

N.J.A.C. 8:85

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

Title 8, Chapter 85 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

N.J.S.A. 30:4D-6a(4)(a), b(13) and (14), 7, and 17.15; and 42 U.S.C. § 1396a(a)(13)(a) and 42 U.S.C. § 1396r.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: November 21, 2017.

See: 49 N.J.R. 4007(b).

CHAPTER HISTORICAL NOTE:

Chapter 63, Skilled Nursing Home Services Manual, was adopted as R.1971 d.163, effective September 22, 1971. See: 3 N.J.R. 206(b).

Chapter 63, Skilled Nursing Home Services Manual, was repealed and Chapter 63, Long-Term Care Services Manual, was adopted as new rules by R.1979 d.126, effective March 29, 1979. See: 10 N.J.R. 190(b), 11 N.J.R. 248(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, General Provisions, was readopted as R.1984 d.123, effective March 21, 1984. See: 16 N.J.R. 204(a), 16 N.J.R. 896(a).

Pursuant to Executive Order No. 66(1978), Subchapter 3, Cost Study, Rate Review Guidelines and Reporting System for Long-Term Care Facilities, was readopted as R.1984 d.573, effective November 29, 1984. See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services Manual, was readopted as R.1989 d.622, effective November 29, 1989. See: 21 N.J.R. 2752(a), 21 N.J.R. 3918(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services Manual, was readopted as R.1994 d.624, effective November 23, 1994. As a part of R.1994 d.624, Chapter 63 was renamed Long-Term Care Services; former Subchapters 1, 2, 2A and 4, and Appendix I were repealed; Subchapter 1, General Provisions, Subchapter 2, Nursing Facilities Services, and Appendices A through Q were adopted as new rules; and Subchapter 5, Audits, was recodified as Subchapter 4, effective January 3, 1995. See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services, was readopted as R.1999 d.364, effective September 24, 1999. See: 31 N.J.R. 1759(a), 31 N.J.R. 3116(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 63, Long-Term Care Services, was extended by gubernatorial directive from March 23, 2005 to March 23, 2006. See: 37 N.J.R. 1185(a).

Chapter 63, Long-Term Care Services, was readopted as R.2005 d.389, effective October 18, 2005. As a part of R.2005 d.389, N.J.A.C. 10:63 was recodified as N.J.A.C. 8:85, Long-Term Care Services, effective January 17, 2006. See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Chapter 85, Long-Term Care Services, was readopted as R.2011 d.121, effective March 24, 2011. As a part of R.2011 d.121, Subchapter 3, Cost Report, Rate Review Guidelines and Reporting System for Long-Term Care Facilities, was renamed Cost Report, Rate Calculation and Reporting System for Long-Term Care Facilities; Subchapter 5, Provider Reimbursements, Appendices U, V and W were adopted as new rules; and Appendix D was repealed, effective April 18, 2011. See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 85, Long-Term Care Services, was scheduled to expire on March 24, 2018. See: 43 N.J.R. 1203(a).

Chapter 85, Long-Term Care Services, was readopted, effective November 21, 2017. See: Source and Effective Date.

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N.J.A.C. 8:85-1.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.1 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

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N.J.A.C. 8:85-1.2

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

"AIDS" means acquired immune deficiency syndrome, a condition affecting an individual who has a reliably diagnosed disease that meets the criteria for AIDS specified by the Centers for Disease Control and Prevention of the United States Public Health Service in the following volumes of the Morbidity and Mortality Weekly Review (MMWR): Volume 41 RR-17 of the MMWR published on December 18, 1992; Volume 43 No. RR-17 of the MMWR published on September 30, 1994; Volume 48 No. RR-13 of the MMWR published on December 10, 1999; Volume 57 No. RR-10 of the MMWR published on December 5, 2008; and updates found at www.cdc.gov/mmwr.

"AIDS-defining illness" means the 26 clinical conditions that affect people with advanced HIV disease listed in Categories B and C of the 1993 Revised Classification System, including, but not limited to, pneumocystis carinii pneumonia or PCP, toxoplasmosis, cytomegalovirus or CMV, oral-esophageal candidiasis, wasting, bacterial pneumonia, lymphoma, cryptococcal meningitis, mycobacterium avium complex or MAC, and Kaposi's sarcoma.

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

"Allowable costs" means those costs of a nursing facility that are allowable for reimbursement pursuant to the Medicare Provider Reimbursement Manual unless modified by specific provisions of N.J.A.C. 8:85-3.

