

N.J.A.C. 10:52

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > **TITLE 10. HUMAN SERVICES** >
CHAPTER 52. HOSPITAL SERVICES MANUAL

Title 10, Chapter 52 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

[N.J.S.A. 30:4D-1](#) et seq., and [30:4J-8](#) et seq.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: January 23, 2025.

See: [57 N.J.R. 382\(b\)](#).

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).

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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: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 52, Hospital Services Manual, was scheduled to expire on December 6, 2017. See: [43 N.J.R. 1203\(a\)](#).

Chapter 52, Hospital Services Manual, was readopted as R.2018 d.104, effective April 16, 2018. See [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Chapter 52, Hospital Services Manual, was updated by administrative change, effective November 4, 2024, to change all references to county welfare agencies (CWA) and county welfare boards to county social service agencies (CSSA) and county social services boards, respectively. See: [56 N.J.R. 2299\(a\)](#).

Chapter 52, Hospital Services Manual, was readopted, effective January 23, 2025. See: Source and Effective Date.

Annotations

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 52, Hospital Services Manual, expires on January 23, 2032.

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CHAPTER 52. HOSPITAL SERVICES MANUAL	>	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/NJ FamilyCare fee-for service beneficiaries. These policies and procedures apply to 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/NJ FamilyCare fee-for-service beneficiaries and to Medicaid/NJ FamilyCare fee-for-service services that are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services that 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.

History

HISTORY:

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).

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a), substituted "These" for "The hospitals that are included in these" and "apply to" for "are".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

§ 10:52-1.1 Purpose and scope

Substituted "Medicaid/NJ" for "Medicaid and NJ" throughout; in (a), inserted a comma following the third occurrence of "hospitals"; and in (b), substituted the first two occurrence of "that" for "which".

Annotations

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§ 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. See [N.J.A.C. 10:52A](#).

"Advanced practice nurse (APN)" means a person currently licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with [N.J.A.C. 13:37-7](#), and with [N.J.S.A. 45:11-24](#) and 45 through 52, or similarly licensed and certified by a comparable agency of the state in which he or she practices.

"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.

"Clinically licensed mental health professional" means a mental health professional possessing a Master's or Doctoral degree from an accredited university in psychiatry, psychology, social work, psychiatric nursing or psychiatric rehabilitation counseling. In addition to the degree, the applicable training must be completed, including the appropriate residency (fellowship), internship or student placement required by the professional standards of the respective discipline, as well as the applicable State license.

"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.

"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.

"DoAS" means the Division of Aging Services in the New Jersey Department of Human Services.

"DOH" means the State Department of Health.

"Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid/NJ FamilyCare-Children's Program-Plan A beneficiaries under

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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.

"Group outpatient hospital psychiatric services for youth or young adults" means an outpatient therapeutic intervention for a youth or young adult with similar behaviors or functionality provided in a group of no more than eight individuals, in which interventions are provided directly by or under the direction of a clinically licensed mental health professional.

"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:

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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 paragraphs 1 through 5 above, listed in the definition of "Hospital (Approved Private Psychiatric)" or in addition to paragraphs 1 and 5 above, has facility accreditation by the Joint Commission.

"Hospital (Approved Special)" means an institution that 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 that 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. Is licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;
2. Is accredited by the Joint Commission 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

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sessions which last between 30 minutes and one hour and which are provided on a regular basis for a defined period of time.

"Individual outpatient hospital psychiatric services for youth or young adults" means an outpatient therapeutic intervention that is provided directly to or on behalf of an individual youth or young adult, which may last between 30 minutes to one and a half hours and is provided on a regular basis as part of an integrated plan of service that may be supported by other strategies, interventions, and supports in the community. Such interventions may include family conferencing or family counseling with the purpose of the intervention to support a plan of treatment for the youth or young adult.

"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.

"Managed Long-Term Services and Supports (MLTSS)" means services that are provided under the Comprehensive Waiver through Medicaid/NJ FamilyCare managed care organization plans, the purpose of which is to support clients who meet nursing home level of care in the most appropriate setting to meet their specific needs.

"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 management for youth or young adults" means therapeutic services provided by a qualified medical/mental health professional who, within the scope of their practice, evaluates, prescribes,

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administers, or monitors the use of therapeutic medications to assist in improving the ability of a youth or young adult to function in the community with, primarily, such therapeutic medications addressing the mental/behavioral health challenges of the youth or young adult. This service also includes providing education to the youth or young adult and their family/caregiver, as appropriate, about the benefits, side effects, and potential impact of the medications on the physical/mental health of the youth or young adult.

"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.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health for participation in Title XIX Medicaid and Title XXI Children's Health Insurance Program, which is known in New Jersey as NJ FamilyCare, and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid/NJ FamilyCare beneficiaries, (children and adults) who, due to medical disorders, developmental disabilities, and/or related cognitive impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for care and treatment of mental diseases that require continuous 24-hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

"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. The institution shall be licensed or formally approved as a hospital by the New Jersey State Department of Health, or certified by the officially designated authority in the state in which the hospital is located; shall meet the requirements for participation in Medicare (Title XVIII) as a hospital; and shall meet 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-

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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.

"Young adult" means, for purposes of outpatient mental health/psychiatric services, an individual who is at least 18 years old and under 21 years old.

"Youth" means, for purposes of outpatient mental health/psychiatric services, an individual under 18 years old.

"Youth and young adult partial hospital" means an intensive, highly structured outpatient treatment program, provided in a hospital-based setting as approved by the Division of Medical Assistance and Health Services, that provides services designed primarily for youth and young adults under age 21 and intended to minimize the need for hospitalization that meets the requirements of this chapter and all other State rules and laws regarding youth and young adult partial hospital services.

History

HISTORY:

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.

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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".

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

See: [40 N.J.R. 4667\(a\)](#), [40 N.J.R. 6966\(b\)](#).

Added definitions "Clinically licensed mental health professional", "Group outpatient hospital psychiatric services for youth or young adults", "Individual outpatient hospital psychiatric services for youth or young adults", "Medication management for youth or young adults", "Young adult", "Youth" and "Youth and young adult partial hospital".

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In definition "Adult acute partial hospital", inserted "See [N.J.A.C. 10:52A](#)."; and added definitions "Advanced practice nurse (APN)" and "Nursing facility (NF)".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Deleted definition "DHSS"; added definitions "DoAS", "DOH", and "Managed Long-Term Services and Supports (MLTSS)"; substituted definition "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)" for definition "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)", and in that definition, substituted "Medicaid/NJ" for "Medicaid and NJ"; rewrote definitions "Hospital (Approved Private Psychiatric)" and "Hospital (Approved Special)", in definition "Nursing facility (NF)", deleted "and Senior Services" following "Health", inserted "Title XXI Children's Health Insurance Program, which is known in New Jersey as NJ FamilyCare, and", inserted a comma following "beneficiaries" and "disabilities", and substituted "Medicaid/NJ FamilyCare" for "Medicaid"; and in definition "Outpatient hospital services", inserted a comma following "outpatient", substituted ". The institution shall be" for "and the institution is", and substituted "shall meet" for "meets" twice.

Annotations

Notes

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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](#).

§ 10:52-1.2 Definitions

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[N.J.A.C. 10:52-1.2A](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

<i>NJ - New Jersey Administrative Code</i>	>	<i>TITLE 10. HUMAN SERVICES</i>	>
<i>CHAPTER 52. HOSPITAL SERVICES MANUAL</i>	>	<i>SUBCHAPTER 1. GENERAL</i>	
<i>PROVISIONS</i>			

§ 10:52-1.2A (Reserved)

History

HISTORY:

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Annotations

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N.J.A.C. 10:52-1.3

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§ 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/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/NJ FamilyCare fee-for-service program 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, 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;

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

- 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.

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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.

(d) Once the Division approves the entity to be reimbursed as an outpatient hospital service, the Division or its settlement agent, as specified in [N.J.A.C. 10:52-4.9](#), shall ensure that the information submitted is in compliance with (b) above. A review may occur at any time at the Division's discretion, including, but not limited to, the time of the audit of the hospital's cost report. If it is determined that the service provided by the entity is not provided consistent with the criteria for participation, as specified in (b) above, the Division shall notify the hospital of its denial of the service and disallow the costs and the related reimbursement for any time that service or entity was not in compliance with these rules.

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

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

for an exception for new entities attempting to be reimbursed as a hospital outpatient service after September 15, 1997 shall be sent to the Division in accordance with (c)3 above.

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

- i. When access and/or availability to a particular service within a particular geographic area is limited; or
- ii. When the availability of transportation to a particular service within a particular geographical area is limited.

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

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

History

HISTORY:

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

See: [29 N.J.R. 1003\(a\)](#), [29 N.J.R. 4132\(b\)](#).

Recodified from [N.J.A.C. 10:52-1.2A](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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

Amended by R.2002 d.378, effective November 18, 2002.

See: [34 N.J.R. 2246\(a\)](#), [34 N.J.R. 2549\(b\)](#), [34 N.J.R. 3980\(a\)](#).

Added (b)1ii.

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" preceding "fee-for-service" and deleted "of Medical Assistance and Health Services "known as the "Division")," preceding "in accordance with this rule"; in (c), substituted "FamilyCare" for KidCare" preceding "fee-for-service" in 3, amended the address in 4 and added 6; in (d), amended the N.J.A.C. reference.

Public Notice: Moratorium on New or Relocated Hospital-Based Off-Site Clinic Services Applications.

See: [37 N.J.R. 3860\(a\)](#).

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

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

In (d), updated the N.J.A.C. reference.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a) and the introductory paragraph of (b), substituted "Medicaid/NJ" for "Medicaid or NJ"; in the introductory paragraph of (b), substituted "program" for "programs"; and in (b)2, deleted "and Senior Services" following "Health".

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Division's interpretation of [N.J.A.C. 10:52-1.3\(b\)\(7\)](#) to require that an offsite outpatient hospital facility entitled to hospital-level rates be located in a building that is solely for the hospital facility was arbitrary, capricious, or unreasonable and constituted improper rulemaking in violation of [Metromedia, Inc. v. Director, Div. of Taxation, 97 N.J. 313 \(1984\)](#). [N.J.A.C. 10:52-1.3\(b\)\(7\)](#) only requires that the entity be held out and appear to the public to be part of a hospital, and no regulation requires separate entrances or that the building be used solely for the hospital; signage and notices in and around the facilities, the size, layout, and the equipment in the facilities, as well as the hospital identification badges worn by the staff, sufficiently presented the entities to the public as being affiliated with the hospital. [Bacharach Physical Therapy v. DMAHS, OAL Dkt. Nos. HMA 2363-07 and HMA 2548-07, 2007 N.J. AGEN LEXIS 814](#), Initial Decision (December 11, 2007).

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

(a) A hospital shall adhere to the following procedure for completing the form, the "Public Assistance Inquiry (PA-1C)" to inform the appropriate agency that an individual intends to file a Medicaid/NJ FamilyCare application:

1. For those aged, blind or disabled persons with limited income and resources who appear to be eligible for Supplemental Security Income (SSI)/ Medicaid, a hospital shall complete the form PA-1C and send it to the Social Security Administration (SSA) District Office serving their locale to initiate the eligibility process. The date of the inquiry shall protect the application date provided that the individual follows through with filing of an application.
2. For the aged, blind and/or disabled individuals, and/or pregnant women and/or children who do not qualify or who do not want an SSI money payment from the Social Security Administration and/or do want to be a Medicaid beneficiary through "Medicaid Only" or New Jersey Care . . . Special Medicaid Programs, a hospital shall complete the form PA-1C and send it to the appropriate county social service agency (CSSA).
3. A hospital shall submit the form PA-1C to the county social service agency (CSSA) immediately after the birth of a newborn of a mother who is or may become eligible for Medicaid/NJ FamilyCare. (Information on the newborn shall be included in item 1, 2, 3, 11a, and 15 only. The mother's signature shall be included in Item 22.)
 - i. There shall be no requirement for joint hospitalization of a mother and newborn as the sole condition for which claims for services to the newborn may be submitted using the mother's Person Number.
 - ii. With the exception of mothers receiving benefits through the Emergency Services for Aliens Program, a mother who is a Medicaid/NJ FamilyCare beneficiary and her newborn shall have the same Health Benefits Identification (HBID) Number when they are a part of the same household, but each shall be assigned his or her own Person Number. A mother receiving benefits through the Emergency Services for Aliens Program shall be assigned an HBID Number, and her newborn shall be assigned a separate HBID Number after being determined eligible in accordance with [N.J.A.C. 10:69](#) or 10:72, as applicable.
 - iii. A hospital shall be permitted to submit a claim for services to a newborn of a mother not enrolled in managed care for 60 days from the date of the birth through the end of the month in which the 60th day occurs or until the newborn is assigned his or her own Person Number, whichever happens first.
 - iv. After the extended time frame of 60 days from the date of birth through the end of the month in which the 60th day occurs or upon the assignment of the newborn's Person Number, the newborn's personal data shall be used on the claim form as soon as it is available to the hospital. The mother's personal data shall not be used on the claim form after this time frame or after the newborn's Person Number is available to the hospital.

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

4. Previously submitted PA-1C forms shall be updated by the hospital if subsequent facts emerge that alter the original referral.

i. When it is determined that the original referral to the Social Security Administration was incorrect, the hospital shall forward a copy of the original PA-1C to the CSSA with a note of explanation (see also N.J.A.C. 10:49-2 in Administration for further information on Medicaid eligibility).

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.3](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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

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)3, substituted "3" for "4" and "22" for "23" in the introductory paragraph, rewrote ii and inserted "of a mother not enrolled in managed care" preceding "for 60 days" in iii.

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a)2 and the introductory paragraph of (a)3, substituted "welfare agency (CWA)" for "board of social services (CBOSS)"; and in (a)4i, substituted "CWA" for "CBOSS".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (a) and of (a)3, and in (a)3ii, substituted "Medicaid/NJ FamilyCare" for "Medicaid"; in the introductory paragraph of (a)3, inserted a comma following "11a"; and in (a)3ii, substituted "Health Benefits Identification (HBID)" for the first occurrence of "Medicaid Eligibility Identification", substituted "an HBID" for "a Medicaid Eligibility Identification", and substituted the second occurrence of "HBID" for the third occurrence of "Medicaid Eligibility Identification".

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

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§ 10:52-1.5 Eligibility of beneficiary for hospital services

(a) Hospital services shall not be reimbursed by the Medicaid/NJ FamilyCare fee-for-service program when hospital services were rendered prior to or after the period of beneficiary eligibility, as determined in accordance with [N.J.A.C. 10:49-2.7](#); except that, when a Medicaid/NJ FamilyCare beneficiary in an acute care general hospital loses eligibility during an inpatient hospital stay, but was eligible on the date of admission, eligibility shall continue for hospital inpatient services for the entire length of that hospital stay.

(b) When a patient is admitted to a hospital and is determined Medicaid/NJ FamilyCare eligible subsequent to the date of admission, charges incurred during the ineligible period of the hospital stay shall not be reimbursable, unless coverage is pursued and approved under retroactive eligibility.

(c) For coverage of services rendered prior to date of application for Medicaid/NJ FamilyCare, the beneficiary shall apply for retroactive eligibility, in accordance with [N.J.A.C. 10:49-1.1](#).

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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

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" preceding "fee-for-service" and substituted "prior to or after the period" for "prior to and after period" preceding "of beneficiary eligibility".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; and in (a), substituted "program" for "programs".

Annotations

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§ 10:52-1.6 Covered services (inpatient and outpatient)

(a) The Division will cover those inpatient services ordinarily furnished by an approved hospital maintained for the treatment and care of patients, and provided to any Medicaid/NJ FamilyCare fee-for-service beneficiary, for whom professionally developed criteria and standards of care were used to determine that the beneficiary warranted an appropriate hospital level of care for a given diagnosis or problem.

1. Inpatient psychiatric services in approved beds in a general hospital for patients of any age shall be covered services.
2. Inpatient room and board service shall be provided in a semi-private accommodation. Accommodations other than semi-private require certification of medical necessity or lack of availability of semi-private accommodations.
3. Inpatient services in an acute general hospital rendered the day after acute care is no longer medically necessary shall be covered only under specified conditions. (See Social Necessity Days in [N.J.A.C. 10:52-1.14](#) and Administrative Days in [N.J.A.C. 10:52-1.9](#).)
4. Non-physician services, supplies, and equipment supplied by an outside vendor to Medicaid/NJ FamilyCare beneficiaries who are receiving inpatient acute care hospital services shall be covered directly under the hospital reimbursement system. Vendor claims for these services are the responsibility of the acute care hospital where the beneficiary is a patient and shall not be billed directly to the Medicaid/NJ FamilyCare fiscal agent.
5. For beneficiaries in the Medically Needy Program, inpatient hospital services shall be available only to pregnant women. For information on how to identify a Medicaid beneficiary in the Medically Needy Program, refer to [N.J.A.C. 10:49-2.3\(c\)](#), Administration.

(b) The Division shall pay for eligible ancillary services provided during a non-covered period in an acute care hospital for the following situations:

1. When the Utilization Review Organization (URO) denies the entire admission for acute level of care; or
2. When the URO certifies the admission as acute but "carves out" days from the approved continued stay. For eligible ancillary services that were provided during days that were "carved out" or "non-covered" and occurring in an inlier stay, no additional reimbursement by Medicaid/NJ FamilyCare fee-for-service shall be made, because the services are already included in the DRG reimbursement rate; or
3. When the URO certifies that only part of the stay is acute.

(c) Medically necessary inpatient psychiatric services provided in an approved private psychiatric hospital shall be covered by the Division for any Medicaid/NJ FamilyCare beneficiary age 65 or older; or for any other Medicaid/NJ FamilyCare-Children's Program beneficiary before reaching the age of 21, except that a Medicaid/NJ FamilyCare beneficiary receiving the services immediately before attaining age 21 may

§ 10:52-1.6 Covered services (inpatient and outpatient)

continue to receive the services until they are no longer needed or until the beneficiary reaches age 22, whichever occurs first.

(d) Outpatient services include those medically necessary items or services (preventive, diagnostic, therapeutic, rehabilitative, or palliative) provided to an outpatient, by or under the direction of a physician or dentist, except for the supervision of certified nurse midwife services, pursuant to the rules of the Division, State and applicable Federal regulations, including those services listed below:

1. Outpatient psychiatric services in general hospitals and private psychiatric hospitals for patients of all ages;
 2. Same day surgery shall be:
 - i. Identified on the UB-92 claim form as a 131 or 136 bill type in accordance with [N.J.A.C. 8:31B-3.11\(a\)](#)1;
 - ii. The patient shall be discharged before midnight of the day of admission so the admission date and discharge date are the same;
 - iii. The patient shall have had surgery performed in a fully equipped operating room, for example, one routinely equipped and capable of providing general anesthesia, and identified by an operating room charge on the claim; and
 - iv. The patient shall have had a normal discharge, for example was not transferred, did not leave "against medical advice," and was not discharged dead. (See [N.J.A.C. 8:31B-3.11](#) Same day surgery.)
 3. Physician services in hospitals (that is, specifically unbundled physicians): A physician practicing in a hospital out-patient department whose reimbursement is not part of the hospital's cost may bill fee-for-service if the arrangement with the hospital permits it.
- (e) Transfer from one outpatient facility to another outpatient facility, or a change from an outpatient facility to a private practitioner's care is allowable; however, effort shall be made to avoid duplication of diagnostic tests or services.
- (f) For policies and procedures for Ambulatory Surgical Centers, see [N.J.A.C. 10:52-2.1](#) and N.J.A.C. 10:66-5, Independent Clinic Services.
- (g) For policies and procedures for hospital-affiliated home health agencies, see [N.J.A.C. 10:52-2.6](#) and [N.J.A.C. 10:60](#), Home Care Services.
- (h) For policies and procedures for Medical Day Care Centers (Hospital Affiliated), see [N.J.A.C. 10:52-2.7](#) and [N.J.A.C. 8:86](#), Adult Day Health Services.
- (i) For policies and procedures for HealthStart (Comprehensive Maternity and Pediatric Care Services), see N.J.A.C. 10:52-3. For policies and procedures for Early and Periodic Screening Diagnostic and Treatment, see [N.J.A.C. 10:52-2.4](#).
- (j) For other policies and procedures related to specific services, both inpatient and outpatient, see N.J.A.C. 10:52-2.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.5](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

§ 10:52-1.6 Covered services (inpatient and outpatient)

Substituted references to beneficiaries for references to recipients throughout; in (a), inserted a reference to NJ KidCare fee-for-service beneficiaries in the introductory paragraph, changed N.J.A.C. references in 3 and 5, and inserted a reference to NJ KidCare fiscal agents in 4; in (b)2, inserted a reference to NJ KidCare--Plan A, B, or C fee-for-service; in (c), inserted a reference to NJ KidCare beneficiaries; rewrote (d); and in (g) through (i), changed N.J.A.C. references. Former [N.J.A.C. 10:52-1.6](#), Disproportionate share of adjustments, recodified to [N.J.A.C. 10:52-1.7](#).

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.2011 d.010, effective January 3, 2011.

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a)5, updated the N.J.A.C. reference; and in (h), substituted "Adult Day Health" for "Medical Day Care".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; and in (a)4, inserted a comma following "supplies".

Annotations

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N.J.A.C. 10:52-1.7

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§ 10:52-1.7 Offset of disproportionate share hospital payments

The Division shall, upon receipt of documentation from the Department of Health, apply an offset to a hospital's disproportionate share hospital Medicaid/NJ FamilyCare payments to collect delinquent statutory and regulatory debts owed by the hospital to the State arising under the Health Care Facilities Planning Act, [N.J.S.A. 26:2H-1](#) et seq., and the implementing regulations.

History

HISTORY:

New Rule, R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.6](#), Non-Covered Services (Inpatient and Outpatient), recodified to [N.J.A.C. 10:52-1.7](#).

Recodified from [N.J.A.C. 10:52-1.6](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Former [N.J.A.C. 10:52-1.7](#), Non-Covered Services (Inpatient and Outpatient), recodified to [N.J.A.C. 10:52-1.8](#).

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Deleted "and Senior Services" following "Health", and substituted "Medicaid/NJ" for "Medicaid and NJ".

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§ 10:52-1.7 Offset of disproportionate share hospital payments

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§ 10:52-1.8 Non-covered services (inpatient and outpatient)

(a) The following non-covered services (inpatient and outpatient) shall not be eligible for payment by the Division:

1. Hospital admissions of the following description:
 - i. Admission for any condition for which hospitalization is not medically necessary;
 - ii. Admission primarily for rest cure, custodial care, convalescent care or diet therapy for exogenous obesity;
 - iii. Admission for illnesses which, according to generally accepted professional standards, are not amenable to favorable modification. However, psychiatric services in a general hospital shall be covered for the purpose of determining that such disorders or illness (such as senility) are not amenable to favorable modification;
 - iv. Admission for diagnostic procedures which may be done on an out-of-hospital basis including, but not limited to, laboratory tests, electrocardiograms and diagnostic radiological services;
 - v. Admission or extension of hospital stay solely for research or teaching studies;
 - vi. Admission for inpatient services provided in an approved private psychiatric hospital unless:
 - (1) The Medicaid beneficiary is age 65 or over;
 - (2) The Medicaid beneficiary has not attained age 21, except that a beneficiary who is receiving such services immediately preceding the date on which he or she attained age 21 will continue to be covered until the date the individual no longer requires such services or the date the individual reaches age 22, whichever occurs first;
 - (3) The NJ FamilyCare-Plan A beneficiary has not attained the age of 21; or
 - (4) The FamilyCare-Children's Program-Plan B, C or D beneficiary has not attained the age of 19; and
 - vii. Admission of beneficiaries in the Medically Needy Program, except for pregnant women. For information on how to identify a Medically Needy beneficiary, see [N.J.A.C. 10:49-2.3\(c\)](#), Administration.
2. Any service or item requiring prior authorization (see [N.J.A.C. 10:52-1.10](#), Prior authorization) which has been performed without prior authorization.
3. Medically unnecessary items and services, as follows:
 - i. Any service or item which is not medically necessary for the prevention, diagnosis, palliation, rehabilitation or treatment of a disease, injury or condition;

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- ii. Inpatient hospital services rendered prior to the day it is medically necessary for the diagnostic services or surgical or medical treatment for which the patient is admitted.
 - iii. Inpatient hospital services rendered in a general hospital at any time following the day that such services are no longer medically necessary, except when special circumstances, that is, "social necessity," exist which prevent the discharge or transfer of the patient or when an inpatient is eligible for "administrative days" (see [N.J.A.C. 10:52-1.14](#), Social Necessity and [N.J.A.C. 10:52-1.9](#), Administrative Days).
 - iv. Inpatient hospital services denied for lack of medical necessity shall not be covered.
4. Private duty nursing services in the hospital inpatient setting;
 5. Research or Teaching Studies;
 6. Surgery (Elective), as follows:
 - i. Cosmetic Surgery, except that the Division shall consider authorization of a request from the patient's physician for elective cosmetic surgery, if a significant redeeming medical necessity can be demonstrated; and,
 - ii. Second Opinion Elective Procedures without meeting the Second Opinion requirement (see [N.J.A.C. 10:52-1.13](#) Second Opinion Program);
 7. Transportation, except as in [N.J.A.C. 10:52-2.16](#) Transportation-Services (Hospital-based);
 8. Fee-for-service billed by a hospital-based physician who is salaried and whose services are reimbursed as part of the hospital's cost;
 9. Other services and items not directly related to the care of the patient, such as:
 - i. Inpatient items and services including guest meals and accommodations, television, telephone, and similar items and services. Personal items shall be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items; and,
 - ii. Outpatient items and services which are not usually part of the outpatient service; for example, eyeglasses, custom-made limbs and braces, or surgical supplies.
 10. Services and items that are billed by, and payable to, another vendor;
 11. Services and items furnished by the hospital, for which the hospital does not normally charge;
 12. Services and items not medically required for the diagnosis or treatment of a disease, injury or condition; and,
 13. Services provided to a patient during the same period for the same condition by both private practitioner and outpatient facility, or by two different facilities, shall not be covered. Payment shall be made for only one service, except in a medical emergency. (For definition of a medical emergency, see [N.J.A.C. 10:49-6.1\(a\)2.](#))

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.6](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.7](#), Administrative Days (Nursing Facility Level of Care)--General, Special (Classification A & B) and Private Psychiatric Hospitals, recodified to [N.J.A.C. 10:52-1.8](#).

§ 10:52-1.8 Non-covered services (inpatient and outpatient)

Recodified from [N.J.A.C. 10:52-1.7](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), substituted references to beneficiaries for references to recipients and changed N.J.A.C. references throughout, inserted 1vi(3), deleted a former 9, and recodified former 10 through 14 as 9 through 13. Former [N.J.A.C. 10:52-1.8](#), Administrative Days (Nursing Facility Level of Care)--General, Special (Classification A & B) and Private Psychiatric Hospitals, recodified to [N.J.A.C. 10:52-1.9](#).

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), rewrote the introductory paragraph, substituted "a beneficiary who is" for "an individual" preceding "receiving such services" in 1iv(2), added a new 1iv(3), recodified former 1iv(3) as 1iv(4) and rewrote the paragraph, deleted "and/" following "diagnostic services" in 3ii, rewrote 3iii and amended the N.J.A.C. reference in 7.

