

The NJ Department of Health and Senior Services, Division of Aging and Community Services is providing this unofficial version of N.J.A.C. 8:85 as a courtesy. The official version of the rules can be found in the *New Jersey Administrative Code*, as published by LexisNexis. In the event there are any discrepancies between the unofficial version and the official version of the rules, the official version governs.

N.J.A.C. 8:85
(Formerly N.J.A.C. 10:63)

LONG-TERM CARE SERVICES

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SUBCHAPTER 1. GENERAL PROVISIONS**8:85-1.1 Scope**

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible children and adults in a nursing facility (NF) and addresses the provision of and reimbursement for services required to meet the individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. The following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement continues to apply to all government psychiatric hospitals, inpatient psychiatric services and programs in long term care facilities. These other types of facilities are addressed for regulatory and administrative matters in the appropriate chapters elsewhere in Title 10 of the New Jersey Administrative Code.

8:85-1.2 Definitions

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

"Advance directive" means a written instruction relating to the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney for health care.

"Air fluidized therapy bed" means a device employing the circulation of filtered air through ceramic spherules (small, round ceramic objects).

"Bed" or "licensed bed" means "bed" or "licensed bed" as those terms are defined at N.J.A.C. 8:39-1.2.

"Beneficiary" means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

"Care management" means a process by which professional staff designated by the Department monitor the provision of NF care to:

Assure that services are rendered as recommended by the HSDP and in accordance with the NF's evaluation of the individual's health service needs;

Assure the delivery of timely and appropriate provider responses to changes in care needs;

Provide, direct or secure needed consultations with Medicaid professional or NF staff so that services are delivered in a coordinated, effective, and cost-prudent manner; and

Facilitate discharge planning and promote appropriate placement to alternate care settings.

"Case mix" means a system of staffing and reimbursement for nursing services based on variation in patient acuity and care needs that influences the type and amount of service needed.

"Clinical audits" means a method of utilization control under the enforcement authority of Section 1902(a)(30)(A) of the Social Security Act, in accordance with 42 CFR 456.1(b)(1), to monitor the utilization of and payment for nursing facility care and services reimbursable under the Medicaid State Plan.

"Comprehensive assessment" means a process conducted by each member of the interdisciplinary team which, for each resident, identifies problems; determines care needs; and in conjunction with the resident and his or her significant other or legal representative, results in an interdisciplinary plan of care.

"Consultant pharmacist" means a pharmacist licensed by the New Jersey State Board of Pharmacy who meets the qualifications in N.J.A.C. 10:51-3.3.

"Conventional nursing facility"-- see nursing facility.

"County welfare agency (CWA)" means that agency of county government with the responsibility to determine income eligibility for public assistance programs including Aid to Families with Dependent Children, the Food Stamp program, and Medicaid. The CWA may be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

"Department of Health and Senior Services" (Department or DHSS) means the New Jersey State Department of Health and Senior Services.

"Department of Human Services" (DHS) means the New Jersey State Department of Human Services.

"Division of Developmental Disabilities" (DDD) means the New Jersey State Department of Human Services, Division of Developmental Disabilities.

"Division of Medical Assistance and Health Services" (DMAHS) means the New Jersey State Department of Human Services, Division of Medical Assistance and Health Services.

"Division of Mental Health Services" (DMHS) means the New Jersey State Department of Human Services, Division of Mental Health Services.

"Health Services Delivery Plan (HSDP)" means a plan of care prepared by professional staff designated by the Department during the Pre-Admission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

"Interdisciplinary care plan" means the care plan developed by the interdisciplinary team which includes measurable objectives and time tables to meet the resident's medical, nursing, dietary and psychosocial needs that are identified through the comprehensive assessment process.

"Interdisciplinary team" means a team consisting of a physician and a registered professional nurse and may also include other health professions relative to the provision of needed services. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

"Long-Term Care Field Office" or "LTCFO" means the regional office of the Office of Community Choice Options of the Division of Aging and Community Services of the Senior Services Branch of the Department.

"Low airloss therapy bed" means a bed frame that is equipped with air sacs which are grouped into zones corresponding to various body areas. The air sacs are inflated by a constant flow of air, some of which is directed through the air sacs to the patient surface.

"Material fact" means any reported costs, statistics, data or supporting documentation submitted to the Medicaid program for the purpose of receiving any benefit, regardless of whether any benefit is ultimately received.

"Medicaid occupancy level" means the average number of Medicaid recipients and recipients of public assistance under P.L.1947, c. 156, as amended (C44.8-107 et seq.) residing in a NF divided by the total number of licensed beds in the facility during the billing month.

"Medical director" means a physician licensed under New Jersey State law who is responsible for the direction and coordination of medical care in a nursing facility.

"Medical staff" means one or more licensed physicians who act as the attending physician(s) to Medicaid recipients in a nursing facility.

"Mental illness" or "MI" means mental illness as that term is defined at 42 CFR §483.102, incorporated herein by reference, as amended and supplemented.

"Mental retardation" or "MR" means mental retardation as that term is defined at 42 CFR §483.102, incorporated herein by reference, as amended and supplemented.

"Minimum Data Set or "MDS" means the MDS version 2.0, incorporated herein by reference, as amended and supplemented a core set of screening, clinical and functional status elements, including common definitions and coding categories that forms the foundation of the comprehensive assessment required to be completed by a NF-registered professional nurse on all residents in Medicare-and/or Medicaid-certified long-term care facilities on or after June 22, 1998. The MDS identifies an individual NF resident's nursing and care needs.

"New nursing facility" means a facility which satisfies the following criteria:

Does not replace a pre-existing facility which was licensed in accordance with N.J.A.C. 8:39;

Does not assume the per diem rate of a pre-existing facility; and

Does not have a specific pre-existing patient base.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health and Senior Services for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid 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 which require continuous 24-hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

"Occupational therapist" means a person who is registered by the American Occupational Therapy Association, 1383 Piccard Drive, P.O. Box 1725, Rockville, MD 20849-1725, or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

"Ombudsman" means the Office of the Ombudsman for the Institutionalized Elderly.

"Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and the American Physical Therapy Association, 1111 N. Fairfax St., Alexandria, VA 22314 or its equivalent; and if practicing in the State of New Jersey, is licensed by the State of New Jersey, or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable, and also meets all applicable Federal requirements.

"Physician's services" means those services provided within the scope of medical practice as defined by the laws of New Jersey and those services which are performed by or under the direct personal supervision of the physician.

"Physician" means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners.

"Direct personal supervision" means services which are rendered in the physician's presence.

"Pre-admission 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 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).

"Pre-admission screening and resident review or "PASRR" means that process by which an individual with MI or MR is screened prior to admission to a NF and when there is a significant change in the individual's condition to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for MI provided by the DMHS and/or MR provided by the DDD, and therefore is ineligible for NF services.

"Prior authorization" means approval granted by the Department through the appropriate Long-Term Care Field Office (LTCFO) for payment for NF services rendered to a Medicaid beneficiary, in accordance with this chapter.

"Professional staff designated by the Department" means a registered nurse or professional social worker who performs health needs assessments and counseling on alternative options and care management as required by this chapter. Professional social workers employed by the State or a political subdivision thereof are not required to be licensed or certified.

"Rehabilitative and/or restorative nursing care" means nursing care provided by a registered professional nurse, or under the direction of a registered professional nurse, qualified by experience in rehabilitative or restorative nursing care.

"Rehabilitative services" means physical therapy, occupational therapy, speech-language pathology services, and the use of such supplies and equipment as are necessary in the provision of such services.