"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:

1. 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;
2. Assure the delivery of timely and appropriate provider responses to changes in care needs;
3. 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
4. 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.

"Case mix index (CMI)" means a numeric score that identifies the relative resource needs for the average resident classified under the resource utilization group (RUG) based on the assessed needs of the resident, whose values, incorporated herein by reference, as amended and supplemented, are set forth as CMI Set B01 located at https://www.cms.gov/MDS20SWSpecs/13_CMIVersion5.asp.

"CD4+ T cell" means a type of white blood cell that plays a major role in the functioning of the immune system and which carries the surface protein CD4.

"CDC" means the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

"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.

"CMS" means the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration or HCFA, a Federal agency within the United States Department of Health and Human Services.

"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.

"Construction bed value" means the implied cost of construction of a nursing facility bed using a year 2010 base value of \$ 89,000 and adjusting to prior years utilizing the index of All Urban Consumers CPI-U U.S. City Average as compiled by the U.S. Department of Labor, Bureau of Labor Statistics and found at <ftp://ftp.bls.gov/pub/special.requests/cpi/cpiiai.txt>.

"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.

"Cost report period case mix index" means the simple average of the day weighted facility case mix indices from the final resident rosters for a nursing facility, carried to four decimal places, for the resident roster periods that most closely match a cost reporting period.

"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.

"DACs" means the Division of Aging and Community Services within the Department of Health and Senior 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.

"Facility average Medicaid case mix index" means the day weighted average case mix index for all identified Medicaid days from each nursing facility's final resident roster for each resident roster quarter as adjusted in accordance with N.J.A.C. 8:85-3.10(a)4iii.

"Fair rental value (FRV) allowance" means a methodology for reimbursing NFs for the use of allowable facilities and equipment based on establishing a rental valuation on a per bed basis of such facilities and equipment and a rental rate in accordance with N.J.A.C. 8:85-3.11.

"Fair Rental Value (FRV) Data Report" means the worksheet attached as N.J.A.C. 8:85 Appendix V, incorporated herein by reference, completed and submitted by the nursing facility that is used to determine the initial effective age for the first FRV allowance for each Class I NF and Class II NF effective on or after July 1, 2010. The worksheet allows the identification of the original year of construction, the original number of licensed beds and any documented allowable capitalized nursing facility additions, deletions and renovations through the period prior to the rate year.

"Fair Rental Value (FRV) Re-age Request" means the worksheet attached as N.J.A.C. 8:85 Appendix W, incorporated herein by reference, completed and submitted by an NF to request modifications to its fair rental value allowance based on allowable capitalized costs of additions, modifications and renovations placed in service during the cost reporting year.

"Federal Medical Assistance Percentage (FMAP)" means the Federal medical assistance percentage applicable for Federal financial participation purposes for medical services pursuant to 42 U.S.C. § 1396b(a), which is incorporated by reference, as amended and supplemented.

"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.

"HIV" means Human Immunodeficiency Virus, the virus that causes AIDS and that meets the case definitions of HIV specified by the Centers for Disease Control and Prevention of the United States Public Health Service in the following volumes of the Morbidity and Mortality Weekly Review (MMWR): Volume 41 No. RR-17 of the MMWR published on December 18, 1992; Volume 43 No. RR-17 of the MMWR published on September 30, 1994; Volume 48 No. RR-13 of the MMWR published on December 10, 1999; Volume 57 No. RR-10 of the MMWR published on December 5, 2008; and updates found at www.cdc.gov/mmwr.

"HIV infection" means a retrovirus infection caused by HIV that destroys CD4+ T cells or interferes with their normal function by triggering other events that weaken an individual's immune function.

"HIV-related medical co-morbidities" means the presence of one or more disorders or diseases in addition to a primary diagnosis of HIV and/or AIDS including, but not limited to, diabetes, cancer, hypertension, hyperlipidemia, asthma, chronic obstructive pulmonary disease, or hepatitis B or C.

"HIV-related psychosocial co-morbidities" means the presence of one or more disorders or diseases in addition to a primary diagnosis of HIV and/or AIDS including, but not limited to, substance abuse, mental illness, or dementia.

"Index factor" means a factor calculated in accordance with N.J.A.C. 8:85-3.6 and based on the Skilled Nursing Home without Capital Market Basket Index published by Global Insight, which is available from CMS at www.cms.gov, or a comparable index available from, and used by, CMS, if this index ceases to be published.