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a)13, substituted "a medical" for "an" twice, updated the N.J.A.C. reference, and deleted ", Administration" from the end.

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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 \(1979\)](#).

ALJ rejected an insurer's denial of an insured's request for outpatient sacroiliac joint surgery because the proposed surgery was not within the scope of Uniform Medical Policy #139 despite the insurer's claims to that effect. The medical records supported a finding that the treatment would be medically necessary and was directly related to an automobile accident in which the insured was injured. [M.A. v. Horizon NJ Health, OAL DKT. NO. HMA 17596-16, 2017 N.J. AGEN LEXIS 103](#), Initial Decision (February 16, 2017).

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§ 10:52-1.9 Administrative days (nursing facility level of care)--general, special (Classification A & B) and private psychiatric hospitals

(a) For a patient who is no longer in need of inpatient acute level of care and who is awaiting placement in a nursing facility, payment shall be made for "administrative days" if the general, special, rehabilitation, or the private psychiatric hospital is able to demonstrate the following:

1. All other possible health insurance benefits have been utilized;
2. Discharge planning was initiated upon admission of the patient to the hospital and was reviewed and updated regularly;
3. Within one working day of identifying a Medicaid/NJ FamilyCare-Plan A beneficiary as being at risk for nursing facility placement, the hospital notified the Medical Assistance Customer Center (MACC), CSSA, and the Office of Community Choice Options (OCCO). See [N.J.A.C. 10:52-1.11](#), Preadmission screening for nursing facility placement; and
4. The care and services provided are medically necessary, that is, the attending physician wrote a discharge order from acute care or made a written entry in the medical record that the patient could be transferred to a nursing facility (NF), a Preadmission Screening Evaluation (PAS) confirmed the necessity for nursing facility services and placement could not be made in a NF, as substantiated by documentation of timely and continuous contact (at a minimum, twice a week) with family members, nursing facilities (NFs), and placement agencies.

(b) Upon satisfaction of all the conditions listed under (a)1 through 4 above, payment will be made at the statewide weighted average per diem rate paid to Medicaid participating NFs, as determined on January 1 of each year;

(c) [N.J.S.A. 30:4D-6.7](#) and 6.8 require every nursing facility in the State to reserve a Medicaid beneficiary's bed for up to 10 days when the beneficiary is transferred from the nursing facility to a general or private psychiatric hospital. This requirement is applicable to NJ FamilyCare-Plan A beneficiaries also. If the discharged Medicaid or NJ FamilyCare-Plan A beneficiary is unable to return to the nursing facility before the end of the 10-day period, the discharged beneficiary shall have priority for the next available Medicaid bed in the facility. When the beneficiary is admitted to the hospital under the bed reserve policy, the hospital shall:

1. Involve the NF in the preparation of the hospital's discharge planning;
2. Advise the NF of an anticipated discharge date;
3. Keep the NF informed of the patient's progress, particularly if something unexpected happens which causes a revision to the discharge plan; and
4. Give the NF as much advanced notice as possible to prepare for the return of the patient.

§ 10:52-1.9 Administrative days (nursing facility level of care)--general, special (Classification A & B) and private psychiatric hospitals

(d) When the 10-day bed reserve is exceeded and no bed is available in the NF from which the beneficiary was transferred, the hospital shall provide the level of NF care determined appropriate by the Department of Human Services' Division of Aging Services (DoAS)-designated professional staff during the Preadmission Screening Evaluation and authorization until such time as a NF bed is available to the Medicaid/NJ FamilyCare-Plan A beneficiary. (See [N.J.A.C. 10:52-1.11](#).)

(e) For the information of hospital staff assisting in the discharge of a patient to an NF, [N.J.S.A. 30:4D-17.3](#) prohibits, in general, a NF from requiring private pay contracts or donations under certain conditions on behalf of Medicaid beneficiaries. To enforce this prohibition, the law establishes both criminal and civil penalties.

(f) [N.J.S.A. 10:5-12.2](#) of the New Jersey Civil Rights Act prohibits a NF from discriminating against Medicaid eligible persons and beneficiaries of municipal general assistance by denying them admission when the NF's Medicaid occupancy level is below the Statewide occupancy level.

(g) Provisions for reimbursement of administrative days (nursing facility level of care) shall not apply to special hospitals (Classifications A and B).

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.7](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.8](#), Prior Authorization, recodified to [N.J.A.C. 10:52-1.9](#).

Recodified from [N.J.A.C. 10:52-1.8](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Substituted references to beneficiaries for references to recipients throughout; in (a), rewrote 2; in (c), inserted a new second sentence, and inserted a reference to NJ KidCare--Plan A beneficiaries in the third sentence in the introductory paragraph; rewrote former (c)5 as (d); recodified former (d) through (f) as (e) through (g); and in the new (e), deleted a former third sentence. Former [N.J.A.C. 10:52-1.9](#), Prior authorization, recodified to [N.J.A.C. 10:52-1.10](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Rewrote (a); in (c), rewrote the introductory paragraph; rewrote (d).

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a)3, substituted "CWA" for "CBOSS".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (a), inserted a comma following "rehabilitation"; in (a)3 and (d), substituted "Medicaid/NJ" for "Medicaid or NJ"; in (a)3, inserted a comma following "CWA" and following the N.J.A.C. cite; and

§ 10:52-1.9 Administrative days (nursing facility level of care)--general, special (Classification A & B) and private psychiatric hospitals

in (d), substituted "Human Services' Division of Aging Services (DoAS)-designated" for "Health and Senior Services-designated", and inserted "and authorization".

Annotations

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§ 10:52-1.10 Prior authorization

(a) Prior authorization shall be required for certain dental procedures (see [N.J.A.C. 10:56](#), Dental Services) and partial hospitalization provided in the outpatient department of an acute care hospital beyond exempt time frames (see [N.J.A.C. 10:52-2.10\(d\)](#) and (e)).

(b) Other services require adherence to special procedures, such as the requirements of the Second Opinion Program, before certain elective surgical procedures are performed. Specific services are described in the "Policies and Procedures for Providing Specific Services" in N.J.A.C. 10:52-2. Hospital entitlement to Medicaid/NJ FamilyCare reimbursement is subject to providing these services in accordance with the policies and procedures as outlined in N.J.A.C. 10:52-2. For general information about prior and retroactive authorization, see [N.J.A.C. 10:49-6.1](#), Administration.

(c) For out-of-State services, see [42 CFR 431.52](#). Prior authorization as outlined in (d) below shall be required for inpatient and outpatient hospital services provided to a beneficiary outside the State of New Jersey, except as provided in (e) below. Hospital covered services for a beneficiary with an Eligibility Identification Number with the 1st and 2nd digits of 90 or the 3rd and 4th digits of 60, residing out-of-State at the discretion of the New Jersey Department of Human Services, shall not require prior authorization. However, any covered service that requires prior authorization as a prerequisite for payment to New Jersey Medicaid/NJ FamilyCare providers also requires prior authorization if it is to be reimbursed by the Division in any other state, except that prior authorization is not required for emergency and interstate transfers.

(d) A request for authorization for reimbursement for out-of-State services shall be directed to the Medical Assistance Customer Center (MACC) in the area where the beneficiary resides except as listed in (d)1 below. For a listing of MACCs, see the Directory at [N.J.A.C. 10:49](#), Appendix, Form 13 or online at: <http://www.state.nj.us/humanservices/dmahs/info/resources/macc/index.html>.

1. Requests for prior authorization of out-of-State psychiatric services shall be directed to the Division of Medical Assistance and Health Services, Mental Health Unit, Office of Utilization Management, PO Box 712, Mail Code #18, Trenton, NJ 08625-0712.

i. For beneficiaries under age 18 and those individuals who are over the age of 18 and under the age of 21 who were receiving mental/behavioral health services through the Department of Children and Families (DCF) and/or the DCF Children's System of Care prior to their 18th birthday, requests for prior authorization of out-of-State psychiatric services shall be coordinated by the Care Management Organization (CMO) or other authorized entity coordinating the beneficiary's mental/behavioral health services and shall be directed by that entity to the DCF Contracted Systems Administrator (CSA). As part of the coordination of inpatient out-of-State psychiatric hospital services for these beneficiaries, the CMO and/or CSA shall direct requests for prior authorization for these services to the DMAHS in accordance with (d)1 above.

2. For a beneficiary who resides in New Jersey in other than a hospital and who is to be admitted or referred to an out-of-State hospital for elective inpatient or outpatient services, the physician planning

§ 10:52-1.10 Prior authorization

such action shall sign a statement that the medically necessary service is not available at a reasonable distance within the State of New Jersey; and

3. For a beneficiary who is traveling outside New Jersey and who is to be admitted to an out-of-State hospital for elective surgery, the attending physician shall justify by a signed statement that an attempt to return to a New Jersey hospital would create a significant risk to life or health or would create the need for an unreasonable amount of travel for the beneficiary.

4. The Division shall notify, in writing, the physician making the request.

i. If authorized, the authorization letter of the Medical Consultant of the Division shall be forwarded to the requesting physician. When arranging for hospital admission, the physician shall forward a copy of the authorization letter to the hospital. When submitting the claim for services to the fiscal agent, the hospital shall attach the authorization letter, or a copy of the letter, to the claim.

(e) Prior authorization shall not be required for emergencies nor for interstate hospital transfers. However, in these instances, the hospital shall attach the attending physician's signed statement to the claim, attesting to the nature of the emergency or, for a hospital interstate transfer, attesting to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey.

(f) For Medicaid/NJ FamilyCare beneficiaries who have the diagnosis of Head Injury, for whom it is medically necessary to discharge the beneficiary from a hospital or special hospital to a special care nursing facility (SCNF), or to home care through enrollment into Managed Long-Term Supports and Services (MLTSS) under the New Jersey 1115 Comprehensive Medicaid Waiver (the Comprehensive Waiver), the hospital discharge planner or social worker shall obtain prior authorization for the placement (for either in-State or out-of-State patients) from the Medicaid/NJ FamilyCare MCO for enrollment into MLTSS. For information on MLTSS, see [N.J.A.C. 10:60](#).

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.8](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.9](#), Pre-Admission screening for nursing facility (NF) placement, recodified to [N.J.A.C. 10:52-1.10](#).

Recodified from [N.J.A.C. 10:52-1.9](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Substituted references to beneficiaries for references to recipients throughout; in (a) and (f), changed N.J.A.C. references; in (b), substituted a reference to Medicaid and NJ KidCare reimbursement for a reference to Medicaid payment; and in (c), substituted a reference to Eligibility Identification Numbers for a reference to HSP (Medicaid) Case Numbers. Former [N.J.A.C. 10:52-1.10](#), Pre-Admission screening for nursing facility (NF) placement, recodified to [N.J.A.C. 10:52-1.11](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

In (b), substituted "FamilyCare" for "KidCare" preceding "reimbursement" and inserted "in N.J.A.C. 10:52-2" following "procedures as outlined"; in (d), substituted references to MACCs for references to MDOs throughout the introductory paragraph and rewrote 1; rewrote (f).

§ 10:52-1.10 Prior authorization

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a), updated the N.J.A.C. reference; in the introductory paragraph of (d), deleted "the end of the" following "Directory at", substituted "Appendix, Form 13 or online at: <http://www.state.nj.us/humanservices/dmahs/info/resources/macc/index.html>" for "Administration"; in (d)1, inserted "Division of Medical Assistance and Health Services,"; added (d)1i; and in (f), updated the N.J.A.C. references, and deleted "Administration" from the end.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; in (c), substituted "outlined" for "out-lined", and substituted "state" for the fourth occurrence of "State"; in (d)1i, substituted "Children's System of Care" for "Division of Child Behavioral Health Services (DCBHS)", and inserted "(CMO)"; and rewrote (f).

Annotations

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§ 10:52-1.11 Preadmission screening for nursing facility (NF) placement

(a) The Department of Health and Senior Services is the agency responsible for administering the Preadmission Screening Program. The following is provided to hospitals so that they understand the process and the rules a hospital shall follow to ensure Medicaid or NJ FamilyCare-Plan A reimbursement for the care of individuals whose discharge planning includes placement into a nursing facility.

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

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared during the Preadmission Screening (PAS) process. The HSDP reflects the individual's current or potential problems, required care needs, the need for Preadmission Screening and Resident Review (PASRR) and the Track of Care.

"Level I PASRR screen" means the process of identification of an individual meeting the criteria for serious mental illness (MI) or mental retardation (MR) or both, as described throughout this section, and determining whether the individual also meets the NF level of care requirements.

"Level II PASRR evaluation" means the process of evaluating and determining whether an individual meets NF level of care, and determining whether an individual needs specialized services for MI or MR or both. An individual who requires specialized services cannot receive those services in a NF.

"Preadmission screening (PAS)" means that process by which all Medicaid eligible beneficiaries seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF, receive a comprehensive needs assessment by professional staff designated by the Department of Health and Senior Services to determine their long-term care needs and the most appropriate setting for those needs to be met, pursuant to [N.J.S.A. 30:4D-17.10](#). (P.L. 1988, c.97.)

"Preadmission Screening and Resident Review (PASRR)" means that process by which all individuals meeting the clinical criteria for mental illness (MI) or mental retardation (MR), regardless of payment source, are screened prior to admission to an NF in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition. PASRR includes two levels, Level I PASRR screen and Level II PASRR evaluation, as defined above and described in this section.

"Professional staff designated by the Department of Health and Senior Services (DHSS professional staff)" means a nurse licensed or certified in accordance with [N.J.A.C. 13:37](#) or a social worker who performs health needs assessments and care management counseling in accordance with this section.

"Specialized Services for Mental Illness (MI)" means those services that are determined to be medically indicated when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based upon a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24-hour

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supervision of the individual, specific therapies and activities are prescribed, with the following objectives: to diagnose and reduce behavioral symptoms; to improve independent functioning; and as early as possible, to permit functioning at a level where less than Specialized Services are appropriate. Specialized Services go beyond the range of services that an NF is authorized to provide and can only be provided in a 24-hour inpatient psychiatric setting.

"Specialized Services for Mental Retardation (MR)" means those services required when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24-hours per day, to teach the individual functional skills. Specialized Services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is authorized to provide.

"Track of care" means designation of the setting and scope of Medicaid/NJ FamilyCare-Plan A services as determined by the PAS process. The PAS is conducted by the professional staff designated by the Department of Health and Senior Services (DHSS) following an assessment of the Medicaid or NJ FamilyCare-Plan A beneficiary or potential Medicaid or NJ FamilyCare-Plan A beneficiary, as follows:

1. "Track I" means long-term NF care;
2. "Track II" means short-term NF care; and
3. "Track III" means long-term care services in a community setting.

(c) Preadmission screening (PAS) authorization shall be required prior to admission to a Medicaid certified NF of a Medicaid or NJ FamilyCare-Plan A beneficiary, or an individual who may become a Medicaid or NJ FamilyCare-Plan A beneficiary within six months following placement in a Medicaid certified NF. If the NF applicant has received psychiatric inpatient care for a year or more, a PASRR shall be performed, in addition to the PAS, prior to admission. Professional staff designated by DHSS shall assess each individual's care needs and determine the appropriate setting for the delivery of needed services. Professional staff designated by DHSS will authorize or deny NF placement based on the clinical eligibility requirements at N.J.A.C. 8:85-2.1 and the feasibility of alternative placement and will designate the track of care, in accordance with N.J.A.C. 8:85-1.8.

(d) PAS authorization is also required for individuals identified as having a serious MI or MR regardless of the payment source. The PASRR assessment and authorization process shall be subsumed within the State's PAS protocols, as required by (e) below.

1. A Level I PASRR screen shall be required for individuals suspected of, or diagnosed as having serious MI, MR, or both or related conditions.
2. An individual is considered to have a serious mental illness (MI) if he or she has a mental illness, such as schizophrenia, mood disorder, paranoia, panic or severe anxiety disorder, or similar condition found in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR 2000 edition) (available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22269-3901 and www.psych.org) that leads to a chronic disability and that meets the PASRR requirements for diagnosis, level of impairment and duration of illness.
 - i. An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR 2000 edition) and does not have a serious mental illness.
3. An individual is considered to have mental retardation (MR) if he or she has a level of retardation (mild, moderate, severe or profound) described in the "American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983)" or a related condition, as defined by, and pursuant to, Section 1905(d) of the Social Security Act (Omnibus Budget Reconciliation Act of 1987 P.L. 100-203); [42 U.S.C. § 1396\(d\)](#), and (d)3i below. An individual with a diagnosis of MR or a related

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condition and a diagnosis of dementia shall receive a Level II PASRR screen prior to admission to a Medicaid certified nursing facility.

i. "Persons with related conditions" means individuals who have a severe and chronic disability that meets all of the following conditions:

- (1) The person has a diagnosis of mental retardation (MR) or other developmental disability, such as cerebral palsy, epilepsy, autism, spina bifida or other neurological impairment; and
- (2) The person has a history or past records which show that the onset of the mental retardation or related conditions occurred prior to age 22.

4. A Level II PASRR evaluation shall be conducted for mentally ill or mentally retarded individuals only if the assessment performed by the professional staff designated by DHSS results in authorization of NF placement.

i. A Level II PASRR evaluation for individuals with serious MI requires that a psychiatric examination be performed by a Board eligible/certified psychiatrist or APN certified in mental health to determine the need for specialized services, in accordance with (e) below. When all reasonable efforts to secure a psychiatrist fail, an M.D. or D.O. who is not a psychiatrist may perform the examination.

ii. A Level II PASRR evaluation for MR individuals will be performed by the Division of Developmental Disabilities (DDD) to determine the need for specialized services, in accordance with (e) below.

5. Hospitals shall not transfer an individual requiring a Level II PASRR evaluation to Medicaid-certified NFs until the Level II PASRR has been conducted and the hospital has received a Department of Health and Senior Services Office of Community Choice Options letter of approval indicating that the individual does not require specialized services.

6. For individuals diagnosed with Alzheimer's or related dementias, documentation to support the diagnosis, including the history, physical examination and diagnostic workup shall be provided to the admitting Medicaid certified nursing facility for the individual's clinical record.

7. After an initial PASRR process has been completed, the individual transferred from a nursing facility to an acute care general hospital or an individual with serious MI being transferred to a psychiatric hospital for less than one year shall not require a Level I PASRR screen or a Level II PASRR evaluation prior to transfer back to a nursing facility. If the individual is transferred to a different facility, the hospital discharge planner shall advise the admitting NF of the individual's former NF placement.

(e) The determination of the necessity for NF level of care shall be performed through Preadmission Screening (PAS), as mandated by [N.J.S.A. 30:4D-17.10](#). Professional staff designated by DHSS shall determine the necessity for NF level of care for Medicaid and NJ FamilyCare-Plan A beneficiaries, for individuals who may become Medicaid and NJ FamilyCare-Plan A beneficiaries within six months following admission to a Medicaid certified facility, and for individuals identified as meeting PASRR Level I criteria. The Office of Community Choice Options (OCCO) having jurisdiction for the area where an acute care hospital is located has the responsibility for completing the PAS assessment regardless of the beneficiary's county of residence or anticipated county of discharge. A listing of the Offices of Community Choice Options can be obtained by writing to the Director, Division of Aging and Community Choice Options, Department of Health and Senior Services, PO Box 807, Trenton, New Jersey 08625-0807, or by accessing the DHSS Division of Consumer Support website at www.state.nj.us/health/consumer/directory.htm, or by accessing the fiscal agent website at www.njmmis.com and clicking on the "Frequently Asked Questions" tab.

1. Professional staff designated by DHSS will review the medical, nursing and social information obtained at the time of assessment, as well as any other supporting data, in order to assess the individual's care needs and determine the appropriate setting for the delivery of needed services. The professional staff designated by DHSS will authorize or deny NF placement based on the clinical

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eligibility requirements found at N.J.A.C. 8:85-2.1 and the feasibility of alternative placement. Professional staff designated by DHSS will also designate the track of care.

- i. If alternative care is available, accessible and appropriate to the needs of the individual, the request for NF placement will be denied.
- ii. If an appropriate alternative placement becomes available and accessible for a person already approved for NF care and awaiting placement, the authorization for NF placement will be rescinded.
- iii. The professional staff designated by DHSS will advise the hospital discharge planner or social worker of the NF level of care approval and the setting for the delivery of needed services. If the individual requires a Level II PASRR evaluation, a letter will be given to the individual advising him or her that the Level II PASRR evaluation must be completed prior to admission to the NF.

2. The professional staff designated by DHSS will schedule and perform the assessment process within three working days of the hospital discharge planner or social worker's initial contact with the OCCO. Individuals who exhibit unstable, severe medical conditions, such as a patient in the Intensive Care or Coronary Care Unit or a patient who is awaiting surgery, shall not be referred for PAS until that condition has stabilized.

3. A signed Release of Information form shall be obtained from the potentially Medicaid-eligible patient. If the patient refuses NF placement, home care services, or participation in the PAS assessment process, the professional staff designated by DHSS will make every effort to obtain a signed participation declination statement, which will be included in the patient's OCCO case record.

4. NF placement approval: The professional staff designated by DHSS will verbally advise the hospital discharge planner or social worker and patient or legal representative of the assessment decision.

- i. For a Track I or II determination, the professional staff designated by DHSS will leave a copy of the HSDP and signed approval letter with the discharge planner or social worker. For individuals requiring a Level II PASRR evaluation, the signed approval letter and HSDP shall be forwarded only after the determination has been made that no specialized services are required.
- ii. For a Track III determination, the professional staff designated by DHSS will leave a copy of the HSDP with the discharge planner or social worker to forward to the home care provider. The discharge planner or social worker shall arrange needed home health services and forward a copy of the HSDP to the home care agency. A Track III determination shall not be an authorization for NF services.
- iii. The original approval letter signed by the professional staff designated by DHSS will be sent by the OCCO to the individual or his or her legal representative with copies to the county social service agency (CSSA).
- iv. A copy of the HSDP must be attached to the hospital discharge material and forwarded with the patient to the admitting NF.

(1) If the patient being transferred will be eligible for Medicare benefits, the transfer shall be made to a Medicare/Medicaid participating NF.

5. NF placement denial: The professional staff designated by DHSS will verbally advise the hospital discharge planner or social worker and patient or the patient's legal representative of the assessment decision. The professional staff designated by DHSS will leave a signed copy of the NF placement denial letter with the discharge planner or social worker. The original denial letter, signed by the professional staff designated by DHSS, will be sent to the patient or the patient's legal representative by the OCCO, with copies to the county social service agency (CSSA).

(f) The hospital discharge planner or social work staff shall be responsible for identifying a Medicaid or NJ FamilyCare-Plan A beneficiary inpatient or a Medicaid or NJ FamilyCare-Plan A applicant inpatient who may be at risk of NF placement.

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1. The identification process shall also include any inpatient in need of NF care who may become a Medicaid or NJ FamilyCare-Plan A beneficiary within six months after NF admission, as well as individuals meeting PASRR Level I criteria. (See [N.J.A.C. 10:52-1.9\(c\)](#).) These patients shall be referred by the hospital to the OCCO and the CSSA on the basis of the "At Risk Criteria for Nursing Facility Placement and Referral to the OCCO for PAS Evaluation" in (g) below. Medicaid or NJ FamilyCare-Plan A beneficiaries already residing in Medicaid participating facilities who are transferred to an acute care hospital and who are transferred to either the same or a different NF, shall not require PAS authorization.

i. Within one working day of identifying an inpatient as being at risk for NF placement, the hospital discharge planner or social worker shall:

(1) Make a telephone or FAX referral to the OCCO and the CSSA;

(2) If not already a Medicaid or NJ FamilyCare-Plan A beneficiary, generate a Public Assistance Inquiry (PA-1C) to initiate the application process for Medicaid or NJ FamilyCare-Plan A; and

(3) Within two working days of the telephone referral to the OCCO and CSSA, the Hospital Discharge Planning Office shall forward the completed "Hospital Preadmission Screening Referral (LTC-4)" to the OCCO, unless the LTC-4 was faxed on the day of the referral.

2. The Level II PASRR evaluation for individuals identified as meeting the PASRR criteria shall be completed by a Board eligible or Board certified psychiatrist or APN certified in psychiatric/mental health:

i. The hospital discharge planning unit or social services department shall immediately arrange through the individual's attending physician, a consultation by a Board eligible, a Board certified hospital staff psychiatrist or an APN certified in mental health to complete the "PASRR Psychiatric Evaluation" (DMHS 2009) form. The "PASRR Psychiatric Evaluation" form shall not be completed until such time as the professional staff designated by DHSS has determined the level of care and the need for a PASRR Level II evaluation.

ii. Within 48 hours of completion of the PASRR Level II evaluation, the completed "PASRR Psychiatric Evaluation" form shall be faxed to (609) 777-0662 or mailed to the Division of Mental Health Services, PO Box 727, Trenton, New Jersey 08625-0727, Attention: PASRR Coordinator.

(1) A copy of the "PASRR Psychiatric Evaluation" form may be requested from the PASRR Coordinator in the Division of Mental Health Services.

iii. The OCCO shall contact the appropriate Regional Office of the Division of Developmental Disabilities (DDD) agency to advise them of the need for a Level II PASRR evaluation. The Level II PASRR evaluation will be completed by the DDD staff within three working days of the OCCO contact.

iv. DMHS or DDD shall notify the OCCO of the determination of need for specialized services who, in turn, shall provide the hospital discharge planning unit or social services department with the approval or denial decision for placement in a Medicaid-certified NF.

(g) The following "At-Risk Criteria for Nursing Facility Placement and Referral to the OCCO for PAS" shall be utilized by the hospital in determining if a referral for long-term care services, either in an NF or in the community, is indicated:

1. The medical criteria are as follows. Has the patient experienced any of the following:

i. Catastrophic illness requiring major changes in lifestyle or living conditions, such as, multiple sclerosis, stroke, multiple trauma, AIDS, amputation, neurological disease, cancer, birth defect(s), or end stage renal disease;

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- ii. Debilitation or chronic illness causing progressive deterioration of self-care skills, such as, severe chronic disease, spina bifida, progressive pulmonary disease or diabetes;
- iii. Multiple hospital admissions within the past six months not including patients admitted directly from NFs;
- iv. Previous NF admissions within the past two years; or
- v. Major health needs, that is, tube feedings, special equipment or treatments, rehabilitation/restorative services.

2. The social criteria are as follows: In addition to the medical criteria, does the patient meet any of the following social situations:

- i. Homeless;
- ii. Lives alone and/or has no immediate support system;
- iii. Primary caregiver is not able to provide required care services; or
- iv. Lack of adequate support systems.

3. The financial criteria are as follows. Does the patient meet any of the income and asset tests:

- i. Currently eligible for Medicaid or NJ FamilyCare-Plan A;
- ii. Monthly income at/or below the current institutional level specified at [N.J.A.C. 10:71-5.6](#).

(1) Has no spouse in the community and resources no greater than those specified at [N.J.A.C. 10:71-4.4](#) and [4.5](#);

(2) Has no spouse in the community and has resources at or below the maximum amount allowable, as determined by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Medicare Catastrophic Coverage Act of 1988 (see [N.J.A.C. 10:71](#)). (This is an indication that the patient may become Medicaid or NJ FamilyCare-Plan A eligible within the next six months by spending down assets in an NF as private pay); or

(3) Has a spouse in the community with combined countable resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see [N.J.A.C. 10:71](#)).

iii. Monthly income at or below the current New Jersey Care . . . Special Medicaid programs maximum monthly income limit specified at [N.J.A.C. 10:72-4.1](#) and:

(1) Has no spouse in the community and resources no greater than those specified at [N.J.A.C. 10:71-4.4](#) and [4.5](#);

(2) Has no spouse in the community and resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see [N.J.A.C. 10:71](#)). This is an indication that the patient may become Medicaid or NJ FamilyCare-Plan A eligible within the next six months by spending down assets in an NF as private pay; or

(3) Has a spouse in the community with combined countable resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see [N.J.A.C. 10:71](#)).