"Replacement nursing facility" means a facility which satisfies the following criteria:

Replaces a pre-existing facility which was licensed in accordance with N.J.A.C. 8:39;

Can assume the per diem rate of the pre-existing facility; and

Has a specific pre-existing patient base.

"Resident" means a Medicaid eligible or potentially eligible beneficiary residing in an NF.

"Respiratory care practitioner" means an individual credentialed by the State Board of Respiratory Care, to practice respiratory care under the direction or supervision of a physician pursuant to State of New Jersey P.L.1971, c. 60; P.L.1974, c. 46; and P.L.1978, c. 73, amended August 1991.

"Skilled nursing facility (SNF)" means a free-standing institution or an identifiable part of an institution which meets all the State and Federal requirements for participation in the Medicare Program as a skilled nursing facility.

"Social services" means those services provided to meet the emotional and social needs of the Medicaid beneficiary and significant other or guardian at the time of admission, during treatment and care in the facility, and at the time of discharge.

"Special care nursing facility (SCNF)" means a NF or separate and distinct unit within a Medicaid certified conventional NF which has been approved by the Department to provide care to New Jersey Medicaid beneficiaries who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. 8:85-2, Nursing Facility Services.

"Specialized services for MI" mean those services offered, in accordance with 42 CFR §483.120, when an individual is experiencing an acute episode of serious MI and psychiatric hospitalization is recommended, based on a psychiatric evaluation.

1. Specialized services for MI entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel.
2. During a period of 24-hour supervision of an individual with MI, specific therapies and activities are prescribed, with the following objectives:
 - i. To diagnose and reduce behavioral symptoms;
 - ii. To improve independent functioning; and
 - iii. As early as possible, to permit functioning at a level where less than specialized services are appropriate.
3. Specialized services for MI go beyond the range of services that a NF is required to provide.

"Specialized services for MR" mean those services offered, in accordance with 42 CFR §483.120, 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 for MR are those services needed to address such skill deficits or specialized training needs.

Specialized services for MR may be provided in an intermediate care facility for the mentally retarded or as defined at 42 CFR §440.150 or in a community-based setting that meets ICF/MR standards.

Specialized services for MR go beyond the range of services that a NF is required to provide.

"Speech-language pathologist" means a person who has a certificate of clinical competence from the American Speech and Hearing Association; meets all applicable Federal regulations; has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate, and, if practicing in the State of New Jersey is licensed by the State of New Jersey; or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable.

"Standardized Resident Assessment (SRA)" means an instrument developed by the State to report minimum data set requirements, including resident assessment protocols and additional State mandated data, which results in a comprehensive, standardized assessment of a NF resident's functional capabilities and service requirements.

"Track of care" means the designation of the setting and scope of Medicaid services as determined by professional staff designated by the Department following PAS of an applicant for Medicaid clinical eligibility for NF placement or services, as follows:

"Track I" means long-term NF care and shall be designated for individuals with respect to whom long-term placement is required because clinical prognosis is poor, and as to whom PAS results in a determination that short-term stays are neither realistic nor predictable and that the individual is eligible for NF level of nursing care in accordance with N.J.A.C. 8:85-2.1.

- i. A Track I designation shall not preclude the possibility of future discharge. The professional staff designated by the Department will monitor those individuals with discharge potential, reassess the individual, and update the HSDP for a change in the track of care if appropriate.

"Track II" means short-term NF care and shall be designated for individuals as to whom PAS results in a determination that the individual requires comprehensive and coordinated NF services, in accordance with N.J.A.C. 8:85-2.1, provided in a therapeutic setting that assures family counseling and teaching in preparation for discharge to the community setting and to achieve at least one of the objectives listed at 2i through iii below; provided that individuals designated for Track II shall also be assigned to short-term NF stays, in spite of technically complex care needs and guarded prognosis, particularly in cases in which the individual is motivated towards NF alternatives and/or in which caregivers, through case management intervention, may obtain services that make return to the community a viable option.

- i. To stabilize medical conditions;
- ii. To promote rehabilitation; or

iii. To restore maximum functioning levels.

"Track III" means long-term care services in the community and shall be designated for individuals as to whom PAS results in a determination of Medicaid clinical eligibility for NF care in accordance with N.J.A.C. 8:85-2.1, but who can be appropriately cared for in the community with supportive health care services. These individuals may be eligible for Medicaid State Plan services or Home and Community-Based Services Waiver Programs.

"Transfer of ownership" means, for reimbursement purposes, a change in the majority ownership that does not involve related parties, related corporations or public corporations. "Majority ownership" is defined as an individual or entity who owns more than 50 percent of the facility.

"Waiting list" means the standardized listing, maintained in chronological order by the NF, of the names of all individuals seeking admission to a Medicaid participating NF who have completed a written application.

8:85-1.3 Program participation

A NF shall comply with the following requirements in order to be eligible to participate in the New Jersey Medicaid program. An in-State NF shall:

1. Be licensed by the Department in accordance with N.J.A.C. 8:39;
2. Be certified by the Department, and in the case of both Medicare and Medicaid, by the Centers for Medicare & Medicaid Services (CMS), which assures that the NF meets the Federal requirements for participation in Medicaid and Medicare;
3. Be approved for participation as a NF provider by the New Jersey Medicaid program. This includes the filing of a New Jersey Medicaid Provider Application PE-1 that establishes eligibility to receive direct payment for services to recipients under the New Jersey Medicaid program (see Appendix A as posted at www.state.nj.us/health/ltc/formspub.htm), the signing of a Participation Agreement PE-3 which is the participation agreement between the nursing facility and DHSS which stipulates that a NF shall provide all NF services required by N.J.A.C. 8:85 (see Appendix B as posted at www.state.nj.us/health/ltc/formspub.htm), and submittal of the CMS-1513 that is required to be completed before the State agency or Federal agency will enter into a contract for reimbursement of medical services, Ownership and Control Interest Disclosure Statement (see Appendix C as posted at www.state.nj.us/health/ltc/formspub.htm). The agreement for participation in the New Jersey Medicaid program stipulates that a NF shall provide all NF services required by N.J.A.C. 8:85. Continued participation as a New Jersey Medicaid provider will be subject to recertification by the Department and compliance with all

- Federal and State laws, rules and regulations. Upon recertification by the Department, each NF will receive notification from the Department's Office of Provider Enrollment, informing the facility that their provider agreement is being continued.
4. File with the Department a completed Cost Study for Nursing Facility form in the form provided at Appendix D, incorporated herein by reference. After the initial cost study is filed, the provider shall file a Cost Study for Nursing Facility form annually.
 5. In accordance with 42 C.F.R. 483.12(d)(1)(i)(ii), not require residents or potential residents to waive their rights to Medicare or Medicaid; and not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for Medicare or Medicaid benefits;
 6. Accept as payment in full the Medicaid program's reimbursement for all covered services delivered during that period when, by mutual agreement between Medicaid and the facility, the beneficiary is under the provider's care, in accordance with 42 CFR § 447.15 and N.J.S.A. 30:4D-6(c); and
 7. Except as provided in (a)7i below, by December 1, 1997, be certified by Medicare as a provider of skilled nursing services for no less than seven percent of the facility's total licensed long-term care beds.
 - i. This requirement shall not apply if a nursing facility cannot be certified as a Medicare skilled nursing facility due to its inability to meet structural requirements for a physical plant as required by the Medicare certification process.
 - ii. Upon receipt of the application, the Department shall determine whether the facility shall be recommended for Medicare certification in accordance with 42 CFR Part 483. If the facility cannot be certified for Medicare participation, the Department shall provide the facility with the reasons for the certification denial in writing.