"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.

"Level I screen and Level II evaluation and determination" means the Level I and Level II evaluations set forth in 42 CFR 483.128, which is incorporated by reference, as amended and supplemented.

"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.

"Major renovation or replacement project" means allowable capitalized costs, which include improvements, replacements, or additions to land, building and capitalized moveable equipment, that are placed in service during the reported period on the FRV data report or the FRV re-age request during the cost report period and in total are equal to or greater than \$ 1,000 per bed.

"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 day weighted median" means the point in the array of per diem costs of included nursing facilities ordered from low to high when the cumulative total of all Medicaid days from those nursing facilities' cost reports, excluding bed hold days, first equals or exceeds half the number of the total Medicaid days for all NFs in the array. The per diem cost at this point is the Medicaid day weighted median cost.

"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.

"Medicare cost report" means the skilled nursing facility cost report required by the Centers for Medicare & Medicaid Services for Medicare reimbursement. Copies of the Medicare cost report may be obtained by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244, or through its website at www.cms.gov/CostReports/03_SkilledNursingFacility.asp.

"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 3.0, required by 42 CFR 483.20 and set forth in the Resident Assessment Instrument (RAI) published by CMS, and available at www.cms.gov, 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 assessment required to be completed on all residents in Medicare- and/or Medicaid-certified long-term care facilities. The MDS identifies an individual NF resident's nursing and care needs.

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

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

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

3. Does not have a specific pre-existing patient base.

"NHA-100" means the form used by the Division of Taxation in the New Jersey Department of the Treasury for collecting the quarterly provider tax assessment from certain long-term care facilities.

"Normalization ratio" means the Statewide average case mix index divided by the facility's cost report period case mix index, the result of which is used for the purpose of removing cost variations associated with different levels of resident case mix.

"Normalized direct care case mix cost" means a facility's total allowable direct care case mix cost per diem multiplied by its normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case mix in order to determine the direct care limit.

"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.

"Office of Community Choice Options" or "OCCO" means a regional office of the Office of Community Choice Options of the Division of Aging and Community Services of the Senior Services and Health Systems Branch of the Department, which is responsible for the management of the pre-admission screening process.

"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.

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

2."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 meeting the clinical criteria for mental illness (MI) or mental retardation (MR/RC), regardless of payment source, is screened prior to admission to an NF to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for that individual's condition and, therefore, is ineligible for NF services. PASRR includes two distinct processes, Level I screen and Level II evaluation and determination.

"Prior authorization" means approval granted by the Department through the appropriate Office of Community Choice Options (OCCO) 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.

"Provider reimbursement manual or Medicare Provider Reimbursement Manual" means the Medicare Provider Reimbursement Manual published by CMS and commonly known as CMS Publication 15-1 and 15-2, available at www.cms.gov/manuals, incorporated herein by reference, as amended and supplemented.

"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.

"Related Condition" or "RC" means a related condition as defined in 42 CFR 435.1010, which is incorporated herein by reference, as amended and supplemented.

"Related Parties" means those individuals or entities defined as related parties in the provider reimbursement manual.

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

- 1.Replaces a pre-existing facility which was licensed in accordance with N.J.A.C. 8:39;
- 2.Can assume the per diem rate of the pre-existing facility; and
- 3.Has a specific pre-existing patient base.

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

"Resident roster" means a list of all residents in an NF for a calendar quarter based on MDS assessments and tracking forms, which are transmitted by the NF and accepted by the applicable submission site approved by CMS, used for the calculated day weighted case mix indices for Medicaid, Medicare and other payment sources.

"Resource utilization group" or "RUG" means the version III (RUG-III), 5.12 34-Group, incorporated herein by reference, as amended and supplemented, a system developed by CMS and set forth at https://www.cms.gov/MDS20SWSpecs/12_RUG-IIIVersion5.asp for grouping nursing facility residents according to the residents' functional status and anticipated uses of services and resources as identified from data supplied by the NF's MDS.

"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, that are determined to be medically indicated when an individual is experiencing an acute episode of serious MI and psychiatric hospitalization is recommended, based on a psychiatric evaluation.

1. Specialized services include 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 exceed the range of services that an NF is authorized to provide and can only be provided in a 24-hour inpatient setting.

"Specialized services for MR/RC" 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.