(h) The hospital discharge planner or social worker shall be responsible for the discharge or placement arrangements of the patient.

1. For each hospital patient referred for PAS, the hospital shall complete and send to the OCCO a "Hospital Preadmission Screening Discharge form (LTC-8)."

§ 10:52-1.11 Preadmission screening for nursing facility (NF) placement

i. For any patient discharged to a NF, a Discharge Package (HSDP, discharge paper work, DHSS approval letter, hospital transfer sheet and PASRR documentation, including any documentation which supports a diagnosis of Alzheimer's disease or related organic dementia) shall be compiled to accompany the patient to the NF.

(1) If the patient being transferred to a NF is eligible for Medicare benefits, the transfer shall be made to a Medicare/Medicaid participating NF.

ii. For those beneficiaries discharged to community locations, the hospital social worker or discharge planner shall be responsible for the implementation of the HSDP by securing home care services.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.9](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.10](#), Recordkeeping, recodified to [N.J.A.C. 10:52-1.11](#).

Recodified from [N.J.A.C. 10:52-1.10](#) and 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. Former [N.J.A.C. 10:52-1.11](#), Recordkeeping, recodified to [N.J.A.C. 10:52-1.12](#).

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.2011 d.010, effective January 3, 2011.

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

Rewrote (b) through (f).

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§ 10:52-1.12 Recordkeeping

Hospitals shall be required to keep legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. This information shall be available upon the request of the Division or its agents.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.10](#) by R.1998 d.564, effective December 7, 1998.

See: [30 New Jersey Register 1257\(a\)](#), [30 New Jersey Register 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.11](#), Second opinion program for elective surgical procedures, recodified to [N.J.A.C. 10:52-1.12](#).

Recodified from [N.J.A.C. 10:52-1.11](#) by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Former [N.J.A.C. 10:52-1.12](#), Second opinion program for elective surgical procedures, recodified to [N.J.A.C. 10:52-1.13](#).

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§ 10:52-1.13 Second opinion program for elective surgical procedures

(a) A second opinion shall be obtained for any elective surgical procedures listed under (b) below. The outcome of the second opinion shall have no bearing on reimbursement. Once the second opinion is rendered, the beneficiary shall retain the right to decide whether or not to proceed with the surgery; however, failure to obtain a second opinion for these procedures shall result in a denial of the hospital claim.

1. If the operating physician determines that the need for surgery is urgent or is an emergency, no second opinion shall be required. "Urgent" or "emergency" includes any situation in which a delay in performing surgery in order to meet the second opinion requirement could result in a significant threat to the patient's health or life.

i. Reimbursement for urgent or emergency surgery shall be made only if a specific statement is attached to the claim form by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. If the Medicaid/NJ FamilyCare beneficiary is covered by another health insurance carrier (except Medicare), which makes only partial payment on the claim, the fiscal agent shall not make supplementary payment unless the second opinion requirement has been met. However, the fiscal agent shall make payment on the claim if the hospital receives documentation that a second opinion was arranged for and paid for by another health insurance carrier. A copy of this documentation shall be attached to the claim form.

(b) The following elective surgical procedures fall under the Second Opinion Program:

1. Hernia Repair (common abdominal wall type);

i. A second opinion shall be required for any herniorrhaphy involving an adult over 18 years of age.

ii. A second opinion shall not be required for herniorrhaphy involving a child or young adult 18 years of age or under.

2. Hysterectomy (See also [N.J.A.C. 10:52-2.14](#));

3. Laminectomy;

4. Spinal fusion;

i. A second opinion shall not be required for spinal fusion for scoliosis in a child or young adult 18 years of age or under.

(c) A second opinion shall be arranged through the Medicaid Second Opinion Referral Services of the Provider Services Unit at the fiscal agent.

1. A consultation ordered by a physician shall not meet the Program's definition of a second opinion and no "Authorization for Payment" shall be granted based on such a consultation. The only exception

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to this policy involves second opinions arranged and paid for by other health insurance carriers. (See (a)2 above.)

2. In order to prevent claim denial as a result of a situation in which one of the elective surgical procedures is scheduled and performed before the second opinion requirement is met, it is suggested that the elective surgery not be scheduled until after the second opinion has been rendered.

(d) Neither the physician claim nor hospital claim associated with one of the second opinion procedures shall be paid unless attached to the hard copy is an "Authorization for Payment," or documentation of a second opinion arranged through another health insurance carrier, or a specific statement from the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

1. Reimbursement shall not be made for a second opinion rendered to an individual who is not a Medicaid/NJ FamilyCare fee-for-service beneficiary. The issuance of a Second Opinion Referral to the beneficiary by the Program's Second Opinion Referral Services of the Provider Services Unit shall not guarantee the individual's eligibility on the date of the second opinion or subsequent surgery. The individual's current Medicaid/NJ FamilyCare eligibility shall be verified by checking the individual's current New Jersey HBID card before rendering any service. (See [N.J.A.C. 10:49-2.2](#) and [2.5](#), Administration--How to Identify a Medicaid/NJ FamilyCare Beneficiary).

(e) For physician requirements regarding Second Opinion procedures, see [N.J.A.C. 10:54](#), Physician Services.

History

HISTORY:

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 "beneficiary" for "recipient" in the introductory paragraph and inserted a reference to NJ KidCare in 2; in (b), rewrote 1, changed the N.J.A.C. reference in 2, and deleted 5; and in (d)1, substituted "beneficiary" for "recipient", deleted references to Medicaid, and inserted references to NJ KidCare throughout.

Recodified from [N.J.A.C. 10:52-1.11](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.12](#), Social Necessity Days, recodified to [N.J.A.C. 10:52-1.13](#).

Recodified from [N.J.A.C. 10:52-1.12](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), substituted a reference to reimbursement for a reference to payment in the introductory paragraph, and substituted a reference to NJ KidCare Plan--A, B or C beneficiaries for a reference to NJ KidCare beneficiaries; in (b)2 and (d)1, changed N.J.A.C. references; and in (d)1, substituted a reference to NJ KidCare fee-for-service beneficiaries for a reference to NJ KidCare beneficiaries. Former [N.J.A.C. 10:52-1.13](#), Social Necessity Days, recodified to [N.J.A.C. 10:52-1.14](#).

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)2, and (d)1, substituted references to FamilyCare for references to KidCare.

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Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a)2 and (d)1, substituted "Medicaid/NJ" for "Medicaid or NJ" throughout; in (a)2, inserted a comma following "Medicare"; and in (d)1, substituted "HBID card" for "Validation Form".

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§ 10:52-1.14 Social Necessity Days

(a) Payment for "Social Necessity Days" shall be made to hospitals for a maximum of 12 calendar days per hospitalization for a Medicaid/NJ FamilyCare-Children's Program fee-for-service beneficiary child admitted with the diagnosis of child abuse or suspected child abuse, if special circumstances (social necessity) prevent the discharge or transfer of the patient and the hospital has taken effective action to initiate discharge or transfer of the patient.

1. For these cases, it is not necessary for the day of admission to be at the acute level of care.
2. Effective action is defined as telephone notification to the county social service agency (CSSA), or Division of Child Protection and Permanency (CP&P) local office, or other responsible officials as may be designated, within 48 hours of the time that the stay is determined to be no longer medically necessary. This telephone contact then shall be confirmed in writing within three working days. A copy of the written notification shall be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).
3. Medicaid/NJ FamilyCare-Children's Program reimbursement for social necessity shall be made to hospitals paid in accordance with the DRG rate setting methodology in N.J.A.C. 10:52-5 through 7 and 9 prior to August 3, 2009, and in accordance with N.J.A.C. 10:52-14 on or after August 3, 2009.
 - i. Payment for Social Necessity Days will be made at the Statewide average per diem rate paid to Medicaid participating nursing facilities (NF) as determined on January 1 of each calendar year.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.12](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.13](#), Utilization control (inpatient services), recodified to [N.J.A.C. 10:52-1.14](#).

Recodified from [N.J.A.C. 10:52-1.13](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), substituted a reference to Medicaid and NJ KidCare--Plan A fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph, substituted a reference to CBOSS for a reference to CWA in 2, and substituted a reference to Medicaid and NJ KidCare--Plan A reimbursement for a reference to Medicaid

§ 10:52-1.14 Social Necessity Days

reimbursement in 3. Former [N.J.A.C. 10:52-1.14](#), Utilization control (inpatient services), recodified to [N.J.A.C. 10:52-1.15](#).

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-Children's Program" for "KidCare Plan A" in the introductory paragraph and 5.

Amended by R.2009 d.249, effective August 3, 2009.

See: [41 N.J.R. 1351\(a\)](#), [41 N.J.R. 2895\(a\)](#).

In (a)3, inserted "7 and" and "prior to August 3, 2009 and in accordance with N.J.A.C. 10:52-14 on or after August 3, 2009".

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

Added (a)3i.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (a), and in (a)3, substituted "Medicaid/NJ" for "Medicaid or NJ"; and rewrote (a)2.

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§ 10:52-1.15 Utilization control (inpatient services)

(a) This section provides information on the requirements for utilization control for inpatient services for approved acute general hospitals, special hospitals, and private psychiatric hospitals, with the exception of inpatient psychiatric hospital services for individuals under the age of 21. See [N.J.A.C. 10:52-1.16](#).

(b) For purposes of this rule, the following words and terms shall have the following meanings:

"Utilization control" means an approved program instituted, implemented and operated by or under the authorization of a utilization review organization (URO) which effectively safeguards against unnecessary or inappropriate Medicaid/NJ FamilyCare services and assesses the quality of those services to Medicaid/NJ FamilyCare fee-for-service beneficiaries.

(c) Under the Social Security Act, Section 1903(g) and (h), the Division is responsible for an effective program to control the utilization of services in hospitals. (See 42 CFR Part 456, Utilization Control, Subchapter B, C, and D). The required reviews of inpatient hospital services shall be conducted by Quality Improvement Organizations (QIOs), which shall be reimbursed by the State once a contract has been secured to provide these services in accordance with [N.J.A.C. 10:52-14.6\(a\)2i](#). Included under utilization control are: Certification and recertification of the need for inpatient care; medical, psychiatric and social evaluations; a plan of care established and periodically reviewed and evaluated by a physician; and a continuous program of utilization review under which the admission of each beneficiary is reviewed or screened. Hospital entitlement to Medicaid/NJ FamilyCare reimbursement for services rendered to a Medicaid/NJ FamilyCare fee-for-service beneficiary for each period of hospitalization shall be subject to the following requirements:

1. A physician shall certify, for each beneficiary or applicant, that inpatient services in the acute care or in the private psychiatric hospital are or were needed.

i. The certification shall be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid/NJ FamilyCare program authorizes payment.

ii. The certification shall be in writing and signed, or initialed, by a physician. The signature or initials are not acceptable if they are rubber stamped unless the physician has initialed the stamped signature. The physician shall date the certification on the date he or she signs it.

iii. The certification for any Medicaid/NJ FamilyCare fee-for-service patient shall be maintained in the beneficiary's medical record.

iv. Acceptable documentation for certification or recertification may be any of the following:

(1) A statement signed and dated, by the attending physician, staff physician, and/or consultant physician who has knowledge of the case, attesting that the beneficiary is in need of hospital care.

(2) Physician's orders which are signed and dated on admission and clearly attest to the need for hospital care.

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(3) A medical evaluation which designates the services and which is signed and dated by a physician who has knowledge of the case.

(4) An admission review form signed and dated by an attending or staff physician who has knowledge of the case.

2. A physician shall recertify, for each Medicaid/NJ FamilyCare fee-for-service beneficiary or applicant, that inpatient services in a hospital are needed.

i. Recertification shall be made at least every 60 days after certification.

ii. The recertification shall be in writing, shall attest to the need for inpatient services, and shall be signed or initialed by a physician who has knowledge of the case.

iii. The physician shall date the recertification on the date that he or she signs it.

iv. The recertification shall demonstrate the need for the level and type of care that the beneficiary is receiving.

v. The recertification for any Medicaid/NJ FamilyCare fee-for-service beneficiary shall be maintained in the beneficiary's medical record.

vi. Acceptable documentation for recertification shall include any one of the following:

(1) A signed and dated statement by the physician who has knowledge of the case, attesting that continued care of a particular level or type is needed; or,

(2) Signed and dated orders by the physician who has knowledge of the case that clearly indicated that continued care is needed; or,

(3) Signed and dated progress notes by the physician who has knowledge of the case that clearly indicate that continued care is needed; or,

(4) Signed and dated reports that a physician might use in caring for the beneficiary that clearly indicate that continued care is needed; or,

(5) An admission certification or recertification form signed and dated by a physician who has knowledge of the case; or

(6) Utilization Review Committee (URC) minutes or form which indicate that the beneficiary's care was reviewed by a physician who had knowledge of the case and that continued care was needed. The physician's signature, with the date, shall be attached to the URC minutes or forms.

3. Any days billed by the hospital that are not in compliance with the certification/recertification requirements in (b)1 and 2 above shall be considered non-certified days and shall not be reimbursed by the Division.

i. Claims submitted that include non-certified days, (that is, "carved out" days or continued stay denials) as determined by the Division or its agents to affect billing, shall be billed "hard copy" and be accompanied by a certification of stay form.

(d) Before admission of an applicant or beneficiary to a private psychiatric hospital or before authorization for payment, the attending or staff physician shall make a medical evaluation of each applicant's or beneficiary's need for care in the hospital; and appropriate personnel shall make a psychiatric and social evaluation.

1. Each medical evaluation shall include the following:

i. Diagnoses;

ii. Summary of present medical findings;

iii. Medical history;

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- iv. Mental and physical functional capacity;
- v. Prognoses; and,
- vi. A recommendation by a physician concerning admission to the mental hospital, or continued care in the hospital for individuals who apply for Medicaid or NJ FamilyCare while in the private psychiatric hospital.

(e) A plan of care shall be established prior to admission. Before admission of an applicant or beneficiary to an acute care general, special hospital, or private psychiatric hospital or before authorization for payment, a physician and other personnel in an acute care general and special hospital or the attending or staff physician in a private psychiatric hospital involved in the care of the individual shall establish a written plan of care for each Medicaid/NJ FamilyCare beneficiary or applicant.

1. The plan of care shall include:
 - i. Diagnoses, symptoms, complaints, and complications, indicating the need for admission;
 - ii. A description of the functional level of the individual;
 - iii. Objectives of the care (in private psychiatric hospitals only);
 - iv. Any order for diagnostic procedures; medications; treatments; consultations; restorative and rehabilitative services; patient activities; therapies; social services; diet; and, for private psychiatric hospitals only, special procedures for the health and safety of the patient;
 - v. Plans for continuing care, as appropriate; and, in a private psychiatric hospital, the review and modification of the plan of care; and,
 - vi. Plans for discharge, as appropriate.
2. Orders and activities shall be developed in accordance with the physician's instructions, (only for acute care general and/or special hospitals).
3. Orders and activities shall be reviewed and revised as appropriate by all personnel involved in the care of an individual (only for acute care general and/or special hospitals).
4. In acute care general and special hospitals, a physician and other personnel involved in the Medicaid/NJ FamilyCare beneficiary's case shall review each plan of care at least every 60 days.
5. In private psychiatric hospitals, for beneficiaries age 65 or over, the attending or staff physician and other personnel involved in the beneficiary's care shall review each plan of care at least every 90 days; and
6. Reports of evaluations and plans of care shall be entered in the applicant's or beneficiary's record, as follows:
 - i. At the time of admission; or
 - ii. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

(f) For the Utilization Review (UR) Plan, each hospital shall evaluate the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. The UR includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices. (See [42 CFR 456.100](#) through [456.145](#), incorporated herein by reference.)

1. Upon admission of the patient to the hospital, a discharge plan shall be initiated and thereafter reviewed and updated regularly.
2. Any Medicaid/NJ FamilyCare-Plan A beneficiary or potential Medicaid/NJ FamilyCare-Plan A beneficiary who is considered for admission to a NF shall receive a preadmission screening in accordance with [N.J.A.C. 10:52-1.11](#).

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3. When an inpatient is to be discharged from the hospital and continuing medical care is required, either in another medical facility (such as a NF, special hospital) or by a community health agency (such as a home health agency), the hospital shall provide the facility or agency with a legible abstract or summary of the patient's care while hospitalized and recommendations for further medical care.

i. This information shall be provided at the time of hospital discharge and shall be signed by the attending physician. The patient information transfer form (adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association) for a transfer from a hospital to a NF, or an equivalent transfer form, shall be used.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.13](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.14](#), Utilization control; inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals, recodified to [N.J.A.C. 10:52-1.15](#).

Recodified from [N.J.A.C. 10:52-1.14](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare fee-for-service throughout; in (b), deleted "Utilization Review Organization (URO)" definition; in (c), substituted a reference to Medicaid and NJ KidCare--Plan reimbursement for a reference to Medicaid payment in the introductory paragraph; in (d)1vi, inserted a reference to NJ KidCare; in (e), inserted references to NJ KidCare beneficiaries throughout; and in (f)2, inserted references to NJ KidCare--Plan A beneficiaries, and changed N.J.A.C. reference. Former [N.J.A.C. 10:52-1.15](#), Utilization control; inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals, recodified to [N.J.A.C. 10:52-1.16](#).

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.2009 d.249, effective August 3, 2009.

See: [41 N.J.R. 1351\(a\)](#), [41 N.J.R. 2895\(a\)](#).

In the introductory paragraph of (c), deleted a comma preceding "and D)", and substituted "Quality Improvement Organizations (QIOs)" for "Utilization Review Organizations (UROs)" and "State once a contract has been secured to provide these services in accordance with [N.J.A.C. 10:52-14.6\(a\)2i](#)." for "hospitals. Reimbursement rates shall include funding for these required reviews."

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; in the introductory paragraph of (c), inserted a comma following "C"; and in the introductory paragraph of (f), inserted a comma following "stay".

Annotations

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§ 10:52-1.16 Utilization control: inpatient psychiatric services for beneficiaries under 21 years of age in private psychiatric hospitals

(a) This section specifies the unique requirements for certification of the need for inpatient psychiatric services provided to beneficiaries under 21 years of age in private psychiatric hospitals. In accordance with Section 1905(a)16 and (h) of the Social Security Act, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the beneficiary's condition. This section also includes general requirements; certification of the need for services, which involves "active treatment" as defined in (c) below; requirements for the team certifying the need for services; and requirement for an individual plan of care. These requirements do not apply to an admission to a psychiatric unit of a general hospital. See [N.J.A.C. 10:52-1.15](#) for requirements on utilization control in an acute care general hospital.

(b) This rule applies only to inpatient psychiatric services in an approved private psychiatric hospital for the treatment of children and youths before NJ FamilyCare-Children's Program beneficiaries reach age 19 and before the Medicaid beneficiary reaches age 21 or, if the Medicaid beneficiary was receiving the services immediately before he reached age 21, before the earlier of the following:

1. The date the beneficiary no longer requires the services; or
2. The date the beneficiary reaches age 22. (See [42 CFR 441.151](#)).

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

1. "Active treatment" means implementation of a professionally developed and supervised plan of care, as described in (f) below, that is:
 - i. Developed and implemented no later than 14 days after admission; and,
 - ii. Designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time.
2. "Independent team" means a team that is not associated with the facility; for example, none of the members of the team has an employment or consultant relationship with the admitting facility. The independent team shall include a physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry and who has knowledge of the individual's clinical condition and situation.
3. "Interdisciplinary team," as described in Federal regulations in [42 CFR 441.156](#), is comprised of those employed by, or those who provide services to, Medicaid/NJ FamilyCare beneficiaries in the facility or program, and include, at a minimum, either a Board-eligible or Board-certified psychiatrist; or a physician and a clinical psychologist who has a doctoral degree; or a physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has

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a Master's degree in clinical psychology or who has been certified by the State psychological association; and one of the following:

- i. A psychiatric social worker;
- ii. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;
- iii. A psychologist who has a Master's degree in clinical psychology or who has been certified by the State or by the State psychological association; or,
- iv. An occupational therapist who is licensed by the State in which the individual is practicing, if applicable, and who has specialized training or one year experience in treating mentally ill individuals.

4. "Plan of care" means a written plan developed for each beneficiary to improve the beneficiary's condition to the extent that the beneficiary no longer needs inpatient care.

(d) Certification of the need for services (see [42 CFR 441.152](#)) shall be made by a team, either independent or interdisciplinary, as specified in (e) below, and shall include the following statements: The team shall certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
2. Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. Services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that inpatient services would no longer be needed.

(e) The certification of the need for services, as stated in (d) above, shall be made by teams, in accordance with Federal regulations, [42 CFR 441.153](#) and specified as follows:

1. Certification for the admission of an individual who is a beneficiary when admitted to a facility or program shall be made by an independent team, as described in (c) above.
2. Certification for an inpatient applying for Medicaid/NJ FamilyCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (c) above.
3. Certification of an emergency admission of a beneficiary shall be made by the interdisciplinary team responsible for the plan of care, in accordance with Federal regulation, [42 CFR 441.156](#), and as described in (f)1 below.

(f) Within 14 days of admission to a private psychiatric hospital, or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or beneficiary to improve the beneficiary's condition to the extent that inpatient care no longer is necessary, in accordance with (e) above. (See [42 CFR 456.180](#) and [456.181](#).)

1. The plan of care shall:

- i. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary's clinical condition and situation and reflects the beneficiary's need for inpatient psychiatric care;
- ii. Be developed by a team of professionals as described in (g) below in consultation with the beneficiary, the beneficiary's parents, legal guardians or others in whose care he or she will be released after discharge;
- iii. State treatment objectives;

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- iv. Prescribe an integrated program of therapies, activities and experiences designed to meet the beneficiary's treatment objectives; and
 - v. Include, at an appropriate time, post discharge plans and coordination of inpatient services with the partial discharge plan and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.
2. The plan shall be reviewed every 30 days by the team to:
- i. Determine that services being provided are or were required on an inpatient basis; and,
 - ii. Recommend changes in the plan as indicated by the beneficiary's overall adjustments as an inpatient.
- (g) Functions of the interdisciplinary team developing the individual plan of care are as follows:
- 1. The individual plan of care as described under [42 CFR 441.155](#), shall be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the psychiatric hospital.
 - 2. Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of the following:
 - i. Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities;
 - ii. Assessing the potential resources of the beneficiary's family;
 - iii. Setting treatment objectives; and,
 - iv. Prescribing therapeutic modalities to achieve the plan's objectives.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.14](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Former [N.J.A.C. 10:52-1.15](#), Utilization control; outpatient psychiatric services, recodified to [N.J.A.C. 10:52-1.16](#).

Recodified from [N.J.A.C. 10:52-1.15](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Substituted references to beneficiaries for references to recipients throughout; in (b), inserted "before the NJ KidCare beneficiaries reach age 19 and" in the introductory paragraph; and in (c)3 and (e)2, inserted references to NJ KidCare. Former [N.J.A.C. 10:52-1.16](#), Utilization control; outpatient psychiatric services, recodified to [N.J.A.C. 10:52-1.17](#).

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.2018 d.104, effective May 21, 2018.

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See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (c)3, substituted "Medicaid/NJ" for "Medicaid and NJ"; and in (e)2, substituted "Medicaid/NJ" for "Medicaid or NJ".

Annotations

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§ 10:52-1.17 Utilization control; outpatient psychiatric services

(a) The following requirements in this rule were developed to help ensure the appropriate utilization of outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a plan of care, performance of periodic reviews for evaluation purposes, and supportive documentation for services rendered. Outpatient psychiatric services include the initial evaluation; individual psychotherapy; group psychotherapy; family therapy; family conference; partial hospitalization (see [N.J.A.C. 10:52-2.10](#)); psychological testing; and medication management.

(b) The intake evaluation shall be performed as follows:

1. An intake evaluation shall be performed within 14 days or by the third outpatient visit, whichever is later, for each Medicaid beneficiary being considered for continued treatment, and shall consist of a written assessment that:
 - i. Evaluates the beneficiary's mental condition; and
 - ii. Determines whether treatment in the program is appropriate, based on the patient's diagnosis; and,
 - iii. Includes certification (signed statement) by the evaluation team that the program is appropriate to meet the patient's treatment needs; and,
 - iv. Is made part of the patient's records.

(c) The evaluation team requirements shall be as follows:

1. The evaluation team for the intake process shall include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified, in accordance with [42 CFR 441.153](#)).

(d) The plan of care requirements shall be as follows:

1. A written individualized plan of care shall be developed by the evaluation team for each patient who receives continued treatment. The plan of care shall be included in the patient's records and shall be designed to improve the patient's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The plan of care shall consist of the following:
 - i. A written description of the treatment objectives which include the treatment regimen, the specific medical and remedial services, therapies, and activities that will be used to meet the objectives;
 - ii. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
 - iii. A description designation of the type of personnel that will be furnishing the services; and,

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iv. A projected schedule for completing reevaluations of the patient's condition and updating the plan of care.

(e) Documentation for outpatient psychiatric services shall be as follows:

1. For psychiatric services, the outpatient department shall develop and maintain written documentation to support each medical or remedial therapy, service, activity or session for which billing is made. Such documentation shall include, at a minimum, the following:

- i. The specific services rendered, such as individual psychotherapy or family therapy;
- ii. The date and the actual time services were rendered;
- iii. The duration of services provided, such as 1 hour or 1/2 hour;
- iv. The signature of the practitioner who rendered the services;
- v. The setting in which services were rendered; and,
- vi. A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

2. Clinical progress, complications and treatment which affect prognosis or progress shall be documented in the patient's medical record at least once a week for partial hospitalization and at each patient contact or visit for other psychiatric services. Any other information important to the clinical picture, therapy and prognosis shall also be documented.

- i. The individual services provided under partial hospitalization shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, shall be made at least once a week.

3. For services requiring prior authorization, such as partial hospitalization (see [N.J.A.C. 10:52-2.11](#)), a departure from the plan of care requires a new request for prior authorization when a change in the patient's clinical condition necessitates an increase in the frequency and intensity of services or change in the type of services which will exceed the services authorized.

(f) Periodic reviews shall be conducted as follows:

1. The evaluation team shall periodically review the patient's plan of care on a regular basis (at least every 90 days) to determine:

- i. The patient's progress toward the treatment objectives;
- ii. The appropriateness of the services being furnished; and
- iii. The need for the patient's continued participation in the program.

2. The periodic reviews should be documented in detail in the patient's records and made available upon request of the Division or its agents.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-1.15](#) by R.1998 d.564, effective December 7, 1998.

See: [30 N.J.R. 1257\(a\)](#), [30 N.J.R. 4225\(a\)](#).

Recodified from [N.J.A.C. 10:52-1.16](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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In (a) and (e), changed N.J.A.C. references; and in (b), substituted references to beneficiaries for references to recipients throughout.

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.2011 d.010, effective January 3, 2011.