8:85-1.4 Private pay

(a) NFs which are approved for participation as providers of service under the New Jersey Medicaid program shall be prohibited under Section 6(a) of P.L.1985, c. 303 from soliciting or accepting payment, any type of gift, money, contribution, donation or other consideration as a condition of admission or continued stay from a Medicaid recipient or his or her family.

(b) NFs which are providers of service under the New Jersey Medicaid program shall be prohibited under Section 6(b)(c) of P.L.1985, c. 303 from requiring private pay contracts from Medicaid qualified applicants as a condition for admission or continued stay.

1. The prohibitions in (a) and (b) above are applicable regardless of the Medicaid occupancy level in a facility. A violation may be a criminal act punishable as a crime of the third degree.
2. The exception to the above is private pay contracts entered into with life-care communities that are explicitly referenced as such within their Medicaid participation agreement.

(c) An individual may enter a NF on a private pay contract basis only if Medicaid eligibility has not been established and no application to the New Jersey Medicaid program has been made. A private pay contract shall become void as soon as Medicaid eligibility is established.

8:85-1.5 Medicaid occupancy level

The NF Medicaid occupancy level shall be calculated by adding the total days for Medicaid beneficiaries residing in the NF during the month, dividing this sum by the number of days in the month to determine the average daily census, and dividing this amount by the total number of licensed long-term beds.

1. An SCNF that is an identifiable unit within a conventional NF shall calculate its occupancy level separate and apart from the occupancy level of the conventional NF beds using the same formula as cited in (a) above.
2. The NF shall submit the completed Provider Certification Statement for Long Term Care (see Appendix E, incorporated herein by reference), to report the actual calculation of the occupancy level determination of the NF. In addition to the occupancy level determination, the Certification Statement is also used to certify that the billing information is accurate, complete and in accordance with the rules of the New Jersey Health Services Program (Medicaid). The Certification Statement shall be submitted with the monthly Turn Around Document (TAD) (as set forth in Appendix Q, incorporated herein by reference) to the fiscal agent. Billing documents will be returned if the Certification Statement is not completed, signed and attached.
3. The calculation of the occupancy level shall include eligible bed reserve days in the determination of the Medicaid occupancy level.

8:85-1.6 Termination of a Medicaid NF provider agreement

The Department shall terminate a NF's Medicaid provider agreement if:

1. The Long-Term Care Licensing and Certification Program of the Department or the Centers for Medicare & Medicaid Services (CMS) determines that the NF is no longer certified to provide NF services. In that case:
 - i. The Medicaid provider agreement shall be terminated 23 days from the survey date if the Long Term Care Licensing and Certification Program of the Department or the CMS finds that deficiencies pose immediate jeopardy to residents' health and safety.
 - ii. If the deficiencies do not pose immediate jeopardy to the resident's health and safety, the Medicaid provider agreement shall be terminated 180 days from the survey date.
 - iii. The termination of provider agreement shall be rescinded if, prior to the effective date of termination, the Long Term Care Licensing and Certification Program of the Department or the CMS determines that the deficiencies have been satisfactorily corrected and the NF is certified to provide NF services; and
2. The Department determines that other good cause for such termination exists as cited at N.J.A.C. 10:49-11.1 or as a result of a pattern of aberrancies reported in a clinical audit as defined at N.J.A.C. 8:85-1.12.

8:85-1.7 Administrative appeal of denial, termination or non-renewal of NF certification or Medicaid Provider Agreement

Any NF whose certification or Medicaid Provider Agreement is denied, terminated or not renewed shall have the opportunity to request a full evidentiary hearing before an administrative law judge, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

1. In order to obtain a hearing, the NF shall submit, within 20 days from the date of the letter proposing termination, a written request to the Division of Long Term Care Systems, Office of Program Compliance, PO Box 367, Trenton, New Jersey 08625-0367.
2. All hearings requested pursuant to this section shall be completed either before the effective date of the denial, termination or non-renewal, or within 120 days thereafter.
3. If the Division elects to provide a hearing after the effective date of denial, termination or non-renewal, the NF will be entitled to an informal reconsideration to be completed prior to the effective date of the denial, termination or non-renewal.
4. The informal reconsideration, if requested by the NF, will include the following:

- i. Written notice by the Division to the NF outlining the findings upon which the denial, termination or non-renewal is based;
- ii. Notice that the NF is allowed a reasonable opportunity to refute the findings in writing; and
- iii. A written affirmation or reversal of the denial, termination or non-renewal.

A (S)NF whose certification or Medicare/Medicaid provider agreement is denied, terminated or not renewed by CMS, may request a hearing pursuant to 42 CFR 498.40 by submitting a written request to the Centers for Medicare & Medicaid Services, Division of Health Standards and Quality, Attn: Coordinator Hearing and Appeals, Federal Building Room 3821, 26 Federal Plaza, New York, New York 10278.

1. A final decision entered under the Medicare review procedures will be binding for purposes of Medicaid participation.

8:85-1.8 Pre-Admission Screening (PAS), admission and authorization

(a) Pursuant to N.J.S.A. 30:4D-17.10, a Medicaid-participating NF shall not admit an individual who is financially eligible for Medicaid or who may become financially eligible for Medicaid within 180 days of admission to the NF, or, regardless of payment source, an individual with MI or MR, unless that individual has been prescreened by professional staff designated by the Department and determined appropriate for NF placement.

1. An individual who is financially and clinically eligible for Medicaid residing in a Medicaid-participating NF who is transferred to an acute care hospital shall not be subject to PAS prior to returning to the same or another NF.
2. If an individual who is financially and clinically eligible for Medicaid identified as having MI residing in a Medicaid-participating NF is admitted to a psychiatric unit for treatment for less than one year, the individual shall not be subject to PASRR prior to returning to the NF.
3. When a NF resident with MI or MR is transferred to another NF, the admitting NF shall be responsible for ensuring that a copy of the resident's current PASRR determination, MDS (see N.J.A.C. 8:39-11.2(e)), and HSDP (Appendix L, incorporated herein by reference) accompany the transferring resident.

(b) The New Jersey Medicaid program shall not pay for NF services provided to a resident paying from private funds who has applied for Medicaid benefits unless professional staff designated by the Department has determined that the resident is clinically eligible to receive NF services through PAS.

1. If a NF has admitted an individual who is financially eligible for Medicaid or who may become financially eligible for Medicaid within 180 days of admission without the professional staff designated by the Department first determining, through PAS, that the individual is clinically eligible for NF services, the effective date of the initial authorization will be the date the PAS is completed. The New Jersey Medicaid program shall not reimburse NFs admitting such individuals without PAS for any care rendered before PAS.

(c) Within two working days of a NF's admission of an individual who is financially eligible for Medicaid, the NF shall submit a completed Notification From Long-Term Care Facility of the Admission or Termination of a Medicaid Patient, also known as an LTC-2 form, provided at Appendix G, incorporated herein by reference, and available for download at www.state.nj.us/health/ltc/formspub.htm and at <http://nj.gov/health/forms/index.shtml>, to the LTCFO serving the county in which the NF is located.

1. The NF shall obtain from the appropriate CWA a statement of the individual's budgetary information on the Statement of Available Income for Medicaid Payment form, also known as form PA-3L, or form PR-1, provided at Appendix F, incorporated herein by reference.