1. Specialized services are those services needed to address such skill deficits or specialized training needs.
2. Specialized services may be provided in an intermediate care facility for the mentally retarded or ICF/MR as defined at 42 CFR 440.150 or in a community-based setting that meets ICF/MR standards.
3. 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.

"Statewide average case mix index" means the simple average of all cost report period, day weighted case mix indices represented in the limit database established pursuant to N.J.A.C. 8:85-3.8.

"Statewide average Medicaid case mix index" means the Medicaid day weighted average of all Class I and Class II NFs' case mix indices for the Medicaid days identified on the final resident rosters for each resident roster quarter.

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

1."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.

2."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.

3."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 50 percent or more of the facility, or where no individual or entity owns 50 percent or more, the majority owner is the owner who owns the largest percentage.

"Unclassifiable MDS assessment" means an MDS assessment for which one or more MDS items used to calculate a resource utilization group are not present on the MDS assessment.

"Unsupported MDS assessment" means an assessment where one or more MDS items that are required to classify a resident into a resource utilization group are not supported by documentation in the resident's clinical record.

"Validated cost report" means a complete cost report submission that has undergone a minimum of a desk review by the Department and reflects any adjustments made by the Department in accordance with this chapter.

"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.

History

HISTORY:

Amended by R.2001 d.1, effective January 2, 2001.

See: 32 N.J.R. 2859(a), 33 N.J.R. 54(a).

Added "Transfer of ownership" to section.

Amended by R.2001 d.120, effective April 2, 2001.

See: 32 N.J.R. 3710(a), 33 N.J.R. 1108(a).

Added "New nursing facility" and "Replacement nursing facility".

Recodified from N.J.A.C. 10:63-1.2 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Added definitions "Bed", "Beneficiary", "County welfare agency (CWA)", "Department of Human Services", "Division of Medical Assistance and Health Services", "Long-Term Care Field Office", "Material fact", "Mental illness", "Mental retardation", "Minimum Data Set (MDS) version 2.0 or most recent version", "Ombudsman", and "Professional staff designated by the Department"; deleted definitions "Medical evaluation team (MET)", "Medical social care specialist (MSCS)", "Minimum data set (MDS)", "Regional staff nurse (RSN)" and "Section Q"; rewrote "Case management", "Department of Health", "Division of Developmental Disabilities", "Division of

Mental Health and Hospital (DMH & H)", "Health Services Delivery Plan (HSDP)", "Nursing facility (NF)", "Pre-admission screening (PAS)", "Prior authorization", "Resident", "Social services", "Special care nursing facility (SCNF)" and "Track of care".

Amended by R.2007 d.391, effective December 17, 2007.

See: 38 N.J.R. 4795(a), 39 N.J.R. 5338(a).

Added definitions "AIDS", "AIDS-defining illness", "CD4+ T cell", "CDC", "CMS", "HIV", "HIV infection", "HIV-related medical co-morbidities" and "HIV-related psychosocial co-morbidities".

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Rewrote definitions "AIDS", "HIV", " 'Minimum Data Set' or 'MDS' ", "Pre-admission screening and resident review", "Prior authorization", "Specialized service for MI", "Track of care" and "Transfer of ownership"; added definitions "Allowable costs", "Case mix index (CMI)", "Construction bed value", "Cost report period case mix index", "DACS", "Facility average Medicaid case mix index", "Fair rental value (FRV) allowance", "Fair Rental Value (FRV) Data Report", "Fair rental Value (FRV) Re-age Request", "Federal Medical Assistance Percentage (FMAP)", "Index factor", "Level I screen and Level II evaluation and determination", "Major renovation or replacement project", "Medicaid day weighted median", "Medicare cost report", "NHA-100", "Normalization ratio", "Normalized direct care case mix cost", " 'Office of Community Choice Options' or 'OCCO' ", "Provider reimbursement manual or Medicare Provider Reimbursement Manual", "Related Condition", "Related Parties", "Resident roster", " 'Resource utilization group' or 'RUG' ", "Statewide average case mix index", "Statewide average Medicaid case mix index", "Unclassifiable MDS assessment", "Unsupported MDS assessment" and "Validated cost report"; deleted definitions " 'Long-Term Care Field Office' or 'LTCFO' " and "Standardized Resident Assessment (SRA)"; substituted definition "Specialized services for MR/RC" for definition "Specialized services for MR"; and rewrote definition "Specialized services for MR/RC".