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (c)1, substituted "CFR 441.153" for "CFR 153".

Annotations

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§ 10:52-1.18 Advance directives

All hospitals participating in the New Jersey Medicaid/NJ FamilyCare program are subject to the provisions of State and Federal statutes regarding advance directives including, but not limited to, appropriate notification to patients of their rights, development of policies and practices and communication to, and education of, staff, community and interested parties. See [N.J.A.C. 10:49-9.15](#), and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (42 U.S.C. §§ 1396a(a)(58) and 1396a(w)) for detailed information.

History

HISTORY:

New Rule, R.2001 d.294, effective August 20, 2001.

See: [32 New Jersey Register 2687\(b\)](#), [33 New Jersey Register 2808\(a\)](#).

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Substituted "FamilyCare" for "KidCare" in the first sentence and rewrote the last sentence.

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PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.1 Ambulatory Surgical Center (ASC)

(a) An Ambulatory Surgical Center (ASC) shall be any distinct entity that operates for the purpose of providing surgical services to patients not requiring hospitalization which has an agreement with the Centers for Medicare & Medicaid Services (CMS) to participate in the Medicare program and meets the specific conditions for coverage set forth in Federal regulations in 42 CFR Part 416.

(b) An ASC, as described in N.J.A.C. 10:66-5, may be operated by a hospital that is under common ownership or control of a hospital.

1. An ASC operated by a hospital shall be a separately identifiable entity physically and administratively and shall be financially independent and distinct from other operations of the hospital.

History

HISTORY:

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

In (b)1, changed N.J.A.C. reference in the introductory paragraph.

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Rewrote the section.

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§ 10:52-2.2 Blood and blood products

(a) Reimbursement may be made for blood provided to an inpatient or an outpatient of an approved hospital when prescribed and supervised by a licensed physician.

(b) Whole blood and derivatives, and necessary processing and administration thereof, may be reimbursed with the following limitations:

1. Efforts should be made by the family or the provider to arrange for the replacement of blood. This can be done by the contribution of a blood donor or by using a blood replacement plan in which the Medicaid/NJ FamilyCare fee-for-service eligible beneficiary is a beneficiary of the blood replacement plan (if available).
2. The cost of donated blood or blood products (including autologous donation) received through a replacement plan shall not be reimbursable. However, the charge for phlebotomy, cross-matching, indexing, storage and transfusing shall be reimbursable.
3. In order to obtain Medicaid/NJ FamilyCare reimbursement, the hospital shall submit a certification that a voluntary blood donation cannot be obtained.
 - i. When arrangements for payment for the replacement of blood are not accomplished, reimbursement to the hospital shall be 100 per cent of the "add-on" charge.

History

HISTORY:

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)1, substituted a reference to Medicaid and NJ KidCare fee-for-service eligible beneficiaries for a reference to Medicaid recipients.

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (b)1, substituted "Medicaid/NJ" for "Medicaid or NJ".

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N.J.A.C. 10:52-2.3

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§ 10:52-2.3 Dental services

(a) Dental services in the outpatient department shall be provided in accordance with the requirements contained in [N.J.A.C. 10:56](#), Dental Services. The outpatient dental department shall be subject to the same policies and procedures that apply to the Medicaid/NJ FamilyCare fee-for-service provider of dental services in the community, with the following exceptions:

1. Emergency dental care provided under special circumstances in a hospital emergency room; or
2. Outpatient dental services provided to NJ Medicaid/NJ FamilyCare fee-for-service beneficiaries with chronic medical conditions and/or developmental disabilities resulting in special healthcare needs.

(b) A hospital with an outpatient dental department serving Medicaid/NJ FamilyCare fee-for-service beneficiaries is given a unique provider number for that department. A hospital that starts an outpatient dental department shall request a provider number for that department from the fiscal agent.

(c) Reimbursement for a dental service is determined by the Commissioner of the Department of Human Services in accordance with [N.J.A.C. 10:56](#), and is based on the same fee, conditions, and definitions for the corresponding service, utilized for the payment of individual Medicaid/NJ FamilyCare fee-for-service dental practitioners and providers in the community, except in cases in which the beneficiary's special healthcare needs, as described in (a)1 or 2 above, require that dental services be performed in the outpatient operating room setting. Reimbursement for outpatient operating room charges for services provided to clients with special healthcare needs, as described in (a)1 or 2 above, shall be at the hospital's outpatient cost-to-charge ratio. In no event shall the charge to the Division exceed the charge by the provider for identical services to other groups or individuals in the community.

1. If a dental procedure code is assigned both a specialist and non-specialist "Maximum Fee Allowance Schedule", the amount of the payment will be based upon the status (specialist or non-specialist) of the individual practitioner who actually provided the billed service.
 - i. If the dentist providing the services is a resident, intern, or house staff member, the status of the supervising dentist, specialist or non-specialist, determines the amount of the payment.
2. Covered emergency dental care performed in the hospital emergency room shall not be reimbursed if the services were provided in the emergency room and the dental clinic was available at the same time.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

§ 10:52-2.3 Dental services

In (a), inserted a reference to NJ KidCare fee-for-service providers in the introductory paragraph, and substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients in 1; and in (b), inserted a reference to NJ KidCare fee-for-service dental practitioners in the introductory paragraph.

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 "be provided in accordance with the requirements contained in" for "follow the policies and procedures outlined in" in the introductory paragraph; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2012 d.028, effective February 6, 2012.

See: [43 N.J.R. 2641\(b\)](#), [44 N.J.R. 229\(b\)](#).

Rewrote (a); recodified former (a)1 as new (b) and former (b) as (c); and rewrote the introductory paragraph of (c).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (a) and of (c), and in (b), substituted "Medicaid/NJ" for "Medicaid or NJ"; and in the introductory paragraph of (c), inserted a comma following "conditions".

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N.J.A.C. 10:52-2.4

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§ 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federally-mandated comprehensive and preventive child health program for Medicaid/NJ FamilyCare-Children's Program fee-for-service beneficiaries from birth through 20 years of age (see 42 CFR 441 Subpart B). The goal of the program is to assess the beneficiary's health needs through initial and periodic examinations (screenings); to provide health education and guidance; and to assure that health problems are prevented, diagnosed, and treated at the earliest possible time.

1. As a condition of participation in Medicaid/NJ FamilyCare, all ambulatory care facilities (including hospital outpatient departments) providing primary care to children and adolescents from birth through 20 years of age, shall participate in the EPSDT program and shall provide, at a minimum, the required EPSDT screening services.

(b) The required EPSDT services shall include the following:

1. Screening services, the components of which are described below:

- i. A comprehensive health and developmental history, including an assessment of both physical and mental health development;
- ii. A culturally-sensitive and valid developmental assessment. The parameters used in assessing the child's developmental level and behavior shall be appropriate for the child's age. While no specific test instrument is endorsed, it is expected that an evaluation of a young child would, at a minimum, address the child's gross and fine motor coordination, language/vocabulary and adaptive behavior, including self-help and self-care skills and social emotional development. An assessment of a school-age child should include school performance, peer relationships, social activity and behavior, physical and athletic aptitude and sexual maturation;
- iii. A comprehensive unclothed physical examination, including vision and hearing screening, dental inspection and nutritional assessment;
- iv. Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines, incorporated herein by reference, as amended and supplemented. The schedule can be found on the Centers for Disease Control (CDC) website at <https://www.cdc.gov/> or can be requested from the Centers for Disease Control and Prevention, National Immunization Program, Division of Epidemiology and Surveillance, Mail Stop E61, 1600 Clifton Road, NE Atlanta, Georgia 30333;
- v. Age-appropriate laboratory and other diagnostic tests, including:
 - (1) Hemoglobin or hematocrit;
 - (2) Lead screening, using blood lead level determinations, once between nine and 18 months (preferably at 12 months), once between 18 and 26 months (preferably at 24 months) and, for any child who has not been previously tested between 27 months and 72 months;

§ 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(3) Urinalysis;

(4) Tuberculin skin test (Mantoux), intradermal, administered annually and when medically indicated; and

(5) Additional laboratory tests which may be appropriate and medically indicated shall be obtained, as necessary;

vi. Health education, including anticipatory guidance;

vii. Referral for further diagnosis and treatment or follow-up of all correctable abnormalities, uncovered or suspected. Referral may be made to the provider conducting the screening examination or to another provider, as appropriate; and

viii. Referral to the Special Supplemental Food Program for Women, Infants and Children (WIC) for children under five years of age and for pregnant or lactating women.

2. Vision services as follows:

i. Vision screening, which shall include the following:

(1) If a newborn, the examination shall include general inspection of the eyes, visualization of the red reflex and evaluation of ocular motility;

(2) An appropriate medical and family history;

(3) An evaluation, by age six months, of eye fixation preference, muscle imbalance and papillary light reflex; and

(4) A third examination with visual acuity testing by age three or four years;

ii. Vision testing for school-aged children, which shall be performed at the following grades and ages:

(1) Kindergarten or first grade (five or six years);

(2) Second grade (seven years);

(3) Fifth grade (10 or 11 years);

(4) Eighth grade (13 or 14 years); and

(5) Tenth or eleventh grades (15 or 17 years).

iii. Referral for vision testing if a child:

(1) Cannot read the majority of the 20/40 line before his or her fifth birthday;

(2) Has a two-line difference of visual acuity between the eyes;

(3) Has suspected strabismus; or

(4) Has an abnormal light or red reflex.

3. Dental services as follows:

i. Dental screening, which shall include the following:

(1) An intraoral examination, including observation of tooth eruption, occlusion pattern and presence of caries or oral infection;

ii. A recommended referral to a dentist at one year of age;

iii. A mandatory referral for a child three years of age or older; and

iv. Dental inspection and prophylaxis, which shall be performed every six months until a child is 17 years of age and annually for any beneficiary 18 years of age or older who is eligible for EPSDT services.

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4. Hearing services including the following:

- i. A hearing screening for infants that shall include, at a minimum, an observation of an infant's response to auditory stimuli;
- ii. A speech and hearing assessment, which shall be part of each preventive visit for an older child;
- iii. An individual hearing screening, which shall be administered annually to all children through the age of eight and to all children at risk of hearing impairment;
- iv. An individual hearing screening of each child every other year after the age of eight; and
- v. An objective audiometric test, such as a pure-tone screening test, if performed as part of an EPSDT screening examination, shall be eligible for separate reimbursement.

5. Other medically necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

- i. For requirements regarding community private duty nursing services for EPSDT beneficiaries, see N.J.A.C. 10:60-5.

(c) EPSDT screening services shall be provided periodically according to the following schedule, based on the age of the child:

- 1. Under six weeks;
- 2. Two months;
- 3. Four months;
- 4. Six months;
- 5. Nine months;
- 6. Twelve months;
- 7. Fifteen months;
- 8. Eighteen months;
- 9. Twenty-four months; and
- 10. Annually through 20 years of age.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Rewrote (a); in (b), changed N.J.A.C. reference; in (c), substituted references to beneficiaries for references to recipients throughout, and inserted a reference to NJ KidCare--Plan A fee-for-service beneficiaries and changed N.J.A.C. reference in 5i; and in (e)1iv(5), substituted "ova" for "oral" preceding "and parasites".

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.2018 d.104, effective May 21, 2018.

§ 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare; and in (b)1iv, substituted ". The schedule can be found on the Centers for Disease Control (CDC) website at <http://www.cdc.gov/> or can be requested" for "(available", and deleted ")" following "30333".

Annotations

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§ 10:52-2.5 Family planning services

(a) Family planning services shall include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

(b) Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory, radiological and diagnostic services and surgical procedures shall not be covered services, except:

1. When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the hospital shall submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Provider Relations, PO Box 712, Mail Code #27, Trenton, New Jersey 08625-0712.

History

HISTORY:

New Rule, R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Former [N.J.A.C. 10:52-2.5](#), Home health agencies; hospital-based, recodified to [N.J.A.C. 10:52-2.6](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

In (b), substituted "FamilyCare" for "KidCare-Plan A, B and C" in the introductory paragraph; in (f), deleted "Medical Affairs and" preceding "Provider Relations" and substituted "27" for "14" following "Mail Code #" in 1.

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

Deleted (b) through (e); and recodified (f) as (b).

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§ 10:52-2.6 Home health agencies; hospital-based

(a) A home health agency (hospital-based) shall be licensed by the New Jersey State Department of Health, certified as a home health agency under Title XVIII (Medicare), possess a valid and current provider agreement from the Division, and be an identifiable part of a hospital.

(b) The provision of home health care services can range from a complex concentrated professional program (for acute care cases) which would require the services of a public health nurse, registered professional nurse, a licensed practical nurse, physical therapist, occupational therapist, speech pathologist, medical social worker, and homemaker/home health aide to a less complex program (as in chronic care cases) involving a homemaker/ home health aide, personal care assistant and/or therapist and minimal visits by a registered nurse. The types of services provided, the frequency and the duration of these services are determined by the needs of each beneficiary. Only medically necessary home health services shall be reimbursed by the Division.

(c) Division requirements for Home Health Agencies (Hospital-based) are located in [N.J.A.C. 10:60](#), Home Care Services. A hospital wishing to become a provider of home health services should contact Molina Medicaid Solutions Provider Enrollment, PO Box 4804, Trenton, NJ 08650, or the website www.njmmis.com and click on the Provider Enrollment Application. The application can be completed online or downloaded and mailed or faxed to Molina Medicaid Solutions at (609) 584-1192.

History

HISTORY:

Recodified from 10:52-2.5 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (b), substituted a reference to speech pathologists for a reference to speech-language pathologists, and substituted a reference to beneficiaries for a reference to recipients. Former [N.J.A.C. 10:52-2.6](#), Medical day care centers; hospital affiliated, recodified to [N.J.A.C. 10:52-2.7](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

In (b), inserted "medical" preceding "social worker" in the first sentence, substituted "beneficiary" for "beneficiaries" following "each" in the second sentence and substituted "shall be" for "are" preceding "reimbursed" in the last sentence; rewrote (c).

Amended by R.2018 d.104, effective May 21, 2018.

§ 10:52-2.6 Home health agencies; hospital-based

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), substituted a comma for "and Senior Services;" following "Health", and substituted a comma for a semicolon following "(Medicare)" and following "Division"; and in (c), substituted "Molina Medicaid Solutions" for "Unisys" twice, and substituted "NJ" for "N.J.".

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§ 10:52-2.7 Medical day care centers; hospital affiliated

- (a) An adult or pediatric day health services facility shall be affiliated and identified as part of a hospital which is licensed by the New Jersey State Department of Health, in accordance with its Manual of Standards for Licensure of Adult and Pediatric Day Health Services and shall possess a valid and current provider agreement from the Division.
- (b) Adult Day Health Services is a program of medically supervised, health-related services provided in a hospital affiliated ambulatory care setting to persons who are non-residents of the facility, who do not require 24-hour inpatient institutional care but, due to their physical or mental impairment, need health maintenance and restorative services to live in the community. Pediatric Day Health Services is a program which provides additional health-related services in order to provide for the needs of technology-dependent or medically unstable children.
- (c) The Department of Health administers the Medicaid/NJ FamilyCare fee-for-service Adult Day Health Services and Pediatric Day Health Services programs. For program requirements, see [N.J.A.C. 8:86](#).
1. Medical day care transportation services shall not be reimbursed by the fiscal agent as a separate service.
 2. All direct and indirect costs associated with hospital-affiliated medical day care centers shall be reported separately on New Jersey State Department of Health cost filings for payment purposes and shall not be considered an allowable cost under the DRG reimbursement system.
- (d) The Division shall not reimburse for medical day care services and partial hospitalization services provided to the same beneficiary on the same day.

History

HISTORY:

Recodified from 10:52-2.6 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Rewrote (c); in (d), substituted a reference to beneficiaries for a reference to recipients; and deleted a former (e). Former [N.J.A.C. 10:52-2.7](#), Narcotic and drug abuse treatment centers; fee-standing, recodified to [N.J.A.C. 10:52-2.8](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Rewrote (a), (b), and the introductory paragraph of (c).

§ 10:52-2.7 Medical day care centers; hospital affiliated

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), the introductory paragraph of (c), and (c)2, deleted "and Senior Services" following "Health"; and in the introductory paragraph of (c), substituted "Medicaid/NJ" for "Medicaid and NJ".

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N.J.A.C. 10:52-2.8

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§ 10:52-2.8 Substance use disorder treatment facilities; free-standing

(a) Division requirements for substance use disorder treatment facilities are located in [N.J.A.C. 10:66](#), Independent Clinic Services. Services provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary by a free standing hospital-affiliated substance use disorder treatment facility shall be covered only if those services are eligible for Federal Financial Participation under the Medicaid Program (Title XIX of the Social Security Act) or the NJ FamilyCare program (Title XXI of the Social Security Act) and the following conditions are met:

1. The treatment is prescribed or certified by a physician or an advance practice nurse (APN); and
2. The treatment is provided in a substance use disorder treatment facility licensed or approved by the New Jersey State Department of Health pursuant to [N.J.S.A. 26:2G-21](#) et seq., and [N.J.A.C. 10:161A](#) for residential services, [N.J.A.C. 10:161B](#) for outpatient services, and/or N.J.A.C. 10:161B-11 for opioid treatment services, as applicable; and
3. The staff of the treatment facility includes a medical director.

(b) Payment for outpatient services provided in a free-standing substance use disorder treatment facility shall be made on a fee-for-service basis. The services include mental health services, methadone maintenance, and other related health services. The Division's payment shall be accepted as payment in full for Medicaid/NJ FamilyCare-Plans A and B. For NJ FamilyCare-Plan C, the Division's payment shall be considered as payment in full except for the Division's requirements regarding the personal contribution to care responsibilities of the NJ FamilyCare-Plan C beneficiaries which are codified at N.J.A.C. 10:49-9 and [10:52-4.7](#). Mental health and substance use disorder services for beneficiaries of NJ FamilyCare-Plans A, B and C who are also clients of the Division of Developmental Disabilities are provided by their MCO.

(c) Inpatient and outpatient substance use disorder services for Plan D beneficiaries shall be limited to detoxification.

(d) Approved centers shall submit claims only for those procedure codes which correspond to the allowable services included in their New Jersey Medicaid/NJ FamilyCare provider approval letter. Room, board, and other residential services shall not be covered. Claims for reimbursement shall be submitted to the fiscal agent in an accepted format approved by the fiscal agent.

History

HISTORY:

Recodified from 10:52-2.7 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

§ 10:52-2.8 Substance use disorder treatment facilities; free-standing

In (a), inserted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries in the introductory paragraph; and rewrote (b). Former [N.J.A.C. 10:52-2.8](#), Organ procurement and transplantation services, recodified to [N.J.A.C. 10:52-2.9](#).

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), rewrote the introductory paragraph; rewrote (b); added a new (c); recodified former (c) as (d) and substituted "CMS 1500" for "1500 N.J." in the last sentence.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Section was "Substance abuse treatment centers; free-standing". Rewrote the section.

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§ 10:52-2.9 Organ procurement and transplantation services

(a) The Division shall reimburse for medically necessary transplantation services, including organ procurement, except those transplants categorized as experimental. (See (d) below for further information on organ procurement and transplantation.)

1. Claims for transplant services and organ procurement services rendered to or items dispensed or furnished to an organ donor shall be submitted using the Health Benefits Identification Number of the Medicaid/NJ FamilyCare beneficiary who is receiving the transplant.
2. The organ donor's claim will be paid by the Medicaid/NJ FamilyCare program whether the claim is from the same hospital where the transplant service was provided to the Medicaid/NJ FamilyCare patient or from a different hospital.

(b) Federal organ procurement service requirements are listed in the Social Security Act, Section 1138 as amended by Section 9318(a) of the Omnibus Budget Reconciliation Act of 1986 ([42 U.S.C. § 1320](#)).

1. Organ procurement services, with the exception of bone marrow transplant and cornea procurement services, are covered only when the Organ Procurement Organization (OPO) meets the requirements as outlined in the Section 1138 of the Social Security Act ([42 U.S.C. § 1320 \(b\)](#)-8 Note) and when the OPO is designated and certified by the Secretary of the Department of Health and Senior Services and Human Services as the OPO for that geographical area in which the hospital is located.

(c) The covered organ transplantation procedures shall be performed in an organ transplant center approved or certified by a nationally recognized certifying or approving body, or one designated by the Federal government. In the absence of such a certification or approval of a nationally recognized body, the approval or certification, whichever applies, shall have been obtained from the appropriate body so charged in the State in which the organ transplant center is located.

(d) The candidate for transplantation shall have been accepted for the procedure by the transplant center. All out-of-State hospitalizations for transplantations shall require prior authorization from the Medical Assistance Customer Center (MACC) serving the beneficiary's county of residence.

(e) Organ transplantations shall be medically necessary. Transplantations, with the exception of cornea transplantations, shall be performed only to avert a potentially life-threatening situation for the patient.

1. If all factors pertinent to decision-making concerning the site of performance of a transplant procedure are essentially equal, preference shall be given to a New Jersey transplant center. However, Medicaid policy of equitable access also applies (see [42 CFR 431.52\(c\)](#)).

(f) For organ transplants for Medicaid/NJ FamilyCare beneficiaries enrolled with a managed care organization, the managed care organization shall be responsible for all costs, except for the costs of the hospital, for an individual placed on a transplant list while in the Medicaid/NJ FamilyCare fee-for-service program prior to enrollment in a managed care organization under contract with the Department of Human Services.

History

HISTORY:

Recodified from 10:52-2.8 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (b)1 and (e), substituted references to beneficiaries for references to recipients throughout; in (e), substituted a reference to the Office of Health Service Administration for a reference to the Office of Medical Affairs and Provider Relations; and added (h). Former [N.J.A.C. 10:52-2.9](#), Psychiatric services; partial hospitalization, recodified to [N.J.A.C. 10:52-2.10](#).

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.2011 d.010, effective January 3, 2011.

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

Rewrote (a)1; added (a)2; and in (f), deleted the last sentence.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a)1 and (f), made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare.

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§ 10:52-2.10 Psychiatric services; partial hospitalization

(a) Partial hospitalization (PH) means a psychiatric service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. A PH program shall provide, as listed below, a full system of services necessary to meet the comprehensive needs of the individual Medicaid/NJ FamilyCare fee-for-service beneficiary. These services shall include:

1. Assessment and evaluation;
2. Service procurement;
3. Therapy;
4. Information and referral;
5. Counseling;
6. Daily living education;
7. Community organization;
8. Pre-vocational therapy;
9. Recreational therapy; and,
10. Health-related services.

(b) Pre-vocational therapy, recreational therapy, and health related services, as required in (a) above, may be provided directly or arranged by partial hospitalization staff through other programs' elements or agencies. To avoid duplication of payment, these services shall not be billed separately from the claim submitted for partial hospitalization reimbursement.

(c) The requirements of the PH program shall include the following:

1. PH shall serve ambulatory, non-residential patients who spend only a part of a 24-hour period (a minimum of two hours and a maximum of five hours of active participation per day in active programming exclusive of meals) in the hospital.
2. A PH program shall be available daily for five days a week, with additional planned activities each week, during evening and/or weekend hours, as needed. Individual clients need not attend every day but as needed.
3. The staff of the PH program shall include a director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field, with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the PH program on a regularly scheduled basis. Other staff deemed necessary to implement a PH program shall include qualified mental health professionals, para-professionals, and volunteers.

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- (d) Authorization for PH services for individuals aged 18 and older who have no involvement with the Children's System of Care within the Department of Children and Families (DCF/CSOC), shall be obtained in accordance with [N.J.A.C. 10:52A](#), Adult Acute Partial Hospital and Partial Hospital Services.
- (e) Authorization for PH services for individuals under age 18, and individuals at or over the age of 18 and under the age of 21 who had been receiving services from the (DCF/CSOC) prior to their 18th birthday, shall be obtained as follows:
1. CSOC behavioral healthcare providers may include a referral for PH services in their plans of care. These referrals shall be submitted to the Contracted Systems Administrator (CSA) for approval.
 2. If approved, the CSA shall provide the PH provider an authorization number to be used when requesting reimbursement from the Medicaid/NJ FamilyCare programs or any other entities designated by DCBHS to provide reimbursement.
 3. Authorization for PH services shall not exceed six months without written permission from CSOC or the CSA.
 4. For lengths of stay in the PH program exceeding six months, requests for authorization shall be considered on a case-by-case basis by the DCF or the CSA. The request for authorization shall include sufficient documentation to indicate progress previously made towards the defined treatment goals and justification for the need for continued PH services. In no case shall continued authorizations for PH services exceed 12 months without a discharge plan that provides for a transition to other community-based interventions and supports within the following three months.
- (f) Mental health services provided by or through the partial hospitalization program shall not include:
1. Student education, including preparation of school-assigned classwork or homework; or
 2. Incentive programs, including, but not limited to, non-therapeutic token economies and subcontract work responsibilities.
- (g) The Division shall not reimburse a hospital and/or any other provider for providing both PH services and medical day care center services to the same beneficiary on the same day.
- (h) The Division shall not reimburse a hospital for any mental health service (including medication management) provided in addition to PH services provided to the same beneficiary on the same day.
- (i) Additional requirements related to Partial Hospitalization (PH) services and Adult Acute Partial Hospitalization (APH) services available to eligible Medicaid/NJ FamilyCare beneficiaries age 18 and older are found at [N.J.A.C. 10:52A](#).

History

HISTORY:

Recodified from 10:52-2.9 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph; and in (d), substituted a reference to the Division's fiscal agent for a reference to the Medicaid fiscal agent and added a reference to NJ KidCare in 4, and substituted references to beneficiaries for references to recipients in 5 and 6. Former [N.J.A.C. 10:52-2.10](#), Rehabilitative services; hospital outpatient department, recodified to [N.J.A.C. 10:52-2.11](#).

Special amendment, R.2002 d.82, effective February 15, 2002 (to expire December 21, 2004).

See: [34 N.J.R. 1279\(a\)](#).

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Rewrote (c)1i; in (d), inserted ", except as provided in (e) below"; added (e).

Special amendment, R.2002 d.191, effective May 24, 2002 (to expire December 21, 2004).

See: [34 N.J.R. 2149\(a\)](#).

In (c), rewrote 1i; in (d), substituted "30" for "90" and deleted ", except as provided in (e) below"; deleted (e).

Amended by R.2003 d.182, effective May 5, 2003.

See: [34 N.J.R. 4303\(a\)](#), [35 N.J.R. 1901\(a\)](#).

Rewrote (d)2.

Amended by R.2004 d.75, effective February 17, 2004.

See: [35 N.J.R. 2154\(a\)](#), [36 N.J.R. 952\(b\)](#).

In (d), inserted a new 7; added (e).

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" preceding "fee-for-service" in the introductory paragraph; in (d), deleted former 3, recodified former 4 as 3 and substituted "FamilyCare" for "KidCare", and recodified former 5 through 7 as 4 through 6.

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (c)1, substituted "two" for "three" and "and a maximum" for "of participation in active programming for a half day program exclusive of meals and a minimum", inserted "per day", and deleted "for a full day program" preceding "exclusive of meals"; deleted (c)1i; rewrote (d); added new (e) and (g) through (i); and recodified former (e) as (f).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (a), substituted "Medicaid/NJ" for "Medicaid or NJ"; and rewrote (d) and (e).