(d) Professional staff designated by the Department shall conduct PAS by reviewing the individual's medical, nursing, and social information and 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 the Department will authorize or deny NF placement based on the results of the standardized assessment performed by professional staff designated by the Department, in accordance with (e) below, that documents the individual's clinical eligibility pursuant to N.J.A.C. 8:85-2.1 and the feasibility of alternative placement, and then, depending on the placement professional staff designated by the Department determine to authorize, if any, the staff will designate the track of care.

1. If alternative care is available, accessible, and appropriate to the needs of the individual, the request for NF placement will be denied.
 - i. If an appropriate alternative plan of care becomes available and accessible for a person already approved for NF care and awaiting placement, the Department will rescind authorization for NF placement and will authorize the alternative plan of care.
2. For each NF applicant with MI or MR whose standardized assessment and PAS results in a determination that the individual is clinically eligible for NF placement, the DMHS or the DDD, as appropriate, will conduct PASRR, prior to the Department's issuance of a written determination authorizing NF placement.
 - i. With respect to an individual with MI seeking authorization for NF placement, the individual, or the individual's legal representative, social worker, or other entity referring the individual, or with respect to an individual with MI who is

already a NF resident who is experiencing a change from the condition described on the resident's MDS, the NF, shall complete part 1 on page 1 and part A of page 6 of the Psychiatric Evaluation form provided at Appendix I, incorporated herein by reference; shall have parts 2 through 9 beginning on page 1 and section B on page 6 completed by a psychiatrist, physician (doctors of medicine or osteopathy), certified nurse practitioner, certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health, or clinical nurse specialist, certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health; and shall send the completed form to the DMHS, which will conduct PASRR based upon the information provided in the Psychiatric Evaluation form.

- (1) Individuals having a primary diagnosis of dementia including Alzheimer's disease are not subject to PASRR by DMHS as a precondition to a determination of Medicaid clinical eligibility for NF admission.
- ii. With respect to an individual with MR, the LTCFO will contact the appropriate DDD staff to conduct PASRR.
 - (1) Individuals with MR and a diagnosis of dementia including Alzheimer's disease are subject to PASRR by DDD as a precondition to a determination of Medicaid clinical eligibility for NF admission.
 - iii. In the case of an individual dually diagnosed with MI and MR, the conduct of PASRR by DMHS shall precede the conduct of PASRR by DDD.
 - iv. The DMHS and/or the DDD, as applicable, will each transmit its respective PASRR determination to the LTCFO and the LTCFO will transmit the PASRR determination to the individual or, if applicable, the individual's legal representative, or other referring entity.
 - (1) If the PASRR results in a determination that no specialized services are required, the Department will approve NF placement and will issue a NF approval letter to the individual or, if applicable, the individual's legal representative, in the form provided at Appendix M, incorporated herein by reference, and will enclose with the letter a copy of the PASRR determination.
 - (2) If the PASRR results in a determination that the individual requires specialized services for MI or MR, then NF placement is inappropriate and the Department will issue to the individual or, if applicable, the individual's legal representative, and the referring individual a letter denying Medicaid authorization for NF placement in the form provided at Appendix N, incorporated herein by reference, and the

DMHS or the DDD will assist in finding appropriate placement and/or services for the individual.

- v. If PAS results in a determination that the individual is not clinically eligible for NF placement pursuant to the requirements of N.J.A.C. 8:85-2.1, PASRR is not required.

(e) The following procedure is to be used by a referent when seeking Medicaid authorization of NF placement through PAS prior to the admission of individuals who are financially eligible for Medicaid or individuals residing in a NF paying from private funds who may become eligible for Medicaid within 180 days.

1. If the referent is a hospital, the hospital shall identify individuals who are or potentially are at risk for NF placement, including individuals with MI and/or MR who may require PASRR, by consulting the "At-Risk Criteria for Nursing Facility Placement" also known as form LTC-D1, provided at Appendix J, incorporated herein by reference, and available for download at <http://www.state.nj.us/health/forms>. The hospital shall refer such individuals to the LTCFO for a PAS and, if appropriate, to the CWA for determination of financial eligibility. The hospital should submit to the LTCFO the completed Hospital Preadmission Screening Referral form, also known as form LTC-4, provided as Appendix T, incorporated herein by reference, and available for download at <http://www.state.nj.us/health/forms> and at www.state.nj.us/health/ltc/formspub.htm, to notify the LTCFO for PAS and, if appropriate, the CWA for determination of financial eligibility.
 - i. Professional staff designated by the Department will conduct PAS using a standardized assessment instrument provided at Appendix K, incorporated herein by reference, and upon the conclusion of the assessment, shall verbally advise the referent, the individual, and the individual's family member or legal representative as to whether the individual is clinically eligible for NF placement and whether PASRR is required.
 - (1) If the individual is clinically eligible for NF placement and does not require PASRR, then upon conclusion of PAS, the professional staff designated by the Department shall provide the referent with a copy of an executed approval letter in the form provided at Appendix M and a completed HSDP in the form provided at Appendix L, and the LTCFO shall mail the original approval letter to the individual or, if applicable, the individual's legal representative, and shall send a copy of the approval letter to the CWA.
 - (2) If the individual is clinically ineligible for NF placement, the LTCFO will mail a letter denying Medicaid authorization for NF placement in the form provided at Appendix N to the individual or, if applicable, the

individual's legal representative and will mail a copy of the letter to the CWA.

- (3) If the individual is clinically eligible for NF placement but PASRR is required, the professional staff designated by the Department shall provide the individual or the individual's legal representative, with written notice of the necessity of PASRR in the form provided at Appendix R, incorporated herein by reference, also known as form LTC-L6a, with respect to individuals with MI, and in the form provided at Appendix S, incorporated herein by reference, also known as LTC-L7a, with respect to individuals with MR.
 - (4) Upon conclusion of PASRR, if PASRR results in a determination that the individual does not require specialized services for MI or MR, then the LTCFO will mail the original approval letter in the form provided at Appendix M to the individual, or, as appropriate, to the individual's legal representative and to the referring individual, and will mail a copy of the executed approval letter and a completed HSDP in the form provided at Appendix L to the referent.
 - (5) Upon conclusion of PASRR, if PASRR results in a determination that the individual requires specialized services for MI or MR, then the LTCFO will mail a letter denying Medicaid authorization for NF placement in the form provided at Appendix N, incorporated herein by reference, to the individual or, as appropriate, the individual's legal representative, and the DMHS or the DDD, as appropriate, will assist in finding appropriate placement and/or services for the individual.
 - (6) If an individual being transferred from a hospital setting to a NF is or will be eligible for Medicare benefits, the transfer shall, to the extent possible, be made to a Medicare and Medicaid participating NF.
2. If the referent is a NF, the referent shall refer an individual no later than 180 days prior to the individual's anticipated date of Medicaid eligibility by submitting the completed Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient form, also known as the LTC-2 form, provided at Appendix G, incorporated herein by reference, and available for download at www.state.nj.us/health/forms and at www.state.nj.us/health/ltc/formspub.htm, to the LTCFO for PAS and by submitting a copy of the form to the CWA for a determination of financial eligibility.
 - i. Professional staff designated by the Department will conduct PAS in accordance with the procedure provided in (d) above and by completing the standardized assessment.

- ii. When the CWA determines that the individual is financially eligible for Medicaid, the CWA will forward the LTC-2 form to the LTCFO indicating a change in the individual's status from private pay to financially eligible for Medicaid.

