52-10.2 Sampling methodology
 10:52-10.3 Charity care write off amount
 10:52-10.4 Charity care screening and documentation requirements
 10:52-10.5 Identification
 10:52-10.6 New Jersey residency
 10:52-10.7 Income eligibility criteria and documentation
 10:52-10.8 Proof of income
 10:52-10.9 Assets eligibility criteria

- 10:52-10.10 Limit on accounts with alternative documentation
- 10:52-10.11 Additional information to be supplied to facility by applicant
- 10:52-10.12 Application and determination
- 10:52-10.13 Collection procedures and prohibited action
- 10:52-10.14 Adjustment methodology

SUBCHAPTER 10A. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

- 10:52-10A.1 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund
- 10:52-10A.2 Basis of pricing for charity care claims

SUBCHAPTER 11. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

- 10:52-11.1 Introduction
- 10:52-11.2 HCPCS Procedure Codes and Maximum Fee Allowance Schedule for Pathology/Laboratory
- 10:52-11.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT-4)
- 10:52-11.4 Pathology and Laboratory HCPCS Codes—Qualifiers
- 10:52-11.5 Pathology and Laboratory HCPCS Codes—Modifiers

SUBCHAPTER 12. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

- 10:52-12.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed
- 10:52-12.2 Distribution of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement
- 10:52-12.3 Establishment of GME and IME interim method of reimbursement
- 10:52-12.4 Establishment of GME and IME final method of reimbursement
- 10:52-12.5 Hospital fee-for-service reimbursement for Graduate Medical Education (GME) effective on or after July 6, 1998
- 10:52-12.6 Distribution of Graduate Medical Education (GME) effective on or after July 6, 1998

APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:52-1.1 Purpose and scope

This chapter of the Hospital Services Manual outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid recipients. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and private psychiatric hospitals, unless specifically indicated otherwise.

Petition for Rulemaking.
See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

10:52-1.2 Definitions

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

“Adjusted admissions” means inpatient admissions increased to reflect outpatient activity, which is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

“Base year” means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

“Bundled drug service” means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost of the drug, the drug product and ancillary services, such as, but not limited to, case management and laboratory services.

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

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

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

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid recipients under 21 years of age for the purpose of assessing a recipient’s health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

“Entity,” as used in N.J.A.C. 10:52-1.2A, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

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

“Financial Elements” means the reasonable cost of items approved as reimbursable under Medicaid (see N.J.A.C. 10:52-5.10).

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

“Hospital” means an institution which is primarily engaged in providing the following services to inpatients, by or under the supervision of physicians:

1. Diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or,
2. Rehabilitative services for the rehabilitation of injured, disabled, or sick persons; and that
3. Maintains clinical records on all patients;
4. Has by-laws in effect with respect to its staff of physicians;
5. Requires every patient to be under the care of a physician;
6. Provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a registered professional nurse or licensed practical nurse on duty at all times;
7. Has in effect a hospital utilization review plan that meets the requirement of the law (Sec. 1861(K) of the Social Security Act); and has in place a discharge planning process that meets the requirements of the law (Sec. 1861(ee)) of the Social Security Act;
8. Is licensed as a hospital in the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located, or approved by the agency of the state or locality responsible for licensing hospitals meeting the standards established for such licensing;
9. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of health and safety of individuals who furnished services in the institution; and
10. For the purposes of N.J.A.C. 10:52-1.2A only, is where the main inpatient hospital services are located.

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

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid provider);
2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act);

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

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

“Hospital (Approved Private Psychiatric)” means an institution which is approved to participate as a provider in the Division and:

1. Is licensed by the State of New Jersey as a psychiatric (mental-non-governmental) hospital or licensed as a private psychiatric hospital (non-governmental) by the appropriate agency under the laws of the respective state in which the hospital is located;
2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a psychiatric hospital;
3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX);
4. Meets the special Medicare standards relative to staffing requirements and clinical medical records; and,
5. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

“Hospital (Approved Private Psychiatric) facility that provides inpatient services to children under 21 years of age” means an institution that shall meet the requirements of 1., 2., 3., 4. and 5. above, listed in the definition of “Hospital (Approved Private Psychiatric): or in addition to 1. and 5. above, has facility accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

“Hospital (Approved Special)” means an institution which is approved by the New Jersey State Department of Health as a special hospital (for definition of special hospital, see N.J.A.C. 8:43G-1.3(b)2) and which includes any hospital which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation, where applicable, on an inpatient basis for one or more specific categories of patients; and approved to participate as a provider in the Division if it meets the appropriate standards of participation for one of the following classifications:

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

1. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;
2. Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation as a hospital or rehabilitation facility; and/or

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

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

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

“Informed Consent” means the voluntary knowing assent from the individual on whom any sterilization is to be performed after he or she has been given (as evidenced by a document executed by such individual) and has been given:

1. A fair explanation of procedures to be followed;
2. A description of attendant discomforts and risks;
3. A description of benefits to be expected;