Annotations

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N.J.A.C. 10:52-2.10A

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§ 10:52-2.10A Psychiatric services; partial hospitalization prevocational programs

(a) The provisions of this section shall apply when prevocational services are provided within a partial hospitalization program, in accordance with [N.J.A.C. 10:52-2.10\(a\)](#)8.

(b) The following words and terms, when used in this chapter, shall have the following meanings, unless the context indicates otherwise:

"Mental health services worker" means an individual who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

"Prevocational services" means interventions, strategies, and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes, and skills needed to take on the role of worker and in other life domains, such as: responding to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms, and adherence to prescribed medication directions/schedules. Examples of interventions not considered prevocational or covered by Medicaid/NJ FamilyCare include: technical occupational skills training, college preparation, student education, including preparation of school assigned classwork or homework and individualized job development.

"Special minimum wage certificate" means a certificate issued by the U.S. Department of Labor pursuant to 29 C.F.R. § 525, which permits a worker with a disability to be paid at a rate below the rate which would otherwise be required by statute.

"Therapeutic subcontract work activity" means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program by the U.S. Department of Labor.

"Vocational services" means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(c) The Division will reimburse a provider for prevocational services provided within the context of a partial hospitalization program, in accordance with this section.

(d) Prevocational services shall be those interventions, strategies and activities within the context of a partial hospitalization program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as responding appropriately to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and medication adherence. Services or interventions which are not considered prevocational will

§ 10:52-2.10A Psychiatric services; partial hospitalization prevocational programs

not be reimbursed by the Medicaid/NJ FamilyCare programs. Examples of services or interventions not considered to be prevocational include:

1. Technical or occupational skills training;
2. College preparation;
3. Student education, including preparation of school-assigned classwork or homework; and
4. Individualized job development.

(e) The Division will not reimburse any provider for vocational services provided within the context of a partial hospitalization program.

1. Vocational services means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(f) When, in the judgment of the treatment team, an individual is appropriate for discharge or referral to another employment-related service provider or situation, and, has demonstrated mastery of individualized goals and objectives, such as: an ability to respond appropriately to criticism, make decisions, negotiate for needs, deal with interpersonal issues, manage psychiatric symptoms and adhere to medication prescriptions, the service provider shall:

1. Update the individual treatment goal;
2. Revise the discharge plan; and
3. Refer the individual to a community work setting, if such referral is appropriate for the individual.

(g) The Division will reimburse prevocational services provided to eligible beneficiaries within the context of a partial hospitalization program when the services consist of therapeutic subcontract work activity, and when all of the following requirements are met:

1. The therapeutic subcontract work activity shall consist of production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage, and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program, by the U.S. Department of Labor;
2. The individuals plan of care shall contain a stipulation that the therapeutic subcontract work activity is a form of intervention intended to address the individual deficits of the patient as identified in the clients assessment;
3. The therapeutic subcontract work activity shall be facilitated by a qualified mental health services worker;
4. The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health services worker; and
5. The staff to client ratio shall not exceed a ratio of 1:10 qualified mental health services worker to client.

History

HISTORY:

New Rule, R.2004 d.75, effective February 17, 2004.

See: [35 N.J.R. 2154\(a\)](#), [36 N.J.R. 952\(b\)](#).

Amended by R.2018 d.104, effective May 21, 2018.

§ 10:52-2.10A Psychiatric services; partial hospitalization prevocational programs

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (b), in definition "Prevocational services", inserted a comma following "strategies", following "attitudes", and following "symptoms", and substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

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N.J.A.C. 10:52-2.11

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§ 10:52-2.11 Rehabilitative services; hospital outpatient department

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

1. "Rehabilitative services" means physical therapy, occupational therapy, speech pathology and audiology services, and the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services and other restorative services shall be provided for the purpose of attaining maximum reduction in disability and restoration of a Medicaid beneficiary to his or her highest possible functional level. Rehabilitative services shall be made available to Medicaid/NJ FamilyCare beneficiaries as an integral part of a comprehensive medical program.
2. "Occupational therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist. These services include necessary supplies and equipment.
3. "Qualified occupational therapist" means an individual who is:
 - i. Registered by the American Occupational Therapy Association (AOTA); or,
 - ii. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association. If treatment and/or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure, if applicable, and shall also meet all applicable Federal requirements.
4. "Physical therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified physical therapist. These services include necessary supplies and equipment.
5. "Qualified physical therapist" means an individual who is:
 - i. Licensed by the State of New Jersey as a physical therapist in accordance with [N.J.A.C. 13:39A](#);
 - ii. A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and
 - iii. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

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6. "Speech-language pathology" and "audiology services" mean diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech-language pathologist or audiologist. The services include necessary supplies and equipment.
7. "Speech-language pathologist" or "audiologist" means an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with [N.J.A.C. 13:44C](#), and who meets all applicable Federal requirements including:
- i. A certificate of clinical competence in Speech-Language Pathology (CCC-SLP) or Audiology (CCC-A) from the American Speech-Language-Hearing Association (American Speech-Language-Hearing Association, 2200 Research Blvd., Rockville, MD 20850-5650, or <http://www.asha.org>); or completion of the equivalent educational requirements and work experience necessary for the certificate; or completion of the academic program and is in the process of acquiring supervised work experience in order to qualify for the certificate;
 - ii. If treatment or services are provided in a state other than New Jersey, the speech-language pathologist or audiologist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements;
 - iii. If the attending physician orders an evaluation for speech-language therapy, the speech-language pathologist may make an initial visit for a screening examination. If, as a result of the screening examination, a comprehensive evaluation is necessary, the comprehensive evaluation shall be completed at the same time as the screening examination, or at the earliest mutual convenience of the patient and the provider;
 - iv. An initial comprehensive speech-language pathology evaluation should last approximately three hours, and shall include, as an integral part of the evaluation, a written report, as well as discussion and consultation with the patient or family, or both, regarding the findings; and
 - v. The Division shall reimburse for either a screening examination or a comprehensive speech-language evaluation rendered to a beneficiary, but not both. If the documentation reveals that the screening examination did not support the need for a comprehensive evaluation, the request for reimbursement will be downgraded to Speech-Language Therapy--Initial Visit Screening Examination, and reimbursed accordingly.
- (b) All treatment services shall be prescribed by a physician or other medical practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe rehabilitative services within the scope of his or her license and practice and be provided by or under the direction or personal supervision of the appropriate qualified practitioner of the healing arts.
- (c) A plan of treatment shall be completed during the beneficiary's initial evaluation visit for rehabilitative service(s) and shall be retained on file.
- 1. The plan of treatment shall be definitive as to the modality, amount of time per treatment, frequency and duration of the rehabilitative services to be furnished. The beneficiary's diagnosis and the anticipated goal(s) of the treatment shall be included in the treatment plan.
- (d) A re-evaluation shall be performed at the end of a course of treatment to determine the need to continue with or change the treatment modality.

History

HISTORY:

Recodified from 10:52-2.10 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

§ 10:52-2.11 Rehabilitative services; hospital outpatient department

Rewrote the section. Former [N.J.A.C. 10:52-2.11](#), Renal dialysis services for end-stage renal disease (ESRD), recodified to [N.J.A.C. 10:52-2.12](#).

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.2011 d.010, effective January 3, 2011.

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a)7i, substituted "2200 Research Blvd., Rockville, MD 20850-5650" for "10801 Rockville Pike, Rockville, MD 20852", and deleted "and" from the end; in (a)7iv, inserted "and" at the end; and rewrote (b).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a)2 and (a)4, substituted "Medicaid/NJ" for "Medicaid or NJ".

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§ 10:52-2.12 Renal dialysis services for end-stage renal disease (ESRD)

- (a) A hospital outpatient renal dialysis center shall be approved by the New Jersey State Department of Health to provide renal dialysis treatment for ESRD.
- (b) At the beginning of a maintenance course of renal dialysis treatment for ESRD, renal dialysis centers should direct their Medicaid/NJ FamilyCare fee-for-service beneficiary to the Social Security Administration District Office to file an application for Medicare benefits, if applicable.
- (c) Renal dialysis services for ESRD and Medicare approved "add-on" costs shall be reimbursable by Medicaid/NJ FamilyCare fee-for-service only when the individual is a Medicaid/NJ FamilyCare fee-for-service beneficiary and not a Medicare beneficiary, or during the time frame when ESRD services are not Medicare reimbursable.
1. Medicare coverage usually begins with the first day of the third month after the month in which a maintenance course of renal dialysis services begins. Claims from that date on shall be submitted to Medicare, unless the Medicaid/NJ FamilyCare fee-for-service beneficiary has been denied eligibility for Medicare.
 - i. Exception: Medicare coverage may begin earlier than the time frame stated above if the individual receives renal transplantation services or participates in a self-dialysis training program.
- (d) Reimbursement for hospital inpatient renal dialysis services for ESRD are included in the DRG rates.

History

HISTORY:

Recodified from 10:52-2.11 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (b), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients/patients; and in (c), substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare fee-for-service throughout. Former [N.J.A.C. 10:52-2.12](#), Sterilization, recodified to [N.J.A.C. 10:52-2.13](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

In (c), substituted "services" for "benefits" preceding "are not Medicare reimbursable" in the introductory paragraph; substituted "FamilyCare" for "KidCare" preceding "fee-for-service" throughout.

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

§ 10:52-2.12 Renal dialysis services for end-stage renal disease (ESRD)

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (d), substituted "rates" for "rate methodology determinations".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), deleted "and Senior Services" following "Health"; and in (b) and (c), substituted "Medicaid/NJ" for "Medicaid or NJ" throughout.

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§ 10:52-2.13 Sterilization

(a) The Division covers sterilization procedures performed on Medicaid/NJ FamilyCare fee-for-service beneficiaries based on Federal regulations ([42 CFR 441.250](#) through [441.258](#)) and related requirements outlined in this section and in the billing instructions contained in the Fiscal Agent Billing Supplement. For sterilization policy and procedures, see (b) through (e) below.

(b) "Sterilization" means any medical procedure, treatment, or operation, performed for the purpose of rendering an individual permanently incapable of reproducing. Surgical sterilization procedures are considered to be those whose primary purpose is to render an individual incapable of reproducing. Such procedures require the completion of the Federal "Consent Form" for sterilization.

(c) "Consent Form"--(Pursuant to [42 CFR 441.258](#)--Appendix to Subpart F--Specific Requirements for Use) requirements, including time frames to be met and/or documented on the "Consent Form" prior to the sterilization of an individual, follow:

1. The individual shall be at least 21 years of age at the time the consent is obtained;
2. The individual shall not be mentally incompetent. A "mentally incompetent individual" means an individual who has been declared mentally incompetent by a Federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization;
3. The individual shall not be institutionalized. An "institutionalized individual" means an individual who is:
 - i. Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or,
 - ii. Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness;
4. The individual shall have voluntarily given informed consent;
5. At least 30 days, but not more than 180 days, shall have passed between the date of informed consent and the date of sterilization, except in the case of emergency abdominal surgery or premature delivery;
 - i. In the case of emergency abdominal surgery, at least 72 hours shall have passed between the date he or she gave informed consent and date of sterilization;
 - ii. In the case of premature delivery, informed consent shall have been given at least 30 days before the expected date of delivery and at least 72 hours have passed between the date of informed consent and the date of premature delivery.

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6. In the case where a patient desires to be sterilized at the time of delivery, the "Consent Form" shall be signed by the patient no earlier than the 5th month of pregnancy to minimize the possibility of exceeding the 180 day limit.

(d) An individual shall be considered to have given informed consent only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had or has concerning the procedure, provided a copy of the "Consent Form", and provided orally all of the following information or advice to the individual to be sterilized; and,

i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled; and,

ii. A description of available alternative methods of family planning birth control; and,

iii. Advice that the sterilization procedure is considered to be irreversible; and,

iv. A thorough explanation of the specific sterilization procedure to be performed; and,

v. A full description of the discomfort and risks that may accompany or follow the performing of the procedure, including an explanation of type and possible effects of any anesthetic to be used; and,

vi. A full description of the benefits or advantages that may be expected as a result of the sterilization; and,

vii. Advice that the sterilization will not be performed for at least 30 days except for emergency abdominal surgery or premature delivery.

2. Suitable arrangements were made to insure that the information specified above under "Informed Consent" was effectively communicated to any individual who is blind, deaf, or otherwise handicapped; and,

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the "Consent Form" or the language used by the person obtaining consent; and,

4. The individual to be sterilized was permitted to have a witness of his or her own choice present when consent was obtained; and,

5. The requirements of the "Consent Form" were met, that is, its contents, certification, and signatures (see (e) below). The consent form currently in use by the Division is a replica of the form contained in the Federal regulations and shall be utilized by providers when submitting claims. No other consent form shall be permitted, unless approved by the Secretary, United States Department of Health and Human Services. The form is available from the Division's fiscal agent.

(e) Required consent form information, signatures, certification, and dates: In addition to completing all information (name of doctor or clinic the patient received information from, name of the operation to be performed, the patient's birth date, name of the patient, name of the physician who will perform the sterilization, the method, the language used by an interpreter, name and address of the facility the person obtaining consent is associated with, the date of the sterilization and the specific type of operation) in the appropriate spaces provided, the form shall be signed and dated by hand by the person indicated below:

1. "Consent to Sterilization," by the individual to be sterilized, prior to the sterilization operation (in accordance with the time frames specified in (c)5. above.

2. "Interpreter's Statement," by the interpreter, if one was provided prior to the sterilization operation. The interpreter must certify by signing and dating the "Consent Form" that:

i. He or she translated the information presented orally and read the "Consent Form" and explained its contents to the individual to be sterilized; and,

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- ii. To the best of the interpreter's knowledge and belief, the individual understood what the interpreter told him or her.
- 3. "Statement of Person Obtaining Consent," by the person who obtained the consent prior to the sterilization operation. The person securing the consent must certify, by signing and dating the "Consent Form" that:
 - i. Before the individual signed the "Consent Form", he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized; and,
 - ii. He or she explained orally the requirements for informed consent as set forth on the "Consent Form"; and
 - iii. To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized. The name and address of the facility or physician's office with which the person obtaining consent is associated must be completed in the space provided on the form.
- 4. "Physician's Statement," by the physician who performed the sterilization operation after the surgery had been performed. (A date prior to surgery is not acceptable.) The physician performing the sterilization shall certify, by signing and dating the "Consent Form," that within 24 hours before the performance of the sterilization operation:
 - i. The physician advised the individual to be sterilized that no Federal benefits may be withdrawn from the patient because of the decision not to be sterilized; and,
 - ii. The physician explained orally the requirements for informed consent as set forth on the "Consent Form"; and,
 - iii. To the best of the physician's knowledge and belief, the individual appeared mentally competent and knowingly and voluntarily consented to be sterilized; and,
 - iv. That at least 30 days have passed between the date of the individual's signature on the "Consent Form" and certified that the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature delivery; and,
 - v. In the case of emergency abdominal surgery or premature delivery performed within 30 days of consent, the physician shall certify that the sterilization was performed less than 30 days, but not less than 72 hours after informed consent was obtained, and in the case of abdominal surgery must describe the emergency, or in the case of premature delivery, must state the expected date of delivery.
- 5. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.
- 6. Informed consent shall not be obtained while the individual to be sterilized is:
 - i. In labor or childbirth; or,
 - ii. Seeking to obtain or obtaining an abortion; or,
 - iii. Under the influence of alcohol or other substances that affect the individual's state of awareness.
- (f) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB-92 claim form (including inpatient or outpatient) for all sterilization claims with the "Consent Form" attached to the UB-92 claim form and not submit the claim through the EMC claim processing system.

§ 10:52-2.13 Sterilization

HISTORY:

Recodified from 10:52-2.12 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), substituted a reference to Medicaid and NJ KidCare--Plan A, B or C fee-for-service beneficiaries for a reference to Medicaid recipients; and in (b), substituted a reference to medical procedures for a reference to surgical procedures. Former [N.J.A.C. 10:52-2.13](#), Hysterectomy, recodified to [N.J.A.C. 10:52-2.14](#).

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-Plans A, B or C" preceding "fee-for-service" and deleted "42 CFR" preceding "441.258".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), substituted "Medicaid/NJ" for "Medicaid or NJ", and inserted "Federal regulations (" and ")".

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N.J.A.C. 10:52-2.14

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§ 10:52-2.14 Hysterectomy

(a) The Division covers hysterectomy procedures performed on Medicaid/NJ FamilyCare fee-for-service beneficiaries based on Federal regulations ([42 CFR 441.250](#) through [441.258](#)) and related requirements outlined in this section and in the billing instructions. For hysterectomy requirements see (b) through (d) below. In addition, see [N.J.A.C. 10:52-1.13](#) for the requirements for a Second Surgical Opinion for performing a hysterectomy.

(b) "Hysterectomy" means an operation for the purpose of removing the uterus.

1. A hysterectomy shall not be performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy shall be covered as a surgical procedure if performed primarily for the purpose of removing a pathological organ.

(c) Surgical hysterectomy procedures claim processing and reporting require the completion of the "Hysterectomy Receipt of Information Form (FD-189)" or, under certain conditions (see (d)1iii below), a physician certification. A second opinion shall be obtained and shall be submitted with the claim.

(d) The specific requirements to be met or documented on the "Hysterectomy Receipt of Information," (FD-189) form or, under certain conditions, a physician certification, shall be as follows:

1. A hysterectomy on a female of any age may be performed when medically necessary for a pathological indication, provided the person who secured authorization to perform the hysterectomy has:
 - i. Informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and,
 - ii. Ensures that the FD-189 form is completed and the individual or her representative has signed and dated a written acknowledgement of receipt of that information utilizing the FD-189 form; or,
 - iii. The physician who performed the hysterectomy certifies, in writing, that the individual:
 - (1) Was sterile before the hysterectomy (include cause of sterility); or,
 - (2) Required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible (include a description of the nature of the emergency); or,
 - (3) Was operated on during a period of the person's retroactive Medicaid/NJ FamilyCare-Plan A eligibility and the individual was informed, before the operation, that the hysterectomy would make her permanently incapable of reproducing or one of the conditions described in (d)1iii(1) or (2) above was applicable. (Include a statement that the individual was informed or describe which condition was applicable). "Retroactive Medicaid eligibility" means the consideration of unpaid medical bills incurred during a three-month period prior to the month the person applied for assistance. (See [N.J.A.C. 10:49-2.9](#), Administration.) Although a physician certification is acceptable for situations described in (d)1iii above, the Division recommends that the FD-189

§ 10:52-2.14 Hysterectomy

form be used whenever possible. There is no 30-day waiting period required before a medically necessary hysterectomy may be performed. The standard procedure for a surgical informed consent form within the hospital will suffice.

(e) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB-92 claim form for all hysterectomy claims with the FD-189 form attached to the claim form and must not submit the claim through the EMC claim processing system.

History

HISTORY:

Recodified from 10:52-2.13 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients, and changed N.J.A.C. reference; and in (d)1iii(3), inserted a reference to NJ KidCare--Plan A eligibility. Former [N.J.A.C. 10:52-2.14](#), Termination of pregnancy, recodified to [N.J.A.C. 10:52-2.15](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Rewrote (a); in (c), deleted ", Rev. 7/83" preceding "(FD-189" and added the second sentence; in (d), deleted ", Rev. 7/83" preceding "(FD-189" in the introductory paragraph, and substituted "FamilyCare" for "KidCare", amended the N.J.A.C. reference and substituted "suffice" for "prevail" in 1iii(3).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), substituted "Medicaid/NJ" for "Medicaid and NJ"; and in (d)1iii(3), substituted "Medicaid/NJ" for "Medicaid or NJ".

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[N.J.A.C. 10:52-2.15](#)

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§ 10:52-2.15 Termination of pregnancy

(a) The Division shall reimburse for medically necessary termination of pregnancy procedures on Medicaid/NJ FamilyCare beneficiaries when performed by a physician in accordance with [N.J.A.C. 13:35-4.2](#). These services are reimbursed fee-for-service for all beneficiaries, including individuals enrolled in an MCO.

(b) A physician may take the following factors into consideration in determining whether a termination of pregnancy is medically necessary:

1. The termination of the pregnancy is necessary to save the life of the mother;
2. The pregnancy was the result of an act of rape;
3. The pregnancy was the result of an act of incest; or
4. In the physician's professional judgment, the termination was medically necessary, consistent with the following factors:
 - i. Physical, emotional, and psychological factors;
 - ii. Family reasons; and
 - iii. The age of the mother.

(c) The determination of medical necessity is subject to review by the Division in accordance with the rules of the Division. In addition, the procedure must be performed consistent with [N.J.A.C. 13:35-4.2](#).

(d) A "Physician Certification (Form FD-179)" shall be attached to the hospital's Medicaid claim form, either for inpatient or outpatient services, if any of the procedures on the claim relate to a voluntary elective abortion.

i. A copy of the completed FD-179 shall also be attached to:

- (1) The physician's Medicaid claim form; and,
- (2) The anesthesiologist's Medicaid claim form.

(e) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB-92 claim form (inpatient or outpatient) for all termination of pregnancy claims with the "Physician Certification (Form FD-179)" attached to the UB-92 claim form and must not submit the claim through the electronic billing system.

History

HISTORY:

Recodified from 10:52-2.14 and amended by R.2000 d.29, effective January 18, 2000.

§ 10:52-2.15 Termination of pregnancy

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), substituted a reference to Medicaid and NJ KidCare beneficiaries for a reference to Medicaid recipients, and added a second sentence; and in (c), substituted references to the Division for references to the Medicaid program throughout. Former [N.J.A.C. 10:52-2.15](#), Transportation services; hospital-based, recodified to [N.J.A.C. 10:52-2.16](#).

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" preceding "beneficiaries when performed by a physician"; rewrote (b).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), substituted "Medicaid/NJ" for "Medicaid or NJ" and "MCO" for "HMO", and deleted "the New Jersey Administrative Code," preceding "N.J.A.C.".

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§ 10:52-2.16 Transportation services; hospital-based

(a) Transportation shall be recognized by the Division as a covered outpatient hospital service under the following conditions:

1. Hospital-based emergency ambulance service for inpatient admission or outpatient services. For the definition of "emergency conditions", see [N.J.A.C. 10:49-6.1](#), Administration, Prior and Retroactive Authorization.
2. When a hospital is under contract with a municipality, county, or other government unit, to provide "911" or rescue squad ambulance service, reimbursement shall only be permitted on a fee-for-service basis under the policies and procedures as defined in [N.J.A.C. 10:50-1.2](#), Transportation Services.
3. Each hospital providing ambulance service to Medicaid/NJ FamilyCare fee-for-service beneficiaries shall possess all of the following:
 - i. An approved certificate of need for ambulance service from the New Jersey State Department of Health; and
 - ii. A provider license and vehicle license(s) for ambulance service from the New Jersey State Department of Health.

(b) Mobile Intensive Care Unit/Advanced Life Support (MICU/ALS) service and associated Ambulance/Basic Life Support (Ambulance/BLS) service shall be considered covered services under the following conditions of participation:

1. A hospital shall possess a "Certificate of Need" from the New Jersey State Department of Health and Senior Services to provide MICU/ALS service;
2. A hospital shall complete a "Memorandum of Understanding," issued by the Division of Medical Assistance and Health Services, before reimbursement can be made to the hospital for this service. The "Memorandum of Understanding" may be obtained from and, when completed, shall be returned to the Division of Medical Assistance and Health Services, Provider Enrollment Unit, PO Box 712, Mail Code #9, Trenton, New Jersey 08625-0712;
3. A hospital providing MICU/ALS service without its own associated Ambulance/BLS service or MICU/ALS transport vehicle, may utilize the service of a volunteer ambulance organization or shall enter into an agreement(s) with a proprietary/nonproprietary Ambulance/BLS company for the purpose of defining the responsibility for service. No reimbursement shall be made when the Ambulance/BLS Service is provided by a volunteer ambulance organization.
 - i. A copy of the agreement(s) shall be sent to the Division of Medical Assistance and Health Services, PO Box 712, Provider Enrollment Unit, Mail Code #9, Trenton, New Jersey 08625-0712.
 - ii. The hospital shall bill for the Ambulance/BLS service only upon completion of an agreement.

§ 10:52-2.16 Transportation services; hospital-based

iii. In the absence of an agreement(s) between the hospital providing the MICU/ALS service and a proprietary/nonproprietary Ambulance/BLS company, the hospital shall bill the Division's fiscal agent for the MICU/ALS service only.

iv. Transportation companies providing Ambulance/BLS associated with, and/or in conjunction with a MICU/ALS service, shall bill charges to the hospital providing the MICU/ALS service.

(c) Medicaid/NJ FamilyCare fee-for-service reimbursement of MICU/ALS services shall be based on Medicare principles of reimbursement, using standard cost reporting procedures, and reasonable cost and charge guidelines.

(d) Reimbursement for transportation services to and from hospital-affiliated medical day care centers are included in the medical day care per diem rate and shall not be billed to the New Jersey Medicaid/NJ FamilyCare program by the hospital separately.

(e) Transportation of inpatient beneficiaries transferred to another facility to receive services not available at the sending location, whether the intent is for the beneficiary to return or not, shall be the responsibility of the sending facility. These costs shall be included in the inpatient claim.

History

HISTORY:

Recodified from 10:52-2.15 and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a)4, substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph; in (c), inserted a reference to NJ KidCare fee-for-service reimbursement; and in (d), added "and shall not be billed to the New Jersey Medicaid or NJ KidCare--Plan A program by the hospital separately".

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Substituted references to FamilyCare for references to KidCare throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Rewrote the section.

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N.J.A.C. 10:52-3.1

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MATERNITY AND PEDIATRIC CARE SERVICES			

§ 10:52-3.1 Purpose

The purpose of HealthStart shall be to provide comprehensive maternity care services to pregnant Medicaid/NJ FamilyCare fee-for-service beneficiaries, (including those determined to be presumptively eligible) and preventive child health care services for Medicaid/NJ FamilyCare fee-for-service beneficiaries up to the age of two.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Inserted a reference to NJ KidCare--Plan A beneficiaries.

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Substituted "Medicaid/NJ" for "Medicaid and NJ" twice.

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N.J.A.C. 10:52-3.2

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§ 10:52-3.2 Scope of services

(a) HealthStart maternity care services provided by a HealthStart-certified provider shall be obstetrical care services provided in accordance with the recommendations of the American College of Obstetricians and Gynecologists and a program of support services provided in accordance with the New Jersey Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," dated 1997, available from the Department of Health.

(b) HealthStart comprehensive maternity care includes both medical maternity care services and health support services, which are described in (b)1 and 2 below:

1. Medical maternity care services shall include, but shall not be limited to:

- i. Ambulatory prenatal services;
- ii. Admission arrangements for delivery;
- iii. Obstetrical delivery services; and
- iv. Postpartum medical services.

2. Health support services shall include, but shall not be limited to:

- i. Case coordination services;
- ii. Health education assessment and counseling services;
- iii. Nutrition assessment and counseling services;
- iv. Social-psychological assessment and counseling services;
- v. Home visitation; and
- vi. Outreach, referral and follow-up services.

(c) HealthStart preventive child health care services include nine preventive child health visits, all the recommended immunizations, case coordination and continuity of care, including, but not limited to, the provision or arrangement for sick care, 24-hour telephone access, and referral and follow-up for complex or extensive medical, social, psychological and nutritional needs.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

§ 10:52-3.2 Scope of services

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), substituted "Health's" for "Health and Senior Services' ", and deleted "and Senior Services" following "Health".

