

**CHAPTER 52**

**HOSPITAL SERVICES MANUAL**

**Authority**

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

**Source and Effective Date**

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

**Chapter Expiration Date**

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

**Chapter Historical Note**

Chapter 52, Manual for Hospital Services, was adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c).

Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, Coverage, was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b).

Pursuant to Executive Order No. 66(1978), Subchapter 2, Admissions and Billing Procedures, was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1992 d.327, effective August 17, 1992, operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a).

Subchapter 5, Procedural and Methodological Regulations, Subchapter 6, Financial Reporting Principles and Concepts, Subchapter 7, Diagnosis Related Groups (DRG), Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993, to expire May 10, 1993. See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 1582(a), 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1995 d.123, effective February 3, 1995. As a part of R.1995 d.123, Chapter 52 was renamed Hospital Services Manual, and Subchapter 1, Coverage, Subchapter 2, Admission and Billing Procedures, Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric Services, Subchapter 4, Basis of Payment for Hospital Services, and Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, were adopted as new rules, effective April 17, 1995. See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Subchapter 10, Charity Care, was adopted as R.1995 d.258, effective May 15, 1995. See: 27 N.J.R. 656(a), 27 N.J.R. 1995(a).

Subchapter 12, Graduate Medical Education and Indirect Medical Education, was adopted as R.1997 d.43, effective January 21, 1997. See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was adopted as R.1997 d.520, effective January 5, 1998. See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Hospital Services Manual, was readopted as R.2000 d.29, effective December 21, 1999, and Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, was recodified as Subchapter 13, Eligibility for and Basis of Payment for Disproportionate Share Hospitals, Subchapter 10, Charity Care, was recodified as Subchapter 11, Charity Care, Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was recodified as Subchapter 12, Charity Care Component of the Disproportionate Share Hospital Subsidies, Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, was recodified as Subchapter 10, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, and Subchapter 12, Graduate Medical Education and Indirect Medical Education, was recodified as Subchapter 8, Graduate Medical Education and Indirect Medical Education, by R.2000 d.29, effective January 18, 2000. See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

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

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

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

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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 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 G0001 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 base composite rate and shall include any add-on charge to the base 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 21 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 \$33.08. 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.

9. All outpatient psychiatric services provided to youth and young adults under age 21 shall be paid fee-for-service for the following service categories at the lower of charges or prospective unit rates:

i. Youth and young adult partial hospital services shall be billed on an hourly basis using revenue code 913. The rate is \$73.00 per hour. A claim for such services shall not be billed or reimbursed for any day on which less than two hours of such services are provided to the beneficiary. A claim shall not be billed or reimbursed for more than five hours of such services per day provided to the beneficiary. When revenue code 913 is billed, no other outpatient psychiatric revenue code can be billed for the same day of service.

ii. Individual outpatient hospital psychiatric services for youth or young adults shall be billed on a unit basis of 30 minutes using revenue code 914. The daily billing limit is three units per day, to include family conferencing, which can be up to 1.5 hours per day. The half hour rate is \$50.00. Individual sessions where the youth is the sole participant should not exceed two units per days, unless there are extenuating circumstances that shall be documented in the file prior to the submission of the claim for reimbursement.

iii. Evaluations for youth and young adults shall be billed on a unit basis of 30 minutes using revenue code 918. The daily billing unit is four units per day. The half hour unit rate is \$62.50. Reimbursement is available if the evaluation is performed by a clinically licensed mental health professional and can include specialized assessments, as well as evaluations for admission into a partial hospital program for youth or young adults.

iv. Group outpatient hospital psychiatric services for youth or young adults 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.

v. Medication management for youth or young adults 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-minute unit rate is \$42.00.

(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.

Amended by R.2008 d.375, effective December 15, 2008.

See: 40 N.J.R. 4667(a), 40 N.J.R. 6966(b).

In the introductory paragraph of (b), deleted "for individuals 22 years of age and over" preceding "are excluded"; in (b)8, substituted "21" for "22"; and added (b)9.

Amended by R.2011 d.010, effective January 3, 2011.

See: 42 N.J.R. 1656(a), 43 N.J.R. 43(a).

In the introductory paragraph of (b)3, inserted "base" twice.

Amended by R.2012 d.050, effective March 5, 2012.

See: 43 N.J.R. 2112(a), 44 N.J.R. 594(a).

Section was "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". In (b)8i(2), substituted "\$33.08" for "\$35.00".

#### **10:52-4.4 Basis of payment; hospital capital project adjustment**

(a) Any qualifying hospital that has completed a capital facilities construction project with an approved certificate of need from the New Jersey Department of Health and Senior Services, which meet both conditions in (a)1 below will be eligible for increased payments for capital project funding related to its Medicaid and NJ FamilyCare-Plan A managed care utilization.

1. The conditions required in (a) above are:

i. The approval is for a single capital project in excess of \$20 million, which is for replacement beds, which reduce the number of hospital beds available in the State as of September 15, 1997; and

ii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low income revenue percentage shall be based on the sum of the Medicaid revenue as reported on Forms E-5 and E-6, line 1, column E, plus the Charity Care revenue as reported on Forms E-5 and E-6, line 1, column J, divided by the sum of the total revenue as reported on Forms E-5 and E-6, line 1, column M.