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85-1.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 8:85-1.3 Program participation

(a)An 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 an 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 N.J.A.C. 8:85 Appendix A, incorporated herein by reference, 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 an NF shall provide all NF services required by this chapter (see N.J.A.C. 8:85 Appendix B, incorporated herein by reference, 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 N.J.A.C. 8:85 Appendix C, incorporated herein by reference, as posted at www.state.nj.us/health/ltc/formspub.htm). The agreement for participation in the New Jersey Medicaid program stipulates that an NF shall provide all NF services required by this chapter. 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. If recertification by the Department is denied, the Department's Office of Provider Enrollment shall notify the nursing facility that its provider agreement is not being continued.
4. File with the Department a completed cost report for the nursing facility as required pursuant to N.J.A.C. 8:85-3.2.

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.

History

HISTORY:

Amended by R.1998 d.177, effective April 6, 1998.

See: 29 N.J.R. 4614(a), 30 N.J.R. 1284(b).

In (a), inserted "to be eligible" following "order" in the introductory paragraph, and added 7.

Recodified from N.J.A.C. 10:63-1.3 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In the introductory paragraph of (a), substituted "An" for "A"; and rewrote (a)3 and (a)4.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.4 by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

N.J.A.C. 8:85-1.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 8:85-1.5 (Reserved)

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.5 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Section was "Occupancy level"; in introductory paragraph (a), substituted "beneficiaries" for "and public assistance recipients"; in (a)1, substituted "An SCNF that" for "A Special Care Nursing Facility (SCNF) which".

Repealed by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Medicaid occupancy level".

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N.J.A.C. 8:85-1.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

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

(a) 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.6 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Section was "Termination of a NF provider agreement"; rewrote (a).

NEW JERSEY ADMINISTRATIVE CODE

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End of Document

N.J.A.C. 8:85-1.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

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

(a) 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.

(b) 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.7 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In (a)1, deleted "Division" preceding "letter" and rewrote mailing address; in introductory paragraph (b), substituted "CMS" for "HCFA" and "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration".

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85-1.8

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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/Related Condition (RC), unless professional staff designated by the Department have completed a Level I PASRR for the individual and the individual is determined clinically eligible 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 an NF resident with MI or MR/RC 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 (N.J.A.C. 8:85 Appendix L, incorporated herein by reference) accompany the transferring resident.
4. If the Level I PASRR required by this subsection is positive, professional staff designated by the Department shall refer the individual to either DDD or DMHS for completion of a Level II evaluation and determination.

(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 an 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 N.J.A.C. 8:85 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 OCCO 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 shall 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.

1. 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 evaluation and determination, prior to the Department's issuance of a written determination authorizing NF placement.

i. With respect to an individual with MI/RC 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/RC who is already an NF resident who is experiencing a change from the condition described on the resident's MDS, the NF, shall complete the identifying information on the Psychiatric Evaluation form provided at N.J.A.C. 8:85 Appendix I, incorporated herein by reference; shall have the remainder of the evaluation 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 documented primary diagnosis of dementia including Alzheimer's disease are not subject to a PASRR Level II evaluation by DMHS

as a precondition to a determination of Medicaid clinical eligibility for NF admission.

ii.With respect to an individual with MR/RC, the OCCO will forward the Level I screen to the appropriate DDD staff for the completion of the Level II PASRR evaluation and determination.

(1)Individuals with MR/RC and a diagnosis of dementia including Alzheimer's disease are subject to a PASRR Level II evaluation and determination 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/RC, the PASRR Level II evaluation shall be done by DMHS and DDD concurrently.

iv.The DMHS and/or the DDD, as applicable, will each transmit its respective PASRR determination to the OCCO and the OCCO will transmit the PASRR determination to the individual or, if applicable, the individual's legal representative, the appropriate State authority, admitting or referring NF, individual's attending physician and the discharging hospital.

(1)If the PASRR results in a determination that no specialized services are required, the Department shall approve NF placement and shall issue an NF approval letter to the individual or, if applicable, the individual's legal representative, in the form provided at N.J.A.C. 8:85 Appendix M, incorporated herein by reference, and shall enclose with the letter a copy of the PASRR determination.

(A)DDD and/or DMHS, as applicable, shall forward a copy of the PASRR determination to the individual, or the individual's legal representative, the appropriate State authority, admitting or referring NF, the individual's attending physician and the discharging hospital.

(2)If the PASRR results in a determination that the individual requires specialized services for MI or MR/RC, then NF placement is inappropriate and the Department shall 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 N.J.A.C. 8:85 Appendix N, incorporated herein by reference.