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§ 10:52-3.3 HealthStart provider participation criteria

(a) The following Medicaid/NJ FamilyCare fee-for-service-enrolled provider types shall be eligible to participate as HealthStart providers:

1. Independent clinics;
2. Federally qualified health centers;
3. Hospital outpatient departments;
4. Local health departments;
5. Physician groups; and
6. Certified nurse midwives meeting the New Jersey Department of Health's Improved Pregnancy Outcome criteria.

(b) In addition to New Jersey Medicaid/NJ FamilyCare fee-for-service programs' rules applicable to provider participation, HealthStart providers shall:

1. Sign an Addendum to the New Jersey Medicaid /NJ FamilyCare fee-for-service programs' Provider Agreement;
2. Have a valid HealthStart Provider Certificate for HealthStart Comprehensive Maternity Care, HealthStart Obstetrical Care, HealthStart Health Support Services; and
3. Provide maternity care in accordance with the requirements for issuance of a "HealthStart Certificate," and in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(c) In addition to (a) and (b) above, HealthStart maternity care providers with more than one care site or more than one maternity clinic at the same site that use different staff shall apply for a separate HealthStart Comprehensive Maternity Provider Certificate for each separate clinic. Only those sites which hold a HealthStart Comprehensive Maternity Provider Certificate shall be reimbursed for HealthStart services. Such sites:

1. Shall participate in program evaluation and training activities, including, but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to the New Jersey Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines"; and
2. May determine presumptive eligibility for New Jersey Medicaid/NJ FamilyCare fee-for-service programs, if approved by the Division of Medical Assistance and Health Services.

(d) In addition to (a) and (b) above, HealthStart pediatric care providers shall participate in program evaluation and training activities including, but not limited to, documentation of outreach and follow-up activities in the patient's record.

§ 10:52-3.3 HealthStart provider participation criteria

(e) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Comprehensive Maternity Provider Certificate and to provide services in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(f) A HealthStart Comprehensive Maternity Provider Certificate shall be reviewed by the New Jersey State Department of Health at least every 18 months from the date of issuance.

(g) An application for a HealthStart Comprehensive Maternity Provider Certificate is available from:

HealthStart Program

New Jersey State Department of Health

PO Box 364

Trenton, NJ 08625-0364

(h) A HealthStart Program Provider Agreement is available from:

Chief, Provider Enrollment Unit

Division of Medical Assistance

and Health Services

Mail Code #9

PO Box 712

Trenton, New Jersey 08625-0712

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Made grammatical and/or technical changes regarding references to Medicaid, NJ FamilyCare, and the Department of Health throughout; and in (b)3, moved the end quote from preceding the period at the end to following it.

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§ 10:52-3.3 HealthStart provider participation criteria

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§ 10:52-3.4 Termination of HealthStart Comprehensive Maternity Provider Certificate

(a) The New Jersey State Department of Health shall enforce its requirements for HealthStart Comprehensive Maternity Provider Certificates and for evaluation and enforcement of its requirements within the standards and guidelines for HealthStart providers.

(b) Failure to comply with HealthStart standards shall be cause for termination of the HealthStart Comprehensive Maternity Provider Certificate by the New Jersey State Department of Health.

1. A HealthStart Comprehensive Maternity Provider Certificate shall be time-limited. Failure to complete the recertification process shall result in termination of the provider's HealthStart provider status by the New Jersey State Department of Health.
2. Termination of the HealthStart Comprehensive Maternity Provider Certificate shall result in the termination of the HealthStart Provider Agreement with the Medicaid NJ FamilyCare fee-for-service program. Providers who are terminated shall have the right to request a hearing in accordance with N.J.A.C. 10:49-10.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Deleted "and Senior Services" following "Health" throughout.

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§ 10:52-3.4 Termination of HealthStart Comprehensive Maternity Provider Certificate

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§ 10:52-3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate

- (a) Comprehensive maternity care services shall be integrated and coordinated.
- (b) HealthStart maternity care providers, excluding physicians and nurse midwives who are in private practice, shall provide comprehensive maternity care services within the following organizational requirements:
1. Providers shall provide directly or through an approved agreement, at one contiguous site, the following services: ambulatory prenatal and postpartum care; case coordination services; nutrition assessment; guidance and counseling services; health education assessment and instruction; and social-psychological assessment, guidance and counseling;
 2. Providers shall provide or arrange for the admission of patients to the appropriate level of care facility for obstetrical care delivery services;
 3. Providers shall provide or arrange for all necessary laboratory services;
 4. Providers shall provide one or more prenatal home visits for each high risk patient;
 5. Providers shall provide at least one postpartum home visit for each high risk patient;
 6. Providers shall adopt policies and procedures to assure the delivery of coordinated, integrated and comprehensive care; and
 7. Providers shall provide referral and follow-up services, which shall include, but shall not be limited to: referral for specialized evaluations, counseling and treatment for extensive social, psychological, nutritional and medical needs.
- (c) A provider shall link the mother and newborn infant with a pediatric care provider.
- (d) An independent clinic may provide the HealthStart health support services component alone upon entering into a written agreement with a private practitioner(s) who shall provide the HealthStart medical care services component. This agreement shall delineate which party shall take primary responsibility for provision of all HealthStart services.

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Rewrote the section.

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§ 10:52-3.6 Access to services

- (a) All HealthStart services shall be accessible to patients.
- (b) HealthStart maternity care providers shall facilitate patient access to services by scheduling an initial medical visit appointment within two weeks of the patient's first request for services.
- (c) HealthStart maternity care providers shall provide or arrange for 24-hour access to case coordination and medical services for emergency situations.
- (d) HealthStart maternity care providers shall arrange for language translation or interpretation services.
- (e) HealthStart maternity care providers may implement presumptive eligibility processing if so approved by the Division of Medical Assistance and Health Services.
- (f) HealthStart maternity care providers shall undertake community outreach activities to encourage women to seek early prenatal care and increase awareness of the availability of maternity care services.

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

In (b), inserted "medical visit" preceding "appointment"; in (e), substituted "processing if so" for "determinations if" following "presumptive eligibility".

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§ 10:52-3.7 Plan of care

- (a) A plan of care shall be developed and maintained by the case coordinator for each patient.
- (b) A plan of care shall be based on the medical, nutritional, social-psychological and health education assessments.
- (c) A plan of care shall include, but shall not be limited to: identification of risk conditions and problems, prioritization of needs, outcome objectives, planned interventions, time frames, referrals, follow-up activities and identification of staff responsible for the services.
- (d) The plan of care shall be developed and revised in consultation with the patient and staff providing services to the patient.
- (e) The initial plan of care shall be completed after a case conference and no later than one month after the initial registration visit.

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

In (c), inserted "shall" preceding "not be limited to" and substituted "referrals, follow-up activities and identification of staff responsible" for "referrals and follow-up activities, and identification of staff persons responsible"; substituted "plan of care" for "PoC" throughout.

Annotations

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N.J.A.C. 10:52-3.8

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MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.8 Maternity medical care services

(a) Maternity medical care services shall include antepartum, intrapartum, and postpartum care provided by the obstetrical care practitioner(s) in accordance with New Jersey State Department of Health's HealthStart Comprehensive Maternity Care Services Program Guidelines.

(b) Prenatal services shall be as follows:

1. Frequency of prenatal visits for an uncomplicated pregnancy shall be every four weeks during the first 28 weeks; then every two weeks until 36 weeks; and weekly thereafter. Prenatal visits for complications shall be scheduled as needed.
2. Initial prenatal visit content shall include, but not be limited to:
 - i. History;
 - ii. Review of systems;
 - iii. Comprehensive physical examination;
 - iv. Risk assessment;
 - v. Patient counseling;
 - vi. Routine laboratory tests;
 - vii. Development of the plan of care; and
 - viii. Special tests and/or procedures as medically indicated.
3. Subsequent prenatal visit content shall include, but not be limited to:
 - i. Review and revision of the patient plan of care;
 - ii. Interim history;
 - iii. Physical examination;
 - iv. Patient counseling and treatment;
 - v. Laboratory tests;
 - vi. Special tests and/or procedures which are medically indicated;
 - vii. Identification of new or developing problems; and
 - viii. Management, including transfers, of any new or persistent problems.
4. Transfer of prenatal records to the hospital of delivery shall occur no later than 34 weeks gestation.

(c) Obstetrical delivery services shall include, but not be limited to:

1. Determination of, and arrangements for, delivery site;

§ 10:52-3.8 Maternity medical care services

2. Attendance at or provision for obstetrical delivery by a qualified physician or certified nurse midwife; and
3. Medical care during the entire period of confinement.

(d) A postpartum visit shall be provided by the 60th day after delivery, and shall include, but shall not be limited to, the following:

1. History;
2. Review of the prenatal, labor and delivery record;
3. Physical examination;
4. Patient counseling and treatment;
5. Parent/infant assessment;
6. Referral/consultation, as indicated; and
7. Procedures/tests, as indicated.

(e) All HealthStart maternity care providers shall have policies and protocols which shall be consistent with national standards regarding consultation and transfer of medically high-risk patients to tertiary-level maternity care facilities or specialists and to genetic counseling and testing facilities.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), inserted a comma following "intrapartum", and substituted "Health's" for "Health and Senior Services' ".

Annotations

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§ 10:52-3.9 Health support services

(a) Case coordination services shall facilitate the delivery of continuous, coordinated, and comprehensive services for each patient in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:

1. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit.
2. Prenatal case coordination activities shall include, but shall not be limited to:
 - i. Orienting the patient to all services;
 - ii. Developing, maintaining and coordinating the plan of care in consultation with the patient;
 - iii. Coordinating and monitoring the delivery of all services and referrals;
 - iv. Monitoring and facilitating the patient entry into and continuation with maternity services;
 - v. Facilitating and providing advocacy for obtaining referral services;
 - vi. Reinforcing health teachings and providing support;
 - vii. Providing vigorous follow-up for missed appointments and referrals;
 - viii. Arranging home visits;
 - ix. Meeting with the patient and coordinating patient care conferences; and
 - x. Reviewing, monitoring and updating the patient's complete record.
3. Postpartum case coordination activities shall include, but shall not be limited to, the following:
 - i. Arranging and coordinating the postpartum visit and any home visit;
 - ii. Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;
 - iii. Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children Program (WIC), pediatric care, future family planning, Special Child Health Services, the County-Based Special Child Health and Early Intervention Services Case Management Units, early intervention services for infants with disabilities and other health and social agencies, if needed;
 - iv. Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;
 - v. Coordinating referrals and following up on missed appointments and referrals; and
 - vi. Reinforcing health instruction for mother and baby.

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(b) Nutrition assessment and basic guidance services shall be provided to orient and educate the beneficiary about nutritional needs during pregnancy and to educate the beneficiary about good dietary practices in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines." Specialized nutrition assessment and counseling shall be provided to women with additional needs. Services shall be provided as follows:

1. Initial assessment services, which shall include, but shall not be limited to, the following:
 - i. Review of the patient's chart;
 - ii. Identification of dental problems which may interfere with nutrition;
 - iii. Nutrition history;
 - iv. Current nutritional status;
 - v. Determination of participation in WIC or other food supplement programs; and
 - vi. Identification of need for specialized nutrition counseling;
2. Subsequent nutrition assessment, which shall include, but shall not be limited to, the following:
 - i. Monitoring of weight gain/loss;
 - ii. Identification of special dietary needs; and
 - iii. Identification of need for specialized nutrition counseling services;
3. Prenatal nutrition guidance, which shall include, but shall not be limited to, the following:
 - i. Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;
 - ii. Review and reinforcement of other nutrition and dietary counseling services the patient may be receiving;
 - iii. Instruction on food purchase, storage and preparation;
 - iv. Instruction on food substitutions, as indicated;
 - v. Discussion of infant feeding and nutritional needs; and
 - vi. Referral to food supplementation programs through the case coordinator;
4. Specialized nutrition assessment and counseling, which shall be provided to those women with additional needs;
5. Referral for extensive specialized nutrition services, which shall be initiated by the medical care provider or the nutritionist under the supervision of the medical care provider in coordination with the case coordinator; and
6. Postpartum nutrition assessment and basic guidance services, which shall include, but shall not be limited to:
 - i. Review and reinforcement of good dietary practices;
 - ii. Review of instruction on dietary requirement changes; and
 - iii. Instruction on breast feeding and/or formula preparation and feeding.

(c) Social-psychological assessment and basic guidance services shall be provided to the beneficiary to assist the beneficiary in resolving social-psychological needs in accordance with the "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:

1. Initial social-psychological assessment services, which shall include, but shall not be limited to, the following:

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- i. Determining financial resources and living conditions;
 - ii. Determining the patient's personal support system;
 - iii. Determining the patient's attitudes and concerns regarding the pregnancy;
 - iv. Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;
 - v. Ascertaining educational and/or employment status and needs; and
 - vi. Identification of the need for specialized social-psychological and mental health evaluation and counseling services;
2. Subsequent social-psychological assessment services, which shall include, but shall not be limited to, the following:
- i. Determining the patient's reaction to pregnancy;
 - ii. Ascertaining the reaction of family, friends and the actual support person to the pregnancy;
 - iii. Identifying the need for social service interventions and advocacy; and
 - iv. Identifying the need for specialized social-psychological and/or mental health evaluation and counseling;
3. Basic social-psychological guidance, which shall include, but not be limited to, the following:
- i. Orientation and information on available community resources;
 - ii. Orientation regarding stress and stress reduction during pregnancy; and
 - iii. Assistance with arrangements for transportation, child care and financial needs;
4. Specialized, short-term social-psychological counseling, which shall be provided to women who are identified through assessment or basic counseling as having a need for more intense service;
5. Referral for extensive specialized social-psychological services, which shall be initiated by the medical care provider or by the social worker under the supervision of the medical care provider and in coordination with the case coordinator; and
6. Postpartum social-psychological assessment and guidance, which shall include, but shall not be limited to, the following:
- i. Review of prenatal, labor, delivery and postpartum course;
 - ii. Assessment of the patient's current social-psychological status, including mother and infant bonding and the acceptance of the infant by the father and the family, as applicable;
 - iii. Identification of the need for additional social-psychological services;
 - iv. Review of available community resources for mother and infant, as applicable;
 - v. Counseling regarding fetal loss or infant death, if applicable; and
 - vi. Counseling regarding school/employment planning.
- (d)** Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines." Services shall be provided as follows:
- 1. Initial assessment of health educational needs, which shall include, but shall not be limited to, the patient's:
 - i. Educational background;
 - ii. Health education needs; and

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- iii. Previous education and experience concerning pregnancy, birth and infant care;
 - 2. Health education instruction, which shall be provided for all patients based on their identified health education needs shall include, at a minimum, the following:
 - i. Normal course of pregnancy;
 - ii. Fetal growth and development;
 - iii. Warning signs, such as signs of pre-term labor, and identification of emergency situations;
 - iv. Personal hygiene;
 - v. Exercise and activity;
 - vi. Childbirth preparation, including management of labor and delivery;
 - vii. Preparation for hospital admission;
 - viii. Substance, occupational and environmental hazards;
 - ix. Need for continuing medical and dental care;
 - x. Future family planning;
 - xi. Parenting, basic infant care and development;
 - xii. Availability of pediatric and family medical care in the community; and
 - xiii. Normal postpartum physical and emotional changes.
 - 3. Health education services, which shall include guidance in decision making and in the implementation of decisions concerning pregnancy, birth and infant care; and
 - 4. Postpartum assessment of health education needs shall be conducted.
- (e) One face-to-face preventive health care contact shall be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:
- 1. This contact shall include, but shall not be limited to:
 - i. Review of the mother's health status;
 - ii. Review of the infant's health status;
 - iii. Review of mother/infant interaction;
 - iv. Revision of the plan of care; and
 - v. Provision of additional services, as indicated; and
 - 2. The provider shall provide or arrange for one or more home visits for each high-risk patient in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."
- (f) HealthStart maternity care providers shall utilize existing community services to enhance the maternity care services.
- (g) HealthStart maternity care providers shall have written procedures, which identify specific agencies or practitioners and criteria for referral of patients requiring services which are extensive, complex, or expected to extend beyond the pregnancy. These procedures shall include, but shall not be limited to: nutrition and food supplementation services, substance use disorder treatment facilities, mental health services, county/local social and welfare agencies, parenting and child care educational programs, future family planning services, fetal alcohol syndrome, and AIDS counseling services.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Substituted "Health's" for "Health and Senior Services' " throughout; in the introductory paragraph of (a), inserted a comma following "coordinated"; and in (g), inserted a comma following the first occurrence of "procedures", following "complex", and following "syndrome", and substituted "use disorder" for "abuse".

Annotations

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MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.10 Professional staff requirements for HealthStart Comprehensive Maternity Care services

- (a) All HealthStart comprehensive maternity care services shall be delivered through a team approach by qualified professionals.
- (b) Physicians and certified nurse midwives shall be Medicaid/NJ FamilyCare fee-for-service providers and have obstetrical admitting privileges at a licensed maternity care facility.
- (c) Case coordinators shall have, at a minimum, a license as a registered nurse; or a Bachelor's degree in social work, health or a behavioral science.
- (d) Health professionals shall have a valid license to practice their professions, as required by the State of New Jersey.
- (e) All other professionals, for whom no license to practice is required, shall meet generally accepted professional standards for qualification.
- (f) Paraprofessionals shall be familiar with the local community, have knowledge or skills in maternal and child health services and shall be supervised by a health professional.
- (g) Prenatal, delivery, and postpartum medical services shall be delivered by a physician or a certified nurse midwife.
- (h) Nutrition, social-psychological and health education assessments and development of the plan of care shall be provided by appropriate professionals in each of the specialty areas, or by case coordinators or medical care professionals. If the nutrition or social-psychological assessment portion of the plan of care is provided by a case coordinator or medical care professional, then these portions shall be reviewed by a nutritionist or social worker, respectively.
- (i) Nutrition and social-psychological basic counseling shall be provided by a case coordinator with at least one year of experience in providing services to maternity patients or by the appropriate specialist in each of the areas or by a registered nurse or obstetrical care provider.
- (j) Short term specialized social-psychological and nutrition counseling services shall be provided by a social worker and nutritionist, respectively. The social worker and nutritionist shall be available on site during patient visits.
- (k) There shall be adequate professional, paraprofessional and clerical staff to provide, in a timely manner, maternity care services as described herein which meet the needs of the patients.

History

HISTORY:

§ 10:52-3.10 Professional staff requirements for HealthStart Comprehensive Maternity Care services

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), inserted a reference to NJ KidCare--Plan A fee-for-service providers.

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (b), substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

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§ 10:52-3.11 Records; documentation, confidentiality, and informed consent requirements for HealthStart maternity care providers

- (a) HealthStart maternity care providers shall have policies which protect patient confidentiality, provide for informed consent and document prenatal, labor, delivery, and postpartum services in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."
- (b) An individual record shall be maintained for each patient throughout the pregnancy.
- (c) Each record shall be confidential and shall include at least the following: history and physical examination findings assessment, a plan of care, treatment services, laboratory reports, counseling and health instructions provided and documentation of referral and follow-up services.
- (d) There shall be policies and procedures for appropriate informed consent for all HealthStart services.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Rewrote (a); in (c), substituted "plan of care" for "Care Plan".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Section was "Records; documentation, confidentiality and informed consent requirements for HealthStart maternity care providers". In (a), inserted a comma following "delivery", and substituted "Health's" for "Health and Senior Services'".

Annotations

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§ 10:52-3.11 Records; documentation, confidentiality, and informed consent requirements for HealthStart
maternity care providers

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[N.J.A.C. 10:52-3.12](#)

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§ 10:52-3.12 Standards for HealthStart pediatric care

- (a) Pediatric care services shall be comprehensive, integrated and coordinated.
- (b) HealthStart pediatric care providers shall be Medicaid/NJ FamilyCare fee-for-service providers and shall:
 - 1. Directly provide preventive child health care, maintenance of complete patient history, outreach for preventive care, initiation of referrals for appropriate medical, educational, social, psychological and nutrition services, and follow-up of referrals and sick care;
 - 2. Directly provide or arrange for non emergency room-based, 24-hour physician telephone access for eligible patients; and
 - 3. Directly provide or arrange for sick care and emergency care.

History

HISTORY:

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), inserted a reference to NJ KidCare--Plan A fee-for-service providers.

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

In (b), substituted "FamilyCare" for "KidCare-PlanA" preceding "fee-for-service" in the introductory paragraph, substituted "child health" for ", well-child" following "Directly provide preventive" in 1, and substituted "for eligible" for "to" following "telephone access" in 2.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (b), substituted "Medicaid/NJ" for "Medicaid and NJ".

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§ 10:52-3.12 Standards for HealthStart pediatric care

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§ 10:52-3.13 Professional requirements for HealthStart pediatric care providers

All HealthStart pediatric care providers shall be pediatricians or have a physician on staff who possesses a knowledge of pediatrics. This may be demonstrated by eligibility for board certification by the American Academy of Pediatrics, the American Osteopathic Board of Pediatrics, or by hospital admitting privileges in pediatrics.

History

HISTORY:

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Substituted "pediatricians" for "physicians" following "providers shall be" and substituted "American Academy of Pediatrics, the American Osteopathic Board of Pediatrics, or by hospital admitting privileges" for "American Academy of Pediatrics and/or by hospital admitting privileges" following "board certification by the".

Annotations

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§ 10:52-3.14 Preventive care services provided by HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall provide preventive health visits in accordance with the recommended guidelines of the American Academy of Pediatrics. The schedule shall include a two-to four-week visit, two-month visit, four-month visit, six-month visit, nine-month visit, 12-month visit, 15-month visit, 18-month visit and 23-to 24-month visit. Each visit shall include, at a minimum, medical, family and social history, unclothed physical examination, developmental and nutritional assessment, vision and hearing screening, dental assessment, assessment of behavior and social environment, anticipatory guidance, age appropriate laboratory examinations, and immunizations. Referrals shall be made as appropriate.

(b) Each provider shall provide or arrange for sick care and 24-hour telephone physician access during non-office hours. If not directly provided by the HealthStart provider, sick care and 24-hour telephone access shall be provided for each child by a single designated provider via a documented agreement. Information on care given shall be communicated to the primary HealthStart pediatric care provider. Telephone access provided exclusively via emergency room staff shall not be permitted. Referral to the emergency room should occur only for emergency medical care or urgent care.

(c) Case coordination outreach and follow-up services shall include letter or telephone call reminders to the child's parent or guardian for preventive well-child visits and letter or telephone follow-up of missed appointments. Referrals for home visit services for follow-up shall be made when appropriate. For all referrals and follow-up visits, the provider shall document the completion of such referrals or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and to the referred agency shall be sent or made, encouraging the follow through of the referral. All of the activity shall be recorded on the patient's chart.

(d) All HealthStart pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational, and nutrition services. This may include, but shall not be limited to: the Special Supplemental Food Program for Women, Infants and Children Program (WIC), the Division of Child Protection and Permanency, Special Child Health Services Case Management Units' Child Evaluation Centers, early intervention programs, county social service agencies, certified home health agencies, community mental health centers, and local and county health departments.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

§ 10:52-3.14 Preventive care services provided by HealthStart pediatric care providers

In (d), substituted a reference to County Boards for a reference to County Welfare Agencies/Boards.

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.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (d), inserted a comma following "educational" and following "centers", and substituted "Child Protection and Permanency" for "Youth and Family Services", "Units' " for "Units and", and "welfare agencies" for "boards of social services".

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N.J.A.C. 10:52-3.15

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§ 10:52-3.15 Records; documentation, confidentiality and informed consent for HealthStart pediatric care providers

- (a) HealthStart pediatric care providers shall have policies which protect patient confidentiality, provide for informed consent and document comprehensive care services.
- (b) An individual record shall be maintained for each patient.
- (c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, plan of care, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.
- (d) There shall be policies and procedures for appropriate informed consent for all HealthStart pediatric services.

History

HISTORY:

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Rewrote (a); in (c), substituted "plan of care" for "Care Plan".

Annotations

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§ 10:52-3.16 Reimbursement for HealthStart providers

(a) The HealthStart HCPCS procedure codes listed in this subchapter are governed by the same rules that appear in the HCPCS subchapter of each non-institutional provider services manual (Independent Clinic, Physician and the Nurse Midwifery Services Chapters). The maximum fee allowance schedule and reimbursement requirements for HCPCS HealthStart Maternity Codes (Medical Care and Health Support Services) and HCPCS HealthStart Pediatric Codes are listed under N.J.A.C. 10:66-6.

(b) A hospital outpatient department (OPD) which is a HealthStart Provider shall use the procedure for OPD billing (UB-92 claim form), contained in this chapter; except for the following services:

1. HealthStart Health Support Services (W9040 through W9043), which shall be billed on the CMS 1500 claim form, using the Independent Clinic billing number; and
2. HealthStart pediatric continuity of care services (W9070), which shall be billed on the MC-19 form, EPSDT Referral Report.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (b), substituted a reference to HCFA 1500 claim forms for a reference to 1500 N.J. claim forms in 1, and substituted a reference to EPSDT Referral Report for a reference to Report and Claim for EPSDT/Health--Start Screening and Related Procedures.

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), deleted "policies and" preceding "rules that appear" and amended the N.J.A.C. reference; in (b), rewrote the introductory paragraph and substituted "CMS" for "HCFA" preceding "1500 claim form" in 1.

Annotations

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§ 10:52-3.16 Reimbursement for HealthStart providers

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N.J.A.C. 10:52-3.17

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CHAPTER 52. HOSPITAL SERVICES MANUAL > **SUBCHAPTER 3. HEALTHSTART--**
MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.17 HealthStart Maternity Care billing code requirements

(a) HealthStart Maternity Care billing code requirements shall be as follows:

1. Separate reimbursement shall be available for maternity medical care services and maternity health support services.
2. Maternity medical care services shall be billed as a total obstetrical package, when applicable, but may be billed as separate procedures.
3. The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart maternity medical or health support service.
4. The modifier "WM" in the HCPCS lists of codes (W9025 through W9030) refers to those services provided by certified nurse midwives who shall include the modifier at the end of each code. HCPCS codes for health support services do not require the "WM" modifier on HCPCS codes W9040 and W9043.
5. Laboratory and other diagnostic procedures and all necessary medical consultations shall be eligible for separate reimbursement.

(b) HealthStart maternity medical care procedure codes are provided in N.J.A.C. 10:66-6, the Healthcare Common Procedure Coding System (HCPCS) for Independent Clinic Services.

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

In (a), substituted "applicable" for "feasible" preceding ", but may be billed" in 2; rewrote (b).

Annotations

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§ 10:52-3.17 HealthStart Maternity Care billing code requirements

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N.J.A.C. 10:52-4.1

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§ 10:52-4.1 Basis of payment; acute general hospitals reimbursed under the Diagnosis Related Groups (DRG) system--inpatient services

(a) For inpatient services with discharge dates prior to August 3, 2009, the Division will reimburse acute care general hospitals for inpatient services based upon rates determined under N.J.A.C. 10:52-5 through 7 and 9, except for distinct units of acute care general hospitals. For reimbursement methodology for distinct units of acute care general hospitals, see [N.J.A.C. 10:52-4.2\(e\)](#).