- 3. A person or entity shall refer an individual residing in the community who is seeking admission to a Medicaid-participating NF and who is financially eligible for Medicaid or who may become financially eligible for Medicaid within 180 days of admission to a NF, or an individual with MI or MR, to the LTCFO for PAS and, if appropriate, to the CWA for a determination of financial eligibility by submitting to the LTCFO a completed Certification of Need for Patient Care in Facility other than Public or Private General Hospital, also known as a PA-4 form, provided at Appendix H, incorporated herein by reference, and available for download at <http://nj.gov/health/forms/index.shtml>.
 - i. Upon receipt by the LTCFO of a PA-4 form or a physician statement that substantiates the individual's diagnosis and describes the individual's care needs, professional staff designated by the Department will conduct PAS in accordance with the procedure provided in (d) above and by completing the standardized assessment.
 - (1) Upon conclusion of PAS, the professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, as to whether the individual is clinically eligible for NF services, and the LTCFO will mail either the approval letter in the form provided in Appendix M, or the denial letter in the form provided in Appendix N, to the individual or, if applicable, the individual's legal representative, and will send a copy of the letter to the CWA.
 - ii. For individuals residing in the community with MI, professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, at the conclusion of PAS whether the individual is clinically eligible for NF placement.
 - (1) If the individual is not clinically eligible for NF placement, the LTCFO will mail an executed denial letter in the form provided at Appendix N to the individual or, if applicable, the individual's legal representative.
 - (2) If the individual is clinically eligible for NF placement, the professional staff designated by the Department will provide the individual or, if applicable, the individual's legal representative, with an executed form LTC-L6a advising the individual or representative, of the need to have the Psychiatric Evaluation form provided at Appendix I completed by a psychiatrist, physician (doctors of

medicine or osteopathy), certified nurse practitioner certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health or clinical nurse specialist certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health and the need to forward the form to the DMHS.

- (3) If PASRR by the DMHS results in a determination that the individual requires specialized services for MI, then NF placement is not appropriate and the LTCFO will mail an executed denial letter in the form provided at Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and the DMHS will assist the individual in securing appropriate placement and/or services.
 - (4) If PASRR by the DMHS results in a determination that the individual does not require specialized services for MI, the LTCFO will mail the approval letter in the form provided in Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and will transmit a copy of the approval letter to the CWA.
- iii. For individuals residing in the community with MR, professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, at the conclusion of PAS whether the individual is clinically eligible for NF placement.
- (1) If the individual is not clinically eligible for NF placement, the LTCFO will mail, an executed denial letter in the form provided at Appendix N to the individual, or if applicable, the individual's legal representative.
 - (2) If the individual is clinically eligible for NF placement, professional staff designated by the Department will provide the individual or the individual's legal representative, with an executed form LTC-L7a advising the individual or representative, of the need for the DDD to conduct PASRR.
 - (3) If PASRR by the DDD results in a determination that the individual requires specialized services for MR, then NF placement is not appropriate and the LTCFO will mail an executed denial letter in the form provided at Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative and the DDD will assist the individual in securing appropriate placement and/or services.

- (4) If PASRR by the DDD results in a determination that the individual does not require specialized services for MR, the LTCFO will mail the approval letter in the form provided in Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and will transmit a copy of the approval letter to the CWA.

iv. In the case of an individual dually diagnosed with MI and MR, the conduct of PASRR by the DMHS shall precede the conduct of PASRR by the DDD.

(f) Authorization of out-of-State NF placement is subject to the following additional conditions:

1. Prior authorization shall be obtained from the Department for out-of-State NF services and shall be considered only when a required long-term care service is not available in New Jersey.
2. The out-of-State facility shall be licensed under the laws of that state as a NF or SCNF or equivalent entity, howsoever labeled by that state, and the rate of reimbursement shall not exceed that authorized by the Medicaid program of the state in which the facility is located, or the reimbursement rate authorized by the New Jersey Medicaid Program, whichever is lower.
3. Requests for prior authorization for out-of-State placement shall be accompanied by sufficient evidence that the service is medically necessary and not available in New Jersey. The Department will review the records provided to determine the need for long-term care services and to determine the appropriateness of placing the beneficiary in a NF outside of New Jersey. The request must be submitted to:

Office of Community Choice Options
 Division of Aging and Community Services
 Department of Health and Senior Services
 PO Box 807
 Trenton, NJ 08625-0807

4. Prior to submitting a request for out-of-State placement, the beneficiary shall comply with the requirements of PAS as specified in this subchapter.

(g) The procedure for Department authorization of Medicaid reimbursement for NF continued stay or alternative care is as follows:

1. The professional staff designated by the Department shall periodically assess Medicaid beneficiaries to review the NF's assessments, patient classifications, and case mix reporting, and may recommend continuation of NF stay or, if appropriate, deny continued NF stay and shall recommend discharge to an alternative to NF stay.

2. Professional staff designated by the Department shall provide care management on an ongoing basis to Medicaid beneficiaries following placement in a NF.
3. Professional staff designated by the Department shall examine resident records for proof of continued vigilance and effort by the NF to utilize alternative means of care for all residents.
 - i. Beneficiaries designated as Track II (short-term) shall be monitored closely by the Department to assure active participation by the NF in the discharge planning process.

(h) If a NF resident with MI or MR shows a significant change in condition as defined by the MDS, the NF shall initiate treatment to meet immediate needs. The NF shall arrange for the conduct and completion of a comprehensive reassessment by the end of the 14th day of the documented change in condition. If the reassessment results in a finding that a significant change in the resident's condition has occurred, the NF shall revise the resident's care plan based on that reassessment within seven days of the completion of the reassessment, shall make a clinical judgment, based on the clinical data, as to whether or not PASRR by DMHS or DDD is needed, and if so, shall notify the DMHS and/or the DDD, as appropriate, of the need for PASRR.

(i) Professional staff designated by the Department, after considering and rejecting all possible means of alternative care, shall approve conventional NF placement for Medicaid beneficiaries residing in a NF approved for a SCNF rate of reimbursement who continue to require NF level of nursing care, but who no longer require SCNF level of nursing care.

(j) The NF shall notify the LTCFO, via the LTC-2 form, of the termination of NF services due to the beneficiary's:

- i. Death while either in the NF or hospitalized;
- ii. Discharge to home or other community living arrangement;
- iii. Transfer to another NF; or
- iv. Ineligibility determination.

8:85-1.9 Waiting list

(a) The NF shall establish a single waiting list in chronological order. The order of names shall be predicated upon the order in which a completed written application is received. Hospitalized individuals ready for readmission to the NF are to be added to the top of the list as soon as the hospital notifies the NF of the contemplated discharge. As soon as a bed becomes available, it shall be filled from this waiting list. Provisions can be made for emergency, life-

threatening situations or life-care community admissions or transfers from another nursing facility

1. The NF shall meet the following requirements:
 - i. Maintain only one waiting list; this list shall reflect a roster updated on a regular basis, of all individuals who have applied for admission to the facility;
 - ii. Reflect in chronological order the full name and address of the individual applying by the date the written application for admission is made;
 - iii. Utilize the waiting list to admit individuals on a first-come, first-serve basis in the order in which they apply until the provider's Medicaid occupancy level equals the Statewide occupancy level, or the Medicaid occupancy level set forth in the provider's Certificate of Need, whichever is higher.
 - iv. A file shall be maintained containing full documentation to support any valid reason why the individual whose name appears first on the waiting list is not admitted to the NF.
2. It shall be unlawful discrimination for any Medicaid participating NF whose Medicaid occupancy level is less than the Statewide occupancy level to deny admission to a Medicaid eligible individual who has been authorized for NF services by the LTCFO when a NF bed becomes available in accord with the waiting list.
 - i. Under the provisions of N.J.S.A. 10:5-12.2, a facility with a residential unit or a Life-Care community may give its own residents priority when a NF bed becomes available.