2. Payments to eligible hospitals shall begin upon project completion and facility operation.

3. The hospital-specific capital project funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid and NJ FamilyCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

New Rule, R.2009 d.249, effective August 3, 2009.

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

Former N.J.A.C. 10:52-4.4, Basis of payment and appeal procedure; out-of-State hospital services, recodified to N.J.A.C. 10:52-4.5.

#### **10:52-4.5 Basis of payment and appeal procedure; out-of-State acute care general hospital services**

(a) The Division shall reimburse an out-of-State approved acute care general 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) and (c) below, and for outpatient services is outlined in (d) and (e) below. See (f) below for the procedure for rate appeals for out-of-State acute care general hospitals.

(b) Reimbursement for inpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid or NJ FamilyCare program and participating in the Medicaid program in the state in which the hospital is located, 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 the lesser of the established DRG payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-14 (excluding add-ons), 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, or the total charges reflected on the claim. The Division shall not reimburse out-of-State acute care general 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 acute care general 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. If official documentation is not provided upon request by the Division, the claim will be denied.

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.

(c) In the event an out-of-State acute care general 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:

1. Reimbursement for inpatient services shall be at the lesser of the established DRG payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-14 (excluding add-ons), a rate negotiated with the Division at the time of enrollment for inpatient hospital services, or the total charges reflected on the claim.

2. 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.

3. Cornea transplants, although not life-threatening, shall be reimbursed as any other out-of-State transplant service.

(d) Reimbursement for outpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid or NJ FamilyCare program and participating in the Medicaid program in the state in which the hospital is located 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 the lesser of the New Jersey Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-4.3; 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 (d)2 and (e) below; or the total charges reflected on the claim.

i. The New Jersey Statewide average cost-to-charge ratio is the average cost-to-charge ratio of all New Jersey acute care general hospitals based on the prior calendar year's hospital specific cost-to-charge ratio. This information is updated annually and published on the fiscal agent's website.

2. An out-of-State acute care general 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. If official documentation is not provided upon request by the Division, the claim will be denied.

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.

(e) In the event that an out-of-State acute care general hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with that state's Medicaid agency, reimbursement for outpatient services shall be at the lesser of the New Jersey Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-4.3, or the total charges reflected on the claim.

(f) 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 (f)1 above.

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

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

Amended by R.1998 d.352, effective July 20, 1998.

See: 30 N.J.R. 1258(a), 30 N.J.R. 2653(a).

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

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

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

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

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

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

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

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

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

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

Amended by R.2014 d.034, effective February 18, 2014 (operative July 1, 2014).

See: 45 N.J.R. 243(a), 45 N.J.R. 624(a), 46 N.J.R. 356(c).

Section was "Basis of payment and appeal procedure; out-of-State hospital services". Rewrote the section.

**10:52-4.6 Reimbursement for claims for which there is third-party liability**

(a) For beneficiaries for whom any third-party liability exists, claims for hospital services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with N.J.A.C. 10:49-7.3 and the provisions of this chapter.

(b) For beneficiaries eligible for Medicare and Medicaid (dual eligibles), claims covered under N.J.A.C. 10:52-4.7 shall be reimbursed in accordance with the provisions of that section.

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

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

Rewrote the section.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

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

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

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

Repeal and New Rule, R.2014 d.030, effective February 3, 2014.

See: 45 N.J.R. 103(a), 46 N.J.R. 295(a).

Section was "Reimbursement for third-party claims".

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

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

(b) Medicare/Medicaid and Medicare/NJ FamilyCare third-party claims for hospital services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with N.J.A.C. 10:49-7.3 and the provisions of this chapter.

(c) When Medicaid or NJ FamilyCare is not the primary payer on an inpatient hospital claim, payment by Medicaid or NJ FamilyCare will be made at the lesser of:

1. The Medicaid or NJ FamilyCare allowed amount minus any other payment(s); or

2. The patient liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

(d) The State will perform a post-payment review of inpatient hospital claims for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) when Part A benefits exhaust during the inpatient hospital stay. Based on the post-payment review, the Division will determine whether paying the patient's liability for the stay will result in a lower cost to the Division. If paying the patient's liability results in a lower

cost to the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

1. Where benefits have been exhausted under Medicare Part A, the charges to be billed to the Medicaid/NJ FamilyCare Program must be itemized for the Medicare Part A non-covered services in order to determine the liability of Medicare Part B and other third-party payers.

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

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

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

Rewrote the section.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

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

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

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

Amended by R.2014 d.030, effective February 3, 2014.

See: 45 N.J.R. 103(a), 46 N.J.R. 295(a).

Rewrote the section.

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

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

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

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

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

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

i. Outpatient rehabilitation services, including physical therapy, occupational therapy and speech therapy;

ii. Hospital outpatient department visits and diagnostic testing;

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

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

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

i. No copayment shall be required if the beneficiary was referred to the emergency room by his or her primary care provider for services that should have been rendered in the primary care physician's office or if the beneficiary is admitted into the hospital.

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

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

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

(f) Hospitals shall not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, in-

cluding well child visits and age-appropriate immunizations; for lead screenings and treatment, or for preventive dental services provided to children under the age of 12.

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

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

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

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

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

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

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

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

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

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

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

Substituted "FamilyCare" for "KidCare" throughout.

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

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

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

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

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