(b) For inpatient services with discharge dates on or after August 3, 2009, the Division will reimburse acute care general hospitals for inpatient services based upon rates determined under N.J.A.C. 10:52-14. However, the reimbursement methodology for distinct units of acute care general hospitals is not changed on or after that date. See [N.J.A.C. 10:52-4.2\(e\)](#).

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Changed N.J.A.C. reference.

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Amended the final N.J.A.C reference.

Amended by R.2009 d.249, effective August 3, 2009.

See: [41 N.J.R. 1351\(a\)](#), [41 N.J.R. 2895\(a\)](#).

Designated the existing text as (a); in (a), substituted "For inpatient services with discharge dates prior to August 3, 2009, the" for "The" and "7 and 9" for "8"; and added (b).

Annotations

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§ 10:52-4.1 Basis of payment; acute general hospitals reimbursed under the Diagnosis Related Groups (DRG) system--inpatient services

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N.J.A.C. 10:52-4.2

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PAYMENT FOR HOSPITAL SERVICES

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

(a) The Division will reimburse special hospitals (Classification A) (acute and short term special hospitals) and Classification B (Rehabilitation hospitals), excluding specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services, effective for the 2002 rate year, in accordance with P.L. 2001, c.393, section 5, for inpatient services (including the interim and final settlement), in accordance with Medicare principles of reimbursement (see 42 CFR 413).

(b) Specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services will be reimbursed a prospective per diem rate. The initial prospective per diem rate, effective for the 2002 rate year, shall be based on the total Medicaid inpatient costs divided by the total Medicaid days for Fiscal Year 1999, using the hospital's first finalized audited Fiscal Year 1999 cost report. If the hospital has been in operation less than two full years prior to Fiscal Year 1999, the prospective per diem rate shall be set using the hospital's first finalized audited Fiscal Year 2000 cost report. The initial prospective rate shall be increased annually by an economic factor, as specified in [N.J.A.C. 10:52-5.13\(a\)](#).

1. A hospital may request a change to its prospective per diem rate as either an adjustment to its base year costs in accordance with [42 CFR 413.40\(g\)](#), or assignment of a new base year in accordance with [42 CFR 413.40\(i\)](#).
2. The hospital's request shall be received within 180 days from the end of the fiscal year for which the adjustment or new base was requested, and shall include all supporting documentation.
3. The Division may grant an interim adjustment, subject to final adjudication of the hospital's request. The Division's final determination shall be made based upon financial data from the hospital's audited cost report for the year for which the adjustment or new base year was requested.
4. The Division shall issue a written determination with an explanation for each request for an adjustment or new base year.
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.

§ 10:52-4.2 Basis of payment; special hospitals (Classification A and B), private and governmental psychiatric hospitals and distinct (exc luded units) of acute....

- (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/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.

History

HISTORY:

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.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (d), substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

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N.J.A.C. 10:52-4.3

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PAYMENT FOR HOSPITAL SERVICES

§ 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

§ 10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, and....

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 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 FamilyCare 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.

§ 10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, an....

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 fee-for-service for the following service categories 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 \$ 50.00.

(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 \$ 62.50.

(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 \$ 42.00.

ii. Costs related to all outpatient psychiatric services for individuals 21 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.

§ 10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, and....

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. Separate unit rates shall be reimbursed for the following service categories as defined in [N.J.A.C. 10:52](#) and 10:52A:

(1) 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.

(2) 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.

(3) 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.

(4) 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.

(5) 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.

ii. Costs related to all outpatient psychiatric services for youth and young adults under the age of 21 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 MCO or for Medicaid/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/NJ FamilyCare 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 MCO 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.

§ 10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, an....

History

HISTORY:

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".

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Amended by R.2014 d.118, effective July 21, 2014.

See: [46 N.J.R. 419\(a\)](#), [46 N.J.R. 1693\(a\)](#).

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 the introductory paragraph of (b), inserted a comma following "amounts"; in the introductory paragraph of (b)8, inserted "fee-for-service for the following service categories"; in (b)8i(3), substituted "\$ 50.00" for "\$ 40.00"; in (b)8i(4), substituted "\$ 62.50" for "\$ 50.00"; in (b)8i(6), substituted "\$ 42.00" for "\$ 34.00"; in (b)8ii, substituted "21" for "22", and inserted a comma following "charges"; added new (b)9i; recodified former (b)9i through (b)9v as (b)9i(1) through (b)9i(5), and added (b)9ii.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (b)1, deleted "the" preceding "N.J.A.C."; in (b)1ii(1), the introductory paragraph of (c), and (c)3, made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare; and in the introductory paragraph of (c) and (c)4, substituted "MCO" for "HMO".

Annotations

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§ 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, which meet both conditions in (a)1 below will be eligible for increased payments for capital project funding related to its Medicaid/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/NJ FamilyCare -Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

History

HISTORY:

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](#).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In the introductory paragraph of (a), deleted "and Senior Services" following "Health"; and in the introductory paragraph of (a) and (a)3, substituted "Medicaid/NJ" for "Medicaid and NJ".

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§ 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/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/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/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.

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

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/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.

History

HISTORY:

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

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

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.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a), the introductory paragraph of (b) and of (d), and (c)2, substituted "Medicaid/NJ" for "Medicaid or NJ" throughout.

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N.J.A.C. 10:52-4.6

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§ 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.

History

HISTORY:

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".

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

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§ 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/NJ FamilyCare beneficiary is covered under both programs, Item 57 on the hospital claim form shall be completed showing the Medicaid/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/NJ FamilyCare is not the primary payer on an inpatient hospital claim, payment by Medicaid/NJ FamilyCare will be made at the lesser of:
1. The Medicaid/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.

History

HISTORY:

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 Medicare/Medicaid or Medicare/NJ FamilyCare claims

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.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a) and (c), substituted "Medicaid/NJ" for "Medicaid or NJ" throughout.

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N.J.A.C. 10:52-4.8

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§ 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 use disorder 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.

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

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

History

HISTORY:

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](#).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (d)4iv, substituted "use disorder" for "abuse".

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

1. For disbursements, payment shall be made to the hospital for the full amount due within 30 days from the date of settlement agent's letter.
2. The fiscal agent shall begin recoupment for the full amount of the overpayment 30 days after the date the Division receives the settlement agent's overpayment notification by withholding the Medicaid/NJ FamilyCare fee-for-service payments to the hospital.
3. If the withholding of the New Jersey Medicaid/NJ FamilyCare fee-for-service payments is not acceptable to the hospital, the hospital must submit, prior to the end of the 30-day period, a proposed repayment schedule to the Division. For a repayment schedule in excess of three months, documentation, as specified in Medicare Provider Reimbursement Manual 13-2, Section 2223, Establishing Extended Repayment, shall be submitted. If an approvable repayment schedule is not received by the Division, the withholding of Medicaid/NJ FamilyCare fee-for-service payments shall be implemented to begin recoupment.
4. The proposed repayment plans should be submitted directly to the following address:

Office of Hospital Reimbursement

Division of Medical Assistance and Health Services

PO Box 712, Mail Code #44

Trenton, New Jersey 08625-0712
5. Interest shall be charged at the maximum legal rate as of the date of the repayment agreement or 30 days from the date of the settlement agent letter to the Division, whichever is sooner.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-4.7](#) by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

See: [30 N.J.R. 1060\(a\)](#).

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.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Rewrote (a).

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.

Recodified from [N.J.A.C. 10:52-4.8](#) by R.2009 d.249, effective August 3, 2009.

See: [41 N.J.R. 1351\(a\)](#), [41 N.J.R. 2895\(a\)](#).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a)3, substituted ", as" for "(as" and "Repayment," for "Repayment)".

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N.J.A.C. 10:52-5.1

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§ 10:52-5.1 Derivation of Preliminary Cost Base

For general acute care hospitals, the Division of Medical Assistance and Health Services (hereafter referred to as the Division or its designee), on or before March 12, 1993 and on or before January 31 of each subsequent rate year shall implement a rate. For hospitals with a fiscal year of January 1, the rate year will be the calendar year. For hospitals on a fiscal year beginning other than January 1, but before July 1, the rate year will be the year the fiscal year begins and for hospitals on a fiscal year beginning between July 1 and December 31, the rate year will be the year the fiscal year ends.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Deleted (a) designation.

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N.J.A.C. 10:52-5.2

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<i>METHODOLOGICAL REGULATIONS</i>			

§ 10:52-5.2 Uniform Reporting: Current costs

Hospitals shall be required to submit reports as required in N.J.A.C. 8:31B-4. The Director shall review the actual costs for the institutions as reported in accordance with the Financial Reporting Principles and Concepts (Subchapter 6). The review will be performed according to the methodology outlined below. Costs, so reported, shall be subject to revision due to subsequent audits.

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N.J.A.C. 10:52-5.3

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§ 10:52-5.3 Costs per case

Direct and indirect care costs shall be allocated to the inpatient and outpatient services. Direct and indirect costs allocated to inpatient services shall be used to determine inpatient rates per case according to the patient diagnosis. This cost finding process is described in [N.J.A.C. 10:52-5.7](#) through [5.11](#).

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Changed N.J.A.C. reference.

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Amended the N.J.A.C. reference.

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N.J.A.C. 10:52-5.4

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§ 10:52-5.4 Development of standards

Effective for services provided on or after October 1, 1996, the Director shall develop standard reimbursement amounts for each DRG based on the median cost per case for Medicaid/NJ FamilyCare fee-for-service beneficiaries. The standards shall be adjusted to account for significant differences in labor market areas. These standards are developed according to criteria set forth in [N.J.A.C. 10:52-5.11](#) through [5.17](#). Standards so developed and issued for a rate year shall remain unaffected and no adjustments, modifications, or changes to the standards shall be made except as referenced in [N.J.A.C. 10:52-5.10](#).

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: [28 N.J.R. 4022\(a\)](#), [29 N.J.R. 350\(b\)](#).

In (a), inserted text "For services provided prior to October 1, 1996"; and added (b).

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Changed N.J.A.C. references throughout; and in (b), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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), inserted "(DRG)" following "Diagnosis Related Group" and amended the N.J.A.C. references in the third and fourth sentences; in (b), substituted "DRG" for "Diagnosis Related Group" preceding "based on the median cost", substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiaries", inserted "forth" following "criteria set", and amended the N.J.A.C. references in the third and fourth sentences.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Deleted former (a) and designation (b); and substituted "Medicaid/NJ" for "Medicaid and NJ", and inserted a comma following "modifications".

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N.J.A.C. 10:52-5.5

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§ 10:52-5.5 Current Cost Base

(a) A hospital's Current Cost Base is defined as the actual costs and revenues as identified in the Financial Elements in the base reporting period as recognized by the Division for purposes of rate setting.

(b) The Current Cost Base is used to develop the Preliminary Cost Base (PCB) and Schedule of Rates through:

1. Determination of the costs of Medicaid patients treated in the 1988 base year;
2. Identification of fixed and variable components of the Preliminary Cost Base;
3. Calculation of the economic factor cost component as defined in [N.J.A.C. 10:52-5.13\(a\)](#);
4. Calculation of the technology factor as described in [N.J.A.C. 10:52-5.13\(b\)](#);
5. The costs used to set rates for the rate year will be based on 1988 costs.

(c) A hospital's actual cost reports cannot be substituted or rearranged once the Director has determined that the actual cost submission is suitable for entry into the data base.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Recodified from [N.J.A.C. 10:52-5.9](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

In (b), changed N.J.A.C. references in 3 and 4.

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§ 10:52-5.5 Current Cost Base

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N.J.A.C. 10:52-5.6

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§ 10:52-5.6 Financial elements reporting/audit adjustments

(a) The aggregate Current Cost Base is developed from Financial Elements reported to the Division and includes:

1. Costs related to Medicaid/NJ FamilyCare direct patient care as defined in [N.J.A.C. 10:52-6.14](#);
2. Less net income from specified sources;
3. Capital facilities allowance: Capital cash requirements (as defined in [N.J.A.C. 10:52-5.14](#) and [6.18](#));

(b) All reported financial information shall be reconciled by the hospital to the hospital's audited financial statement. In addition, having given adequate notice to the hospital, the Director may perform a cursory or detailed on-site review at the Division's discretion, of all financial information and statistics to verify consistent reporting of data and extraordinary variations in data relating to the development of the rates. Any adjustments made subsequent to the financial review, including Medicare audits and reviews, shall be brought to the attention of the Division by the hospital, the Department of Health, appropriate fiscal intermediary or payer, where appropriate, and shall be applied proportionately to the Schedule of Rates. All such adjustments shall be determined retroactively to the first payment on the Schedule of Rates and shall be applied prospectively.

History

HISTORY:

Recodified from [N.J.A.C. 10:52-5.10](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a)3, changed N.J.A.C. reference. Former [N.J.A.C. 10:52-5.6](#), Schedule of Rates, repealed.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a)1, substituted "Medicaid/NJ FamilyCare" for "Medicaid"; and in (b), substituted ", including" for "(including" and "reviews," for "reviews)", deleted "and Senior Services" following "Health", and inserted a comma following "payer" and following the second occurrence of "appropriate".

Annotations

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§ 10:52-5.6 Financial elements reporting/audit adjustments

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§ 10:52-5.7 Identification of direct and indirect costs related to Medicaid/ FamilyCare patient care

(a) Costs related to Medicaid/NJ FamilyCare fee-for-service patient care as adjusted for price level depreciation as reported to the Division shall be classified as follows:

1. Direct patient costs:
 - i. Routine service costs;
 - ii. Ambulatory service costs; and
 - iii. Ancillary service costs.
2. Mixed direct and indirect costs.
3. Indirect patient care:
 - i. Institutional costs.

(b) Patient care general service and indirect costs (except as noted below) shall then be distributed to direct cost centers based on allocation statistics reported to the Division on the following basis:

Patient Care General Service		Allocation Basis
CSS:	Central Supply Services	Costed requisitions
DTY:	Dietary	Patient Meals
HKP:	Housekeeping	Hours of Services
L&L:	Laundry and Linen	Pounds of Laundry
MRD:	Medical Records	Percentage of Time Spent
PHM:	Pharmacy	Cost of Drugs
EDR:	Education and Research (not including Schools of Nursing and Allied Health)	Percentage of Time Spent
RSD:	Residents	Accumulated Costs in Patient Care Cost Centers
PHY:	Physicians Coverage (related to research and medical education)	Patient Days
A&G:	Administration and General	Accumulated Cost
FIS:	Fiscal	Accumulated Cost
PCC:	Patient Care Coordination	Percentage of Time Spent
PLT:	Plant (less capitalized interest and depreciation)	Square Feet
UTC:	Utilities Cost	Square Feet
MAL:	Malpractice Insurance	Accumulated Cost
OGS:	Other General Services	Accumulated Cost

History

HISTORY:

Recodified from [N.J.A.C. 10:52-5.11](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

In (a), inserted a reference to NJ KidCare fee-for-service patient care in the introductory paragraph. Former [N.J.A.C. 10:52-5.7](#), Extraordinary expense, repealed.

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service patient care" in the introductory paragraph.

Annotations

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§ 10:52-5.8 Patient care cost findings: direct costs per case, physician and nonphysician

(a) Hospital case-mix shall be determined as follows:

1. Uniform Bill-Patient Summary (UB-PS) data shall be used for determination of hospital case-mix. The appropriate patient records for the reporting period corresponding with the Financial Elements Report shall be classified into Diagnosis Related Groups (DRGs) using the following items:
 - i. Principal diagnosis;
 - ii. Secondary diagnosis;
 - iii. Principal and other procedures;
 - iv. Age;
 - v. Sex;
 - vi. Discharge status; and
 - vii. Birthweight (newborn).
2. Outliers, which are defined as patients displaying atypical characteristics relative to other patients, for example, inordinately long or short lengths of stay, shall be determined by DRG using established trim points; any case beyond a trim point is considered an outlier. Hospitals must make every attempt to correct unacceptable data and hospitals for which more than 10 percent of the UB-PS data are missing or unacceptable must resubmit data or correct the unusable data before case-mix estimation will be attempted.
3. Outpatient case-mix shall consist of emergency service, clinic, home health agency, renal dialysis, home dialysis, ambulatory surgery, same day psychiatry, and private referred patients, as reported to the Division.
4. Same Day Surgical Services shall be considered a clinical, outpatient service but are assigned to a DRG and reported on a UB-PS (a bill type 13X).

(b) Measures of resource use are listed as follows:

1. For each patient with a Uniform Bill (UB), measures of resource use shall be calculated to distribute costs among the UB. Measures of resource use represent services provided to patients associated with each cost center. Patient days are associated with routine service cost, emergency room admissions with emergency service cost, and ancillary and therapeutic charges with ancillary and therapeutic service cost. The measures of resource use is a ratio of admissions reported on the hospital's cost report over the hospital's UB billing data. Costs are derived from the Actual Reporting Forms and are associated with admissions. Therefore, an adjustment is made to align the measures of resource use to the inpatient cost. The adjustment is the ratio of total admissions to total UB records. This results in a

§ 10:52-5.8 Patient care cost findings: direct costs per case, physician and nonphysician

total adjusted measure of resource use. The hospitals shall make reasonable efforts to correct data unacceptable to the Division or Department of Health.

	Center	Measure of Resource Use	Calculation of Inpatients
ROUTINE SERVICES			
MSA &	Medical-Surgical Acute Care Units	Patient Days	Total LOS less ICU, CCU, NBN and OBS LOS ACU
PED &	Pediatrics		
PSA &	Psychiatric Acute Care Units		
PSY &	Psychiatric/Psychological Services		
OBS	Obstetrics		
BCU	Burn Care Unit		BCU LOS
ICU &	Intensive Care Unit	Patient Days	ICU + CCU LOS
CCU	Coronary Care Unit		
NNI	Neonatal Intensive Care Unit	NNI Patient Days	Total ICU LOS for Newborn DRGs
NBN	Newborn Nursery	NBN Patient Days	Total LOS for Newborn DRGs less ICU LOS
AMBULATORY SERVICES			
EMR	Emergency Service	EMR Charges (Inpatient EMR Revenue and EMR Admissions)	EMR Admissions
CLN	Clinics	CLN Charges	None
HHH	Home Health	OHS Charges	None

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	Center	Measure of Resource Use	Calculation of Inpatients
ANCIL LARY SERVI CES	Agency		
ANS	Anesthesiology	ANS Charges	Direct
CCA	Cardiac Catheterization	CCA Charges	Direct
DEL	Delivery and Labor Room	DEL Charges	Direct
DIA	Dialysis	DIA Charges	Direct
DRU	Drugs Sold to Patients	PHM Charges (DRU)	Direct
EKG	Electrocardiology and Diagnostic	EDG Charges	Direct
NEU	Neurology		
LAB	Laboratory	BBK Charges and LAB Charges	Direct
MSS	Medical-Surgical Supplies Sold to Patients	CSS Charges (MSS)	Direct
NMD	Nuclear Medicine	NMD Charges	Direct
OCC	Occupational and Recreational Therapy	OPM Charges	Direct
SPA	Speech Pathology and Audiology		Direct
ORG	Organ Acquisition and	ORR Charges	Direct
ORR	Operating and Recovery Rooms		
PHT	Physical Therapy	PHT Charges	Direct
RAD	Diagnostic Radiology	RAD Charges	Direct
RSP	Respiratory	RSP Charges	Direct

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Center		Measure of Resource Use	Calculation of Inpatients
THR	Therapy	THR Charges	Direct
	Therapeutic		
	Radiology		

(c) Cost per case allocation:

1. The Direct Patient Care Costs of each center (after the allocation of patient care general services in [N.J.A.C. 10:52-5.11](#) and [5.12](#)) are separated between inpatient, outpatient, and Skilled Nursing Facility (SNF) costs. Outpatient and SNF costs are excluded from the inpatient rates based on gross revenue reported to the Division. The total inpatient costs from each cost center are then divided by the hospital's corresponding total adjusted measure of resource use. This calculation produces ratios, including cost per patient day, cost per EMR admission, or a cost ratio per ancillary or therapeutic charge for each cost center. Each ratio is then multiplied by the corresponding cost center's measure of resource use of each DRG to calculate a cost per case for the hospital's case mix.

i. Patient days will be employed as the Measures of Resource Use to allocate MSA, PED, PSA, and OBS nursing costs. While patient days are used, the MSA, PED, PSA, OBS centers will be combined into ACU and ICU, and CCU will be combined into ICU. All other routine centers will remain as above.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Recodified from [N.J.A.C. 10:52-5.12](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (a)2, substituted ", which are defined as patients" for "(patients", and substituted "stay," for "stay)"; and in (b)1, deleted "and Senior Services" following "Health".

Annotations

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§ 10:52-5.9 Reasonable cost of services related to patient care

(a) The reasonable cost of services related to patient care includes:

1. Current non-physician direct patient care costs per case as adjusted by standard costs per case for Medicaid/NJ FamilyCare fee-for-service inpatients;
2. Current physician patient service costs, as modified for physician compensation arrangements pursuant to [N.J.A.C. 10:52-5.8](#);
3. Indirect cost pursuant to [N.J.A.C. 10:52-5.7](#) and [5.12](#);
4. Less a reduction for income not related to patient care, from those sources specified in [N.J.A.C. 10:52-6.25](#) through [6.31](#) except all items reported as expense recovery to the Division, shall be so treated; and
5. Current major moveable equipment amount pursuant to [N.J.A.C. 10:52-6.19](#) and [6.24](#).

(b) The reasonable cost of services related to Medicaid patient care will be adjusted by the application of economic factors pursuant to [N.J.A.C. 10:52-5.13](#).

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Recodified from [N.J.A.C. 10:52-5.13](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a), inserted a reference to NJ KidCare fee-for-service inpatients in 1, and changed N.J.A.C. references in 2 through 4. Former [N.J.A.C. 10:52-5.9](#), Current Cost Base, recodified to [N.J.A.C. 10:52-5.5](#).

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" preceding "fee-for-service inpatients" in 1; in (b), amended the N.J.A.C. reference.

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

§ 10:52-5.9 Reasonable cost of services related to patient care

In (a)5, substituted "[N.J.A.C. 10:52-6.19](#) and [6.24](#)" for "[N.J.A.C. 10:52-6.9](#)".

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§ 10:52-5.10 Standard costs per case

(a) The standard to be used in the calculation of the proposed rates for each inpatient DRG is as follows:

1. For services provided on or after October 1, 1996, the standard to be used in the calculation of the proposed rates for each inpatient DRG is determined as the median non-physician patient care costs per Medicaid/NJ FamilyCare fee-for-service case in all hospitals whose costs are included in the data base, adjusted for labor market differentials. Standards shall be calculated across all hospitals for which current cost bases were derived from a common reporting period.

(b) Determination of the labor equalization factor to calculate Statewide standard costs per case shall be as follows:

1. An equalization factor shall be calculated for the non-physician direct patient care costs of each hospital (excluding ambulatory care centers) to account for differing hospital pay scales in the calculation of standards. Each hospital's equalization factor is determined as non-physician direct patient care costs (prior to allocation of costs from patient care general services) at average pay scales for all New Jersey hospitals (excluding those hospitals classified as Rehabilitation Facilities) divided by Labor Market Area non-physician direct patient care costs.
2. The Labor Market Areas recognized in 1990 by the Department of Health will be used for rate setting in subsequent years.
3. Labor Market Areas are:

Counties or Municipalities

Paterson--Clifton--Passaic

Passaic

Hackensack

Bergen

Newton--Phillipsburg

Sussex, Warren

Trenton--Flemington

Mercer, Hunterdon

Newark, Suburban

Union, Essex, Somerset,

Morris, except cities of

§ 10:52-5.10 Standard costs per case

	Counties or Municipalities
	Elizabeth, Belleville, East
	Orange, Irvington and Newark
Jersey City	Hudson
New Brunswick--Perth Amboy	Middlesex
Long Branch--Toms River	Monmouth, Ocean
Atlantic City--Cape May	Atlantic, Cape May
Vineland--MillvilleCamden--Salem	Burlington,
	GloucesterCumberland
Newark, Central City (not included in	Newark, Elizabeth,
v. above)	Belleville, East Orange, Orange, and Irvington

4. This factor is multiplied by the hospital's actual cost per case for all DRGs.
5. Labor costs shall be adjusted to Statewide averages by first grouping all non-physician direct patient care labor costs (after fringe benefit costs have been distributed) into eight labor categories as follows:
 - i. Registered Nursing: Includes non-physician salaries reported in RNS, CCA, DEL, DIA and ORR cost centers.
 - ii. Licensed Practical Nursing: Includes non-physician salaries reported in LPN cost center.
 - iii. Attendants: Includes non-physician salaries reported in ATT and CSS cost centers.
 - iv. Clerical: Includes non-physician salaries reported in CLR cost center.
 - v. Health Technical: Includes non-physician salaries reported in BBK, EDG, LAB, RAD, NMD, and THR cost centers.
 - vi. Therapists/Technical: Includes non-physician salaries reported in OPM, PHM, PHT, and RSP cost centers.
 - vii. General Services: Includes non-physician salaries reported in DTY, HKP, PLT, and L&L cost centers.
 - viii. Administrative and Clerical: Includes non-physician salaries reported in the MRD, A&G, FIS, EDR, and PCC cost centers.
6. The portion of the routine cost centers that shall be attributed to each of the four types of nursing skill levels is based on the distribution of costs as reported to the Division.

§ 10:52-5.10 Standard costs per case

7. By dividing non-physician direct patient care costs by the non-physician hours in each category, the average hourly rates for the eight labor categories are computed for each hospital. The sum of all of the hospital's non-physician direct patient care costs for the eight labor categories divided by the total non-physician hours is equal to the Statewide average. To determine each hospital's labor equalization factor, the Statewide average cost per hour for each labor category is multiplied by the hospital's number of non-physician labor hours for that category and is added to all other non-physician costs (that is, supplies and other costs). This amount is divided by the result of the same calculation using the Labor Market Area cost per hour, rather than Statewide average, resulting in the hospital's equalization factor.

8. Whenever the number of hospitals in a given labor market area decreases to a number less than four, the Division shall calculate and compare the mean equalization factors of the Labor Market Area, both before and after the decrease. If they differ by plus or minus one percent or more, that Labor Market Area shall be merged with the geographically contiguous Labor Market Area having the most similar hourly wage rate, averaged for all salaried employees and based on the most recent data available; the factors of all Labor Market Areas shall be recalculated and effective in the following rate year.

(c) Calculation of standards shall be as follows:

1. Effective for services provided on or after October 1, 1996, the calculation of standards shall be based on all hospital UB records for Medicaid/NJ FamilyCare patients, where Medicaid/NJ FamilyCare is the primary payor. The cost per case of each hospital's Medicaid/NJ FamilyCare patients with UB records categorized by inpatient DRGs is multiplied by each hospital's equalization factor for the appropriate DRGs and hospitals. The median equalized cost of all such records in all hospitals calculated after teaching costs have been removed from the hospitals' preliminary cost bases is the incentive standard for each DRG.

2. Determination of Labor Unequalization Factor to Calculate Standard Cost Per Case of Each Labor Market Area.

i. An unequalization factor shall be calculated for the non-physician direct patient care costs of each hospital to account for differing prevailing compensation patterns across New Jersey's Labor Market Areas in the comparison of hospital and standard costs per case. The Statewide standard times the unequalization factor is the unequalized standard in terms of the hospital's Labor Market Area.

ii. The reciprocal of the hospital's equalization factor is the hospital's unequalization factor and is applied to non-physician costs only.