8:85-1.10 Involuntary transfer

(a) The Department recognizes that there may be problems in relocating infirm aged persons from a NF. The purpose of this rule is to specify the circumstances in which the involuntary transfer of a Medicaid beneficiary in a NF is authorized and to establish conditions and procedures designed to minimize the risks, trauma and discomfort which may accompany the involuntary transfer of a Medicaid beneficiary from a NF.

(b) This rule shall be interpreted consistent with the Federal requirement that care and service under the Medicaid program be provided in a manner consistent with the best interests of the resident.

(c) This rule shall apply to the involuntary transfer of a Medicaid beneficiary at the request of a NF. This rule shall not apply to the Department's utilization review process, nor to the movement of a Medicaid beneficiary to another bed within the same facility.

(d) A transfer of a Medicaid beneficiary which was not consented to or requested by the beneficiary or by the beneficiary's family or authorized representative shall be considered an involuntary transfer. A Medicaid beneficiary is a Medicaid eligible individual residing in a NF which has a Medicaid provider agreement. This includes Medicaid beneficiaries over the minimum number stipulated in the agreement or an individual who had entered the facility as non-Medicaid and is awaiting resolution of Medicaid eligibility.

(e) A Medicaid beneficiary shall only be involuntarily transferred when adequate alternative placement, acceptable to the Department, is available. A Medicaid beneficiary may be transferred involuntarily only for the following reasons:

1. The transfer is required by medical necessity;
2. The transfer is necessary to protect the physical welfare or safety of the beneficiary or other residents;
3. The transfer is required because the resident has failed, after reasonable and appropriate notice, to reimburse the NF for a stay in the facility from his/her available income as reported on the PA-3L; or
4. The transfer is required by the New Jersey State Department of Health and Senior Services pursuant to licensure action or to the facility's suspension or termination as a Medicaid provider.

(f) In any determination as to whether a transfer is authorized by this rule, the burden of proof, by a preponderance of the evidence, shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled. Where a transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1. The effect of relocation trauma on the beneficiary;
2. The proximity of the proposed placement to the present facility and to the family and friends of the beneficiary; and
3. The availability of necessary medical and social services as required by Federal and State rules and regulations.

(g) The procedure for involuntary transfer shall be as follows:

1. The NF shall submit to the LTCFO a written notice with documentation of its intention and reason for the involuntary transfer of a Medicaid beneficiary from the facility;
2. If the LTCFO determines that an involuntary transfer is appropriate, the beneficiary and/or the beneficiary's authorized representative shall be given 30 days prior written

notice by the NF that a transfer is proposed by the NF and that such transfer will take effect upon completion of the relocation program specified in (h) below.

Additionally, the NF shall forward a copy of the written notice to the LTCFO and Ombudsman. The written notice to the beneficiary and/or authorized representative shall advise of the right to a hearing and shall include the address where to send the request for a hearing. If the beneficiary requests a hearing within 30 days of the date of the written notice, the transfer is stayed pending the decision following the hearing. In those instances where the LTCFO determines that an acute situation or emergency exists, the transfer shall take place immediately. The beneficiary and/or the beneficiary's authorized representative shall be given 30 days after transfer to request a hearing;

3. DMAHS will comply with the hearing time requirements in State and Federal rules and regulations, unless an adjournment is requested by the appellant;
4. The hearing shall be conducted at a time and place convenient to the beneficiary. Notification shall be sent to all parties concerned;
5. All hearings shall be conducted in accordance with the Fair Hearing procedures adopted by the DMAHS.

(h) The relocation procedure shall be as follows:

1. In the event the relocation of a beneficiary is the final Department determination, the Department shall afford relocation counseling for all prospective transferees in order to reduce as much as possible the impact of transfer trauma.
2. The staff of the transferring and receiving NFs shall carry out the transfer process, although responsibility and authority for the coordination and transfer rests with the Department and will include:
 - i. Evaluation and review by appropriate LTCFO staff;
 - ii. Initial beneficiary, family or authorized representative counseling;
 - iii. Involvement of the beneficiary, family or authorized representative in the placement process with recognition of their choices;
 - iv. Beneficiary preparation and site visit for all able to do so within the capability of the transferring agent;
 - v. Accompaniment on the transfer day by a family member, authorized representative or attendant, unless the beneficiary otherwise requests;
 - vi. Follow-up counseling at the new location; and

vii. No right to an administrative hearing on a claim for failure to implement the requirements of this subsection for relocation counseling.

(i) No owner, administrator or employee of a NF shall attempt to have beneficiaries seek relocation by harassment or threats. Such action by or on behalf of the NF may be cause for the curtailment of future admission of Medicaid beneficiaries to the NF or for termination of the Medicaid Provider Agreement with the NF, depending upon the nature of the action.

(j) Any complaints regarding the handling of beneficiaries relative to their transfer shall be referred to the Department for investigation and corrective action.

8:85-1.11 (Reserved)

8:85-1.12 Clinical audit

(a) Clinical audit is a method of utilization control under the enforcement authority of Section 1902(a)(30)(A) of the Social Security Act, to monitor the continued utilization of and payment for NF care and services reimbursable under the Medicaid program. Clinical audit has as its major component verification of NF services provision.

(b) Professional staff designated by the Department shall periodically conduct a post payment review of New Jersey Medicaid beneficiaries for whom NF services have been provided. The review shall principally involve assessment of the Medicaid beneficiary's care needs and evaluation of treatment outcomes, based on direct observation of the beneficiary and examination of clinical and related records. The focus of the review shall be on the following areas:

1. Comparative analysis of a beneficiary's identified care needs to NF claim reports;
2. Appropriate utilization and provision of required services; and
3. Effectiveness and quality of provided services.

(c) Enforcement action will be taken by the Department as follows:

1. As a result of the clinical audits, aberrations in the reporting and/or provision of services and failure to comply with the requirements of this chapter shall be documented and reported to the NF for corrective action.
2. A pattern of practice of significant proportion wherein the NF has provided items or services at a frequency or amount determined unnecessary, or of a quality that does not meet the standards outlined in this chapter, will result in an increase, reduction or termination of services, and ultimate restriction of the NF participation in the Medicaid Program.

8:85-1.13 Clinical and related records

(a) An individual clinical record shall be maintained for each Medicaid beneficiary covering his or her medical, nursing, social and related care in accordance with accepted professional standards and licensing standards as set forth by the Standards for Licensure of Long-Term Care Facilities, N.J.A.C. 8:39. All entries on the clinical record shall be current, dated and signed by the appropriate staff member. The clinical record, HSDP approval letter and if appropriate, PASRR determination shall be readily available at the appropriate nurses' station for review by DHSS staff.

(b) The clinical record of a deceased resident shall be properly completed. It shall include:

1. Written reports of visits made by the physician during the critical stage of illness;
2. Written documentation of death pronouncement completed by the qualified health professional as specified by the NF's policies and procedures;
3. Complete nurse's notes containing all necessary and pertinent information documenting the resident's condition during the illness and apparent demise, notification of physician and next of kin;
4. Autopsy records where appropriate; and
5. A written record of the disposition of the body of the deceased individual.

(c) All clinical records of discharged residents shall be completed promptly and shall be filed and retained for the duration required by N.J.S.A. 26:8-5.

(d) If the resident is transferred to or from another health care facility, a copy of the resident's clinical record or an abstract thereof, including the most recent HSDP, MDS and, if applicable, current copy of the resident's PASRR, and/or the documentation that supports the resident's diagnosis of Alzheimer's disease or related organic dementia, shall accompany the resident.