(d) Effective for services provided on or after October 1, 1996, GME and IME shall no longer be reimbursed through the Medicaid/NJ FamilyCare fee-for-service hospital inpatient DRG rates. After all indirect costs have been fully allocated to the using cost centers, GME and IME costs shall be removed from the cost base before calculating the standards and Medicaid/NJ FamilyCare fee-for-service hospital inpatient rates. GME is removed by removing cost centers that contain adjusted GME costs before the direct patient care (DPC) rate is set. IME is removed from the DPC rate by multiplying by one minus the Indirect Medical Education (IME) factor based on the Medicare cost report and the fiscal agent's settlement data. GME and IME shall be reimbursed in accordance with N.J.A.C. 10:52-8.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

§ 10:52-5.10 Standard costs per case

Amended by R.1997 d.43, effective January 21, 1997.

See: [28 N.J.R. 4022\(a\)](#), [29 N.J.R. 350\(b\)](#).

Substantially amended section.

Recodified from [N.J.A.C. 10:52-5.14](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a)2, inserted a reference to NJ KidCare fee-for-service cases; and in (f), substituted references to Medicaid/NJ KidCare fee-for-service for references to Medicaid throughout, and changed N.J.A.C. reference. Former [N.J.A.C. 10:52-5.10](#), Financial elements reporting/auditing adjustments, recodified to [N.J.A.C. 10:52-5.6](#).

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 "data base" for "date base" preceding ", and adjusted for labor market differentials" and inserted "(GME)" following "Graduate Medical education" in 1, and substituted "FamilyCare" for "KidCare" preceding "fee-for-service case" in 2; in (b), substituted "must submit a letter" for "must a submit letter" in 3ii; rewrote (f).

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 (c)2, substituted the first occurrence of "that" for "which"; in (c)2ii(2), deleted ", Appendix XI B.I" following "8:31B"; in (c)2iii(2), deleted ", Appendix XI B.II, incorporated herein by reference" following "8:31B"; in (c)iv(2), deleted ", Appendix XI B.III" following "8:31B"; in (c)2v(2), deleted ", Appendix XI B.IV" following "8:31B"; in (c)vi(2), deleted ", Appendix XI vii" following "8:31B"; and in (d)2, substituted "by the Department of Health and Senior Services" for "rate setting at N.J.A.C. 8:31B-3.22(d)3".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Rewrote the section.

Annotations

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Case Notes

Burden was on hospitals to show that regulations governing hospital rates for Medicaid patients were invalid. Matter of Adoption of [N.J.A.C. 10:52-5.14\(d\)](#) 2 and [3, 276 N.J.Super. 568, 648 A.2d 509 \(A.D.1994\)](#), certification denied [142 N.J. 448, 663 A.2d 1355](#).

Division of Medical Assistance and Health Services, was not obligated to use components of Medicare rate methodology with respect to Medicaid program. Matter of Adoption of [N.J.A.C. 10:52-5.14\(d\)](#) 2 and [3, 276 N.J.Super. 568, 648 A.2d 509 \(A.D.1994\)](#), certification denied [142 N.J. 448, 663 A.2d 1355](#).

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Regulations governing hospital rates for Medicaid patients were valid. Matter of Adoption of [N.J.A.C. 10:52-5.14\(d\)](#) 2 and [3, 276 N.J.Super. 568, 648 A.2d 509 \(A.D.1994\)](#), certification denied *142 N.J. 448, 663 A.2d 1355*.

Research References & Practice Aids

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§ 10:52-5.11 Reasonable direct cost per case

(a) Inpatient direct cost per case shall be determined as follows:

1. The reasonable direct cost per Medicaid/NJ FamilyCare fee-for-service case for those hospitals receiving rates in accordance with this subchapter for every DRG shall include incentives and disincentives, as appropriate, which shall be termed the boundaries of payment and are calculated as follows:

i. Effective for services provided on or after October 1, 1996, the incentive standard is multiplied by the unequalization factor and the physician mark-up.

(b) Inpatient outliers: The costs of low length of stay outliers shall be divided by the low length of stay days to arrive at a low per diem. The costs of high length of stay outliers shall be divided between both high outlier cost and the inlier rate. The high outlier cost net of the inlier rate times the high outlier cases shall be divided by the acute days of the patient's total stay (admission to discharge) to arrive at a high outlier per diem. High outlier cases shall be reimbursed the inlier rate plus the high per diem multiplied by the acute days of the stay.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: [28 N.J.R. 4022\(a\)](#), [29 N.J.R. 350\(b\)](#).

In (a)1i, inserted text "Effective for services provided prior to October 1, 1996"; and added (a)1ii.

Recodified from [N.J.A.C. 10:52-5.15](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a)1, inserted a reference to NJ KidCare fee-for-service cases. Former [N.J.A.C. 10:52-5.11](#), Identification of direct and indirect costs related to Medicaid patient care, recodified to [N.J.A.C. 10:52-5.7](#).

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" preceding "fee-for-service case" in 1.

§ 10:52-5.11 Reasonable direct cost per case

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Deleted former (a)1i; and recodified former (a)1ii as (a)1i.

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[N.J.A.C. 10:52-5.12](#)

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§ 10:52-5.12 Net income from other sources

(a) The net gain (loss) from Other Operating and Non Operating Revenues (as defined in [N.J.A.C. 10:52-6.25](#) through [6.32](#)) and expenses of the reporting period which are items considered as recoveries of or increases to the Costs Related to Patient Care (see [N.J.A.C. 10:52-6.25](#) through [6.32](#)) as reported to the Division is subtracted from (added to) indirect costs of the Preliminary Costs Base.

(b) Such revenue shall include all Other Operating and Non Operating Revenues and Expenses reported per Standard Hospital Accounting and Rate Evaluation (SHARE) cost center costs and "expense recoveries" as Case B and all other items reported as to their case specified in [N.J.A.C. 10:52-6.25](#) through [6.32](#).

History

HISTORY:

Recodified from [N.J.A.C. 10:52-5.16](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Changed N.J.A.C. references throughout. Former [N.J.A.C. 10:52-5.12](#), Patient care cost findings; direct costs per case, physician and nonphysician, recodified to [N.J.A.C. 10:52-5.8](#).

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§ 10:52-5.13 Update factors

(a) The economic factor is the measure of the change in prices of goods and services used by New Jersey hospitals. The economic factor will be the factor recognized under the TEFRA target limitations.

1. The hospital-specific economic factor is the weighted average of the recorded and projected change in the value of its components. The weight given to each component is its share of that hospital's total expenditure. The projection of individual components shall be based, where appropriate, on legal or regulatory changes which fix the future value of a proxy. Components which are of particular importance may be projected through the use of time series analysis or other relevant indicators.

(b) The technology factor takes into account the costs of adopting quality enhancing technologies.

(c) Base-year direct patient care and indirect rates shall be multiplied in succeeding years by a technology factor to provide prospective funds to support hospital adoption of quality-enhancing technologies. The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Medicare Payment Advisory Commission (MedPAC). The factor shall be composed of the proportion of incremental operating costs associated with MedPAC's identified cost-increasing technologies, and MedPAC's allowance for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by MedPAC.

(d) In addition, the following payment rates will be in effect for these special procedures:

1. Liver Transplants: payment for DRG 480 will be \$ 72,139 in 1988 dollars.
2. Heart Transplants: payment for DRG 103 will be \$ 72,438 in 1988 dollars.
3. Cochlear Implants: payment for DRG 759 will be \$ 21,608 in 1988 dollars.
4. Bone Marrow Transplants: payment for DRG 481 will be \$ 46,599 in 1988 dollars.
5. Neonate rates: payment for neonatal DRGs as defined by New Jersey Grouper 8.0 will be based on 1989 actual New Jersey patient volume.

(e) For determination of the payment rates, direct patient care is increased for the following components:

1. Indirect patient care for items other than listed in [N.J.A.C. 10:52-5.7](#);
2. Health Planning fees;
3. Capital facilities allowance;
4. Physician fee for service;
5. Child psychiatric hospital direct and indirect;
6. Resident count correction (only for services provided prior to October 1, 1996).
7. Special perinatal expense adjustment;

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8. Trauma center adjustment;
9. GME reversal (only for services provided prior to October 1, 1996);
10. Hemophilia adjustment;
11. Regional perinatal adjustment;
12. Personnel health allowance;
13. Pediatric rate adjustment;
14. Sickle cell adjustment;
15. Continuous adjustments;
16. Outlier reversal adjustment; and
17. Poison Control Costs.

(f) No Statewide transition adjustment not otherwise specified in this chapter will be included in the rate.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: [28 N.J.R. 4022\(a\)](#), [29 N.J.R. 350\(b\)](#).

In (a)6 and (a)9, added text "(only for services provided prior to October 1, 1996)".

Recodified from [N.J.A.C. 10:52-5.17](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (e)1, changed N.J.A.C. reference. Former [N.J.A.C. 10:52-5.13](#), Reasonable cost of services related to patient care, recodified to [N.J.A.C. 10:52-5.9](#).

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), added 1; in (b), deleted 1; in (c), substituted references to the Medicare Payment Advisory Commission (MedPAC) for references to the Prospective Payment Assessment Commission (ProPAC) throughout.

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§ 10:52-5.13 Update factors

Interpretation of [N.J.A.C. 10:52-5.17\(a\)](#) (recodified as [N.J.A.C. 10:52-5.13\(a\)](#)) urged by a hospital relative to DMAHS's calculation of its 1995 Medicaid reimbursement rate for inpatient hospital services did not provide assurance that the Medicaid payments would not exceed those that applied for the purpose of Medicare rates did not achieve the dual purposes of the regulation, which was to create an inflation adjustment and provide the assurance required by [42 C.F.R. § 447.272\(a\) \(1992\)](#) that Medicaid payments did not exceed Medicare payments. The canon of interpretation on which the hospital was relying resulted in an interpretation that conflicted with one of those two purposes and thus was properly rejected. [Our Lady of Lourdes Hosp. - Burlington v. DMAHS, OAL DKT. NO. HMA 04005-06, 2015 N.J. AGEN LEXIS 506](#), Initial Decision (November 25, 2015).

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N.J.A.C. 10:52-5.14

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§ 10:52-5.14 Capital facilities

(a) Capital Facilities, as defined in [N.J.A.C. 10:52-6.18](#), shall be included in the rate in the following manner:

1. Building and fixed equipment:

i. The yearly Capital Facilities Allowance is computed using information provided by the Share Cost Reports. For hospitals on a calendar year basis, this amount will be its 1992 depreciation and interest expense, excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery. For those hospitals on a fiscal year basis, actual year's depreciation and interest applicable to rate year 1992 shall be used excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery.

ii. Effective for services provided on or after October 1, 1996, all building and fixed depreciation and interest capital costs as defined in [N.J.A.C. 10:52-6.18](#) related to GME programs shall be determined based on the 1992 audited Medicare Cost Report (HCFA-2552) and shall be excluded from the base year cost used to calculate the Medicaid DRG inpatient rates.

2. Major Moveable Equipment: For the purpose of calculating the Price Level Depreciation Allowance, Major Moveable Equipment is grouped into four categories based on the cost center function where the equipment is utilized: Beds and nursing equipment; Diagnostic and therapeutic equipment; General service equipment; and Business service equipment.

i. The following rules shall apply in calculating the Price Level Allowance for a given year:

(1) Only equipment which has not been fully depreciated at the start of the fiscal year is to be used in the calculation of the Price Level Allowance.

(2) The depreciation recorded and reported on all equipment subject to the Price Level Allowance must be calculated by the straight-line method, using at the time of the cost filing the most recent approved American Hospital Association (AHA) Recommended Useful Life (that is, 1978 revision) or Asset Depreciation Range (ADR).

(3) Only capitalized equipment and related capitalized costs can be used in the calculation of the Price Level Allowance.

(4) The price level factors for each of the four categories will be developed by the Division. For years prior to current cost base year, the factors to be used for price leveling depreciation are as follows:

Category

Beds and Nursing Equipment

Proxy

Marshall and Swift Hospital Equipment

Cost Index

§ 10:52-5.14 Capital facilities

Category	Proxy
Diagnostic and Therapeutic Equipment	Marshall and Swift Hospital Equipment Cost Index
General Service Equipment	Producer Price Index (PPI) 1161, Food Products Machinery (41.18%), PPI 1241.02, Laundry Equipment (23.53%). PPI 113 less 1134 and 1136, Metalworking Machinery less Industrial Furnaces and Abrasive Products (35.29%).
Business Service Equipment	PPI 1193 less 1193.06, Business and Store equipment (less Coin Operated Vending Machines) and PPI 122, Commercial Furniture.

(5) Assets retired before the close of the fiscal year are not to be used in the calculation of the Price Level Allowance.

(6) The amount of the Price Level Allowance shall be calculated as follows:

(A) Current year straight-line depreciation of each asset being depreciated is multiplied by the price level factor corresponding to the year the asset was acquired to determine price level depreciation. Straight-line depreciation is then subtracted from price level depreciation and the result totaled to determine the amount of the Price Level Allowance provided by the following calculation: Algebraically the calculation is as follows:

D . . . (equals) Current year depreciation, ordered by the year of acquisition of the asset being depreciated.

F . . . (equals) Price level factor for the year the asset was acquired.

PLA . . . (equals) Price Level Allowance.

PLA . . . (equals) (D x F) - D.

(7) The interest component of cash disbursements relative to capitalized Major Moveable Equipment leases is to be classified as interest expense, in accordance with GAAP, and not used as a basis for calculating the price level depreciation premium.

(8) The total Price Level Allowance will be allocated to cost centers based upon the accumulated depreciation of all Major Moveable Equipment not fully depreciated.

(b) Any new capital facilities construction with a valid certificate of need from the New Jersey Department of Health may request a capital facilities adjustment in rates through the review and appeal process as described in N.J.A.C. 10:52-9, except that a hospital which meets the requirements of (b)1 below may request a capital facilities adjustment in accordance with (b)2 below.

1. A hospital may submit an appeal specific to its CFA without going through the full rate review process, if:

i. The appeal 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 and as of September 15, 1997, the hospital has an approved certificate of need for this project;

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- ii. The hospital receives no direct State appropriation; and
 - iii. 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/NJ FamilyCare 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. If all of the conditions in (b)1 above are met, the hospital shall submit all supporting documentation to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, PO Box 712, Mail Code #44, Trenton, New Jersey 08625-0712. The Division shall issue a written determination once the supporting documentation is reviewed and the hospital may appeal the determination pursuant to [N.J.A.C. 10:52-9.1\(d\)](#).
3. In addition to an adjustment to its rates, a hospital that meets the condition of (b)1 above shall receive an additional payment for its Capital Project Funding related to its Medicaid/NJ FamilyCare-Plan A managed care utilization.
- i. Payments to eligible hospitals shall begin upon project completion and facility operation.
 - ii. 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/NJ FamilyCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: [28 N.J.R. 4022\(a\)](#), [29 N.J.R. 350\(b\)](#).

Deleted (a)1i, relating to capital cash requirements; recodified former (a)1ii as (a)1i and deleted subparagraph 1 of that paragraph; and inserted new (a)1ii.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: [29 N.J.R. 3227\(a\)](#), [29 N.J.R. 5325\(a\)](#).

In (b), added the exception; and added (b)1 and (b)2.

Amended by R.1998 d.340, effective July 6, 1998.

See: [30 N.J.R. 1260\(a\)](#), [30 N.J.R. 2486\(b\)](#).

Added (b)3.

Recodified from [N.J.A.C. 10:52-5.18](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

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In (b), changed N.J.A.C. references throughout, and substituted a reference to the Office of Provider Rate Setting for a reference to Administrative and Financial Services in 2. Former [N.J.A.C. 10:52-5.14](#), Standard costs per case, recodified to [N.J.A.C. 10:52-5.10](#).

Amended by R.2004 d.194, effective May 17, 2004.

See: [36 N.J.R. 323\(a\)](#), [36 N.J.R. 2424\(a\)](#).

In (b), substituted "N.J.A.C. 10:52-9" for "N.J.A.C. 10:52-8" in the introductory paragraph, amended the Mail Code and N.J.A.C. reference in 2, and rewrote 3i.

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

In (b), amended the address in 2; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

In (b), made grammatical and/or technical changes regarding references to Medicaid, NJ FamilyCare, and the Department of Health throughout; in the introductory paragraph of (b), inserted a comma following the N.J.A.C. reference; in (b)1iii, substituted "low-income" for "low income" twice; and in (b)3, substituted "that" for "which".

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§ 10:52-5.15 Division adjustments and approvals

- (a) Any modifications including any statutory or regulatory changes or changes in patient care physician compensation arrangements shall be classified as direct or indirect, and as to the financial elements affected and each element adjusted proportionately.
- (b) The Division shall also approve adjustments to hospitals' Schedules of Rates for 1993 and subsequent years as necessary to subtract approved costs associated with residents not meeting the minimum requirements as defined in [N.J.A.C. 10:52-5.10\(b\)](#); for any costs associated with residents in programs which have lost accreditation as defined in [N.J.A.C. 10:52-5.10\(b\)](#); and for any costs associated with previously approved but now vacant residency positions which are unfilled as a result of a hospital's inability to recruit residents meeting these minimum standards. These costs shall include, but are not limited to, resident salaries and fringes, faculty salaries, malpractice and supplies.
- (c) The Division may approve hospital appeals to transfer Division approved resident positions and associated costs between hospitals. A hospital may appeal under any option to reduce or increase the number of resident positions by transfer. An addition of resident positions by transfer may not result in a change to a higher teaching status peer group. A reduction of resident positions by transfer may result in a change to a lower teacher status peer group. The approved costs associated with a transferred resident position may not increase solely as a result of the transfer.
- (d) The Division shall decide to which hospitals the approved resident positions and associated costs may be transferred.
- (e) Subsections (a) through (d) above apply for dates of services provided prior to October 1, 1996. Effective for services provided on or after October 1, 1996, this section is no longer applicable.

History

HISTORY:

Amended by R.1997 d.43, effective January 21, 1997.

See: [28 New Jersey Register 4022\(a\)](#), [29 New Jersey Register 350\(b\)](#).

Added (e).

Recodified from [N.J.A.C. 10:52-5.19](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

In (b), changed N.J.A.C. references throughout. Former [N.J.A.C. 10:52-5.15](#), Reasonable direct cost per case, recodified to [N.J.A.C. 10:52-5.11](#).

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[N.J.A.C. 10:52-5.16](#)

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§ 10:52-5.16 Derivation from Preliminary Cost Base

(a) Apportionment of Financial Elements based on direct costs shall be as follows:

1. All other Financial Elements are added to direct Medicaid/NJ FamilyCare fee-for-service patient care costs as percentages of direct costs per Medicaid/NJ FamilyCare case. The Schedule of Rates is set such that all Medicaid/NJ FamilyCare patients' rates are based on the cost of services received by Medicaid/NJ FamilyCare fee-for-service beneficiaries, including a proportionate share of indirect financial elements requirements of operating hospital facilities.
2. In the event that a hospital is self-insured for employee health benefits, the percentage of personnel health allowance recognized in the rates shall be proportioned to the number of Medicaid/NJ FamilyCare fee-for-service beneficiaries serviced by the facility to financial elements from payers for such costs.
3. Each hospital shall receive from the Division a base rate order detailing the Schedule of Rates.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Recodified from [N.J.A.C. 10:52-5.20](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

In (a), substituted a reference to Medicaid NJ KidCare fee-for-service patient care costs for a reference to Medicaid patient care costs, inserted a reference to NJ KidCare cases, and substituted a reference to Medicaid/NJ KidCare patients' rates for a reference to Medicaid patients' rates in 1, and substituted references to Medicaid and NJ KidCare fee-for-service beneficiaries for references to Medicaid recipients in 1 and 2. Former [N.J.A.C. 10:52-5.16](#), Net income from other sources, recodified to [N.J.A.C. 10:52-5.12](#).

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Substituted "FamilyCare" for "KidCare" throughout.

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§ 10:52-5.17 Schedule of rates--effective date

All rates issued pursuant to this subchapter, as approved or modified, shall be effective as of October 1, 1996, of the rate year and then January 31 for subsequent years.

History

HISTORY:

Amended by R.1997 d.43, effective January 21, 1997.

See: [28 New Jersey Register 4022\(a\)](#), [29 New Jersey Register 350\(b\)](#).

Amended effective date.

Recodified from [N.J.A.C. 10:52-5.21](#) and amended by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Substituted a reference to January 31 for a reference to January 1. Former [N.J.A.C. 10:52-5.17](#), Update factors, recodified to [N.J.A.C. 10:52-5.13](#).

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Deleted "except for fiscal year hospitals whose rates shall be effective as of the first day of the "fiscal" rate year".

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§ 10:52-5.18 (Reserved)

History

HISTORY:

Recodified to [N.J.A.C. 10:52-5.14](#) by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

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§ 10:52-5.19 (Reserved)

History

HISTORY:

Recodified to [N.J.A.C. 10:52-5.15](#) by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

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§ 10:52-5.20 (Reserved)

History

HISTORY:

Recodified to [N.J.A.C. 10:52-5.16](#) by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

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§ 10:52-5.21 (Reserved)

History

HISTORY:

Recodified to [N.J.A.C. 10:52-5.17](#) by R.2000 d.29, effective January 18, 2000.

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

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N.J.A.C. 10:52-6.1

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§ 10:52-6.1 Reporting principles

The reporting principles and concepts adopted by the Department of Health at [N.J.A.C. 8:31B-4.1](#) through [4.25](#) shall be used for Medicaid/NJ FamilyCare fee-for-service rates.

History

HISTORY:

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/NJ KidCare fee-for-service rates for a reference to Medicaid rates.

Repeal and New Rule, R.2005 d.214, effective July 5, 2005.

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

Section was "Reporting period".

Amended by R.2018 d.104, effective May 21, 2018.

See: [49 N.J.R. 3294\(a\)](#), [50 N.J.R. 1261\(a\)](#).

Deleted "and Senior Services" following "Health".

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N.J.A.C. 10:52-6.2

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§ 10:52-6.2 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Objective evidence".

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N.J.A.C. 10:52-6.3

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§ 10:52-6.3 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Consistency".

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N.J.A.C. 10:52-6.4

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§ 10:52-6.4 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Full disclosure".

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N.J.A.C. 10:52-6.5

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§ 10:52-6.5 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Materiality".

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N.J.A.C. 10:52-6.6

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§ 10:52-6.6 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Basis of valuation".

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N.J.A.C. 10:52-6.7

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§ 10:52-6.7 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Accrual accounting".

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N.J.A.C. 10:52-6.8

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§ 10:52-6.8 (Reserved)

History

HISTORY:

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

In (a), inserted ", but is not limited to," following "includes", and substituted "and buckets" for ", buckets, etc." following "mops" in the introductory paragraph.

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Accounting for minor moveable equipment".

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N.J.A.C. 10:52-6.9

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§ 10:52-6.9 (Reserved)

History

HISTORY:

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

In (b), inserted ", but are not limited to," following "include", and substituted "and walls" for ", walls, etc." following "fences"; and in (g)6i, changed N.J.A.C. reference.

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Accounting for capital facilities costs".

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N.J.A.C. 10:52-6.10

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§ 10:52-6.10 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Timing differences".

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N.J.A.C. 10:52-6.11

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§ 10:52-6.11 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Self-insurance".

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N.J.A.C. 10:52-6.12

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§ 10:52-6.12 (Reserved)

History

HISTORY:

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Section was "Related organizations".

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N.J.A.C. 10:52-6.13

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§ 10:52-6.13 Financial elements (generally)

The financial elements of the rates shall include the reasonable cost of the following: direct patient care; depreciation expense and interest payments; paid taxes, excluding income taxes; education, research and training programs, not otherwise paid for by the State; and preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements. All non-direct costs must be allocated based upon the proportion of Medicaid/NJ FamilyCare fee-for-service beneficiaries serviced by the hospital.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Substituted a reference to Medicaid/NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Substituted "State; and preservation" for "State; preservation" preceding ", replacement and improvement", deleted "; reasonable working capital; and where applicable and appropriate, reasonable return on investment" following "planning requirements", and substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiaries".

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N.J.A.C. 10:52-6.14

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§ 10:52-6.14 Services related to Medicaid/NJ FamilyCare fee-for-service patient care

(a) Services related to Patient Care include Direct Patient Care; Paid Taxes excluding Income Taxes; and Educational, Research and Training Programs as further defined in [N.J.A.C. 10:52-6.15](#) through [6.17](#).

(b) Services Related to Patient Care include Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services. Costs Related to Patient Care include salaries and wages, physician compensation, employee fringe benefits, medical and surgical supplies, drugs, non-medical and non-surgical supplies, purchased services and other direct expenses and major moveable equipment costs as determined in accordance with [N.J.A.C. 10:52-6.20](#) through [6.24](#).

(c) All non-physician services and supplies provided to hospital inpatients, whether provided directly by the hospital or by a vendor, shall be considered services and costs related to patient care.

(d) All costs of services and supplies purchased from a vendor shall be subject to review for reasonableness by the Division.

History

HISTORY:

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

See: [31 N.J.R. 3151\(a\)](#), [32 N.J.R. 276\(a\)](#).

In (a) and (b), deleted "Medicaid" preceding "Patient", and changed N.J.A.C. references.

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

See: [37 N.J.R. 436\(a\)](#), [37 N.J.R. 2506\(a\)](#).

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

See: [42 N.J.R. 1656\(a\)](#), [43 N.J.R. 43\(a\)](#).

In (a), substituted "10:52-6.15" for "10:52-6.14".

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§ 10:52-6.14 Services related to Medicaid/NJ FamilyCare fee-for-service patient care

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§ 10:52-6.15 Direct patient care

Direct patient care is the provision by a hospital of medically necessary and appropriate health care services to a Medicaid/NJ FamilyCare fee-for-service beneficiary.

History

HISTORY:

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

See: [31 New Jersey Register 3151\(a\)](#), [32 New Jersey Register 276\(a\)](#).

Deleted "Medicaid" at the beginning, and substituted a reference to MEdicaid/NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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

See: [37 New Jersey Register 436\(a\)](#), [37 New Jersey Register 2506\(a\)](#).

Substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiary".

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N.J.A.C. 10:52-6.16

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§ 10:52-6.16 Paid taxes

Taxes are monies paid to a governmental unit for conducting business related to direct patient care within its jurisdiction. Taxes are a financial element of the Preliminary Cost Base except for Federal, State, or local income, excess profit, or franchise taxes, taxes on property not used for direct patient care, and interest and/or penalties paid thereon. Taxes related to financing of operations through the issuance of bonds, property transfers, issuance or transfer of stocks, and the like, are not classified as taxes; rather, they shall be amortized or depreciated with the cost of the security or asset. Sales and real estate taxes paid by a hospital in the provision of Services Related to Patient Care shall be included as Paid Taxes. All sales and real estate taxes for Services Related to Patient Care shall be reported in the General Administrative Services cost center and also reported separately from other classifications of expense. Employment related taxes, such as FICA, Unemployment Compensation, and Workers' Compensation, shall be classified as employee fringe benefits for all employees, including hospital-based physicians. Monies received by a hospital which chooses to self-insure in lieu of payment of Unemployment Compensation taxes and the associated administrative costs of such a self-insurance program are included as financial elements and classified as employee fringe benefits, if such monies are reasonably related to the hospital's unemployment compensation experience.

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