(e) All information contained in the clinical record shall be treated as confidential and shall be disclosed only to authorized persons.

(f) If the NF does not have a full or part-time medical records librarian, an employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed and preserved in accordance with accepted procedures. The designated individual shall be trained by, and must receive regular consultation from, a medical records librarian who is under written contract with the facility.

- (g) Billing and financial records rules are as follows:
1. The Fiscal Agent Billing Supplement identifies the procedures required for the general use of the billing transaction forms and computer generated forms. All appropriate reports shall be retained until audited by the Department.
 2. The facility shall establish and maintain appropriate and accurate records and accounts of all receipts and disbursements of Medicaid beneficiary funds, which shall be subject to review and fiscal audit by the State of New Jersey as may be required. A beneficiary shall be credited with the maximum amount of personal needs allowance funds authorized by Federal or State law for each month that such records or accounts are unavailable.
 3. Any and all financial and other records relating to beneficiary's personal needs allowance accounts, income, cost reports, and billings to the Medicaid program shall be maintained and retained in accordance with professional standards and practices for the longest of the following periods of time:
 - i. At least one year after the resolution of audit findings or the conclusion of recovery proceedings arising out of those audit findings (whichever is later) for the records that are audited;
 - ii. One year after the conclusion of all hearings, appeals and/or other litigation with respect to audits of such records; or
 - iii. Seven years.
 4. The records described in (g)3 above shall be made available for audit upon the request of appropriate State and/or Federal personnel or their agents.
 5. Claims for NF services that are older than 12 months will be rejected.
 - i. A claim for payment for services shall be received by the fiscal agent no later than one year after the "from date of service" on the claim form (TAD). An adjustment request FD999 (see Appendix Q) for a paid claim shall be honored for 180 days from the original date of payment;
 - ii. For purposes of this time limitation, a claim is the submission of a TAD, provided by the fiscal agent for the New Jersey Medicaid program, indicating a request for reimbursement for authorized NF services provided to an eligible beneficiary and which has been returned to the fiscal agent within the time limit specified. An adjustment form (FD999) or an LTC-2 shall not constitute a claim for payment;
 - iii. Other timely filing information is located in the Administrative chapter at N.J.A.C. 10:49-7.2, Timeliness of claim submission and inquiry.

8:85-1.14. Absence from facility due to hospital admission or therapeutic leave; bed reserve

- (a) The bed reserve policy for hospital admissions is as follows:
1. The NF shall reserve and hold the same room and the same bed of the Medicaid beneficiary transferred to a general or psychiatric hospital for a period not to exceed 10 days. The NF shall determine the individual's status or whereabouts during or after the 10-day bed reserve period.
 - i. If the resident is not readmitted to the same room or the same bed or the same NF during a bed reserve period, the NF requesting bed reserve reimbursement shall record on the resident's chart and make available for Department review, a justification for the action taken. Pending outcome of the Department's review, the facility may be subject to forfeiture of bed reserve reimbursement.
 - ii. Said reserved bed shall remain empty and shall not be occupied by another individual during the bed reserve period, unless authorized by the Department.
 2. Reimbursement, not to exceed 10 days, shall be at 50 percent of the rate the NF received prior to the transfer to the hospital.
 - i. The beneficiary's available monthly income shall be applied against the per diem cost of care.
 - ii. Medicaid reimbursement for bed reserve will not be made to a NF when the NF per diem payment for a "Medicaid eligible beneficiary" is being made by a third party insurer.
 3. If readmission to the NF does not occur until after the 10-day bed reserve period, the next available bed shall be given to the Medicaid beneficiary. The beneficiary's name shall be placed on the chronological listing of persons waiting admission/readmission to the NF, and the beneficiary waiting for readmission shall have priority for the next available bed in the facility.
 4. The bed reserve policy applies to any person in the NF eligible to receive Medicaid benefits; for example, a Medicare/Medicaid beneficiary who, at the time of transfer to the hospital, might be eligible for long-term care services under Medicare benefits.
 5. Admission procedures (see N.J.A.C. 8:85-1.8) shall be followed when the Medicaid beneficiary has been readmitted following a period of hospitalization.
- (b) Requirements concerning absence due to therapeutic leave are as follows:

1. The New Jersey Medicaid program will reimburse NFs their per diem rate for reserving beds for Medicaid beneficiaries who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of unused leave days may be carried over into the next calendar year. The facility shall maintain accurate leave day records on the Medicaid beneficiary's chart, for review by the Department.
2. A therapeutic leave shall include therapeutic or rehabilitative home and community visits with relatives and friends. Home visits shall be limited to therapeutic home visits only and shall not include hospital visits.
3. The absence of a Medicaid beneficiary from the facility for the purpose of therapeutic leave shall be authorized in writing by the beneficiary's attending physician and shall be included in the beneficiary's plan of care.
4. In those instances where a beneficiary is in more than one NF within a calendar year, the receiving facility shall determine the number of therapeutic leave days that have been allowed for payment by the sending facility within the same calendar year. A record of any leave days shall be a part of the information provided on the Patient Information Transfer Form.
5. The facility shall reserve and hold the same room and bed for the Medicaid beneficiary on a therapeutic home visit. Said bed shall not be occupied by another individual during the period of time in which the Medicaid beneficiary is on such leave.
6. Where a beneficiary's condition or situation requires more than 24 therapeutic leave days annually, as determined by the beneficiary's attending physician, prior authorization for the additional days shall be obtained from the LTCFO. The request for prior authorization shall be submitted in writing to the LTCFO Field Office Manager, over the signature of the attending physician. A facility shall be reimbursed its per diem rate for reserving a bed for a Medicaid beneficiary for any additional days so authorized.

8:85-1.15 Complaints

(a) The Department will receive, document and investigate complaints from multiple sources and take appropriate corrective action as required. It is the Department's policy that the source of the complaint be held confidential, unless disclosure permission is obtained from the complainant.

(b) In addition to investigation by the Department, when complaints against a facility indicate the facility's failure to correct previously reported survey deficiencies or to comply with established licensure and Medicare/Medicaid certification standards, such complaint reports will be forwarded to the Office of the Ombudsman for the Institutionalized Elderly for review and

action. Any complaints or reports received by the Department indicating legal violations will be referred to the office of the Attorney General for review and action, as required.

8:85-1.16 Utilization of resident's income for cost of care in the NF and for PNA

(a) After provision for the resident's Personal Needs Allowance (PNA) is met, and then after provision for other allocations such as maintenance of spouse and/or dependent's home are satisfied, the remainder of the Medicaid beneficiary's income shall be applied to the cost of care in the NF, which includes per diem, bed reserve and other allowable expenses.

1. The amount of income which shall be collected by the NF from the beneficiary, beneficiary's family or Representative Payee (if any) will be established in the process of determining eligibility and identified by form PA-3L, Statement of Income Available for Medicaid Payment, issued by the CWA. The NF shall collect all of the recipient's income to offset the Medicaid payment.
2. The NF shall notify the CWA immediately whenever there is a change/difference in any income source, as well as when any additional assets or resources come to the attention of the NF.
3. The New Jersey Medicaid program encourages families or any other concerned individual(s) to make voluntary monetary contributions to the State of New Jersey on behalf of Medicaid beneficiaries residing in nursing facilities. Inquiries should be directed to the Division of Senior Benefits and Utilization Management, Office of Administration and Finance, PO Box 722, Trenton, New Jersey 08625-0722.

(b) For all institutionalized aged, blind, and disabled individuals who are eligible for Medicaid, a designated amount of income as determined by State law (N.J.S.A. 30:4D-6a) shall be protected for personal needs allowance.

1. Certain individuals in a NF have no income, or insufficient income to provide a maximum amount of PNA. For those individuals not already deemed eligible for SSI, the facility shall insure that the application for SSI benefits has been made. PA-3L's for those beneficiaries who only receive an SSI check can be obtained from the Division of Senior Benefits and Utilization Management, Office of Provider Relations, PO Box 722, Trenton, New Jersey 08625-0722.
2. Once the NF initiates billing for a Medicaid beneficiary, that Medicaid beneficiary shall be considered a Medicaid beneficiary for the full term of stay in the NF (that is, until death or physician discharge) unless the patient loses eligibility during the stay or the beneficiary or authorized representative submits to the LTCFO, prior to death or discharge, a notarized statement to terminate benefits.
 - i. After a beneficiary dies or is discharged, under no circumstances shall that beneficiary's Medicaid billing status be terminated prior to the date of death or

discharge for the purpose of avoiding utilization of available income against cost share.

(c) Each Medicaid beneficiary residing in a NF shall be permitted to accumulate a sum of money from the PNA which, when combined with other resources retained by or for the person, does not exceed the maximum resource standard in the Department of Human Services Medicaid Only Manual at N.J.A.C. 10:71-4.5.

1. If the NF is handling the PNA, the facility shall closely monitor the PNA account and inform the beneficiary and/or his or her representative when the amount comes within \$200.00 of the resource eligibility cap. If the PNA is in excess of the resource standard defined in N.J.A.C. 10:71-4.5, the beneficiary and/or his or her representative shall be advised of his or her right to reduce the excess monies and that the beneficiary may be terminated from Medicaid coverage, unless the amount in excess of the resource standard is expended.
2. The beneficiary may choose to reduce excess PNA by applying some of the accumulated PNA toward past expenditures paid for his or her care by the Medicaid program. Checks payable to the "Treasurer, State of New Jersey", may be directed to the Division of Senior Benefits and Utilization Management, Office of Administration and Finance, PO Box 722, Trenton, New Jersey 08625-0722.

(d) Standards for management of PNA shall comply with Federal regulations at 42 CFR 483.10(c) and State licensing requirements at N.J.A.C. 8:39-4.1.

(e) The personal needs allowance (PNA) shall be used as follows:

1. The PNA is intended to meet the personal and incidental needs of a beneficiary residing in a NF, in keeping with his or her wishes. The PNA is not intended to be applied against outstanding balances for the cost of care.
2. The NF shall not charge for items the beneficiary has not requested, nor for any items about which the beneficiary has not been informed in advance that he or she will be billed.
3. NFs shall not charge for any item or service reimbursable under the Medicaid program. A facility may charge the difference between the cost of the brand a beneficiary requests and the cost of the brand generally provided by the facility, if the facility chooses to provide the requested brand. NFs shall not require the purchase of non-covered items as a condition for admission.
4. The basic items that NFs shall make available for beneficiary use under the Medicaid program include:

- i. Personal hygiene items such as soap, facial tissues, towels, washcloths, shaving materials (lotion, razor, razor blades), combs, hair brushes, shampoo, tooth brushes, tooth paste, laundry services, denture cleaner and adhesive, dental floss, deodorant, incontinent supplies, sanitary napkins, disinfecting soaps or specialized cleaning agents, when medically indicated to treat special skin problems or to fight infections;
 - ii. Durable medical equipment such as wheelchairs, gerichairs, crutches, canes, walkers, commodes, Hoyer lifts, mattresses;
 - iii. Services, including electricity, TV antenna or cable hook-up when needed for acceptable reception, banking charges that are not deducted from the interest; and
 - iv. Basic room furnishings, such as chairs, table, fans, bed-spreads, curtains.
 5. The facility may not mandate TV rental.
 6. Examples of personal items for which PNA is intended are:
 - i. Small purchases, such as cosmetics, electric shavers, hair spray, special lotions or powders, clothes brushes, tobacco or candy;
 - ii. Personal items, such as clothing, jewelry, watches, accessories, haircuts, beauty parlor services, newspapers or magazines;
 - iii. Personalization of living area with items requested by the resident, such as bed-spread, rug, pictures, furniture, radio or TV;
 - iv. Community contacts, such as home visits, transportation, trips to special events or places of interest, telephone calls, stationery, stamps or gifts;
 - v. Hobbies, such as games, photographic materials, aquariums, plants or audio or video tapes.
 7. The PNA may be used to continue a bed reserve, if a beneficiary transferred to a hospital is unable to return within the 10-day bed reserve period. Payment shall be strictly voluntary, however, and shall be permitted only when the beneficiary's right to return to the NF (see N.J.A.C. 8:85-1.4) has been fully explained to the beneficiary and his representative. The beneficiary's request to use the PNA for this purpose shall be in writing. Under no circumstances shall the facility use overt or implicit coercion in this matter.
- (f) A uniform accounting system shall be maintained by the facility as follows:

1. In compliance with Federal and State rules and regulations, the NF shall accept fiduciary responsibilities for a Medicaid beneficiary's PNA if the beneficiary and/or authorized representative requests that his or her PNA be managed by the facility. The NF shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each beneficiary's personal funds entrusted to the facility on the beneficiary's behalf. In compliance with Federal and State rules and regulations, the facility shall deposit any resident's personal funds in excess of \$50.00 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts. The facility shall credit all interest earned on the resident's account to his or her account.
2. The PNA account and related supporting information, such as receipts, canceled check, bank statement, check register shall be maintained at the facility. The Department recommends that a direct deposit system be utilized.
3. A general ledger control account shall be established to record the total amount of PNA held in escrow by the facility.
4. A subsidiary ledger shall be established whereby each beneficiary's deposits and disbursements are recorded and the total of the beneficiary's balances reconciled to the general ledger control account each month, or as last reported by the banking facility.
5. When recording the beneficiary's income in a cash receipts journal, the PNA shall be segregated from the available income applied to the cost of the beneficiary's care. Within five days of receipt, the PNA shall be deposited directly into the interest bearing checking or savings account restricted for PNA. The general ledger control account shall reflect a credit posting to indicate the total PNA received during the month. Each beneficiary's subsidiary ledger account shall also be posted to record the deposits to the appropriate account.
6. To facilitate the beneficiary's access to the PNA, a portion of the total cash may be transferred periodically from the segregated checking/savings account to a petty cash fund. The amount of the fund shall be reasonable and necessary for the size of the facility and needs of the beneficiaries.
7. In compliance with Federal and State rules and regulations, the facility shall provide, at least quarterly, to the beneficiary and/or his or her authorized representative, an accounting of all transactions with regard to the PNA account. The amount of balance in the beneficiary's account shall be available for the beneficiary and/or his or her authorized representative on request.
8. Management of funds shall be as follows:

APPENDICES A through T

Appendix A - See Appendix A link

Appendix B - See Appendix B link

Appendix C - See Appendix C link

Appendix D - See Appendix D link

Appendix E - See Appendix E link

Appendix F - See Appendix F link

Appendix G - See Appendix G link

Appendix H - See Appendix H link

Appendix I - See Appendix I link

Appendix J - See Appendix J link

Appendix K - See Appendix K link

Appendix L - See Appendix L link

Appendix M - See Appendix M link

Appendix N - See Appendix N link

Appendix O - (RESERVED)

Appendix P - See Appendix P link

Appendix Q - See Appendix Q link

Appendix R - See Appendix R link

Appendix S - See Appendix S link

Appendix T - See Appendix T link