(A)DMHS and/or DDD, as applicable, shall forward a copy of the PASRR determination to the individual, or the individual's legal representative, the appropriate State authority, admitting or referring NF, the individual's attending physician and the discharging hospital, and shall 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 an 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/RC who may require PASRR, by consulting the "At-Risk Criteria for Nursing Facility Placement," also known as form LTC-D1, provided at N.J.A.C. 8:85 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 OCCO for a PAS and, if appropriate, to the CWA for determination of financial eligibility. The hospital should submit to the OCCO the completed Hospital Preadmission Screening Referral form, also known as form LTC-4, provided as N.J.A.C. 8:85 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 OCCO 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 N.J.A.C. 8:85 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 Level II evaluation, 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 N.J.A.C. 8:85 Appendix M and a completed HSDP in the form provided at N.J.A.C. 8:85 Appendix L, and the OCCO 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 OCCO shall mail a letter denying Medicaid authorization for NF placement in the form provided at N.J.A.C. 8:85 Appendix N to the individual or, if applicable, the individual's legal representative and shall mail a copy of the letter to the CWA.

(3)If the individual is clinically eligible for NF placement but PASRR Level II evaluation is required, the professional staff designated by the Department shall provide the individual or the individual's legal representative, the appropriate State authority, admitting or referring NF, individual's attending physician and the discharging hospital, with written notice of the necessity of PASRR in the form provided at N.J.A.C. 8:85 Appendix R, incorporated herein by reference, also known as form LTC-L6a, with respect to individuals with MI,

and in the form provided at N.J.A.C. 8:85 Appendix S, incorporated herein by reference, also known as LTC-L7a, with respect to individuals with MR/RC.

(4) Upon conclusion of PASRR, if PASRR Level II evaluation results in a determination that the individual does not require specialized services for MI or MR/RC, then the OCCO shall mail the original approval letter in the form provided at N.J.A.C. 8:85 Appendix M to the individual, or, as appropriate, to the individual's legal representative, the appropriate State authority, admitting or referring NF, individual's attending physician and the discharging hospital, and shall mail a copy of the executed approval letter and a completed HSDP in the form provided at N.J.A.C. 8:85 Appendix L to the referent.

(5) Upon conclusion of PASRR, if PASRR Level II evaluation results in a determination that the individual requires specialized services for MI or MR/RC, then the OCCO shall mail a letter denying Medicaid authorization for NF placement in the form provided at N.J.A.C. 8:85 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 an 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 N.J.A.C. 8:85 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 OCCO 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 shall 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 shall forward the LTC-2 form to the OCCO 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 an NF, or an individual with MI or MR/RC, to the OCCO for PAS and, if appropriate, to the CWA for a determination of financial eligibility by submitting to the OCCO 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 N.J.A.C. 8:85 Appendix H, incorporated herein by reference, and available for download at <http://nj.gov/health/forms/index.shtml>.

i. Upon receipt by the OCCO 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 shall 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 shall 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 OCCO shall mail either the approval letter in the form provided in N.J.A.C. 8:85 Appendix M, or the denial letter in the form provided in N.J.A.C. 8:85 Appendix N, to the individual or, if applicable, the individual's legal representative, and shall send a copy of the letter to the CWA.

ii. For individuals residing in the community with MI, professional staff designated by the Department shall 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 OCCO shall mail an executed denial letter in the form provided at N.J.A.C. 8:85 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 pursuant to N.J.S.A. 45:11-45 et seq. and the need to forward the form to the DMHS.

(3) If the PASRR Level II determination by the DMHS results in a determination that the individual requires specialized services for MI, then NF placement is not appropriate and the OCCO shall mail an executed denial letter in the form provided at N.J.A.C. 8:85 Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and the DMHS shall assist the individual in securing appropriate placement and/or services.

(4) If the PASRR Level II evaluation by the DMHS results in a determination that the individual does not require specialized services for MI, the OCCO shall mail the approval letter in the form provided in N.J.A.C. 8:85 Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and shall transmit a copy of the approval letter to the CWA.

iii.For individuals residing in the community with MR/RC, professional staff designated by the Department shall 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 OCCO shall mail, an executed denial letter in the form provided at N.J.A.C. 8:85 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 shall 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/RC, then NF placement is not appropriate and the OCCO shall mail an executed denial letter in the form provided at N.J.A.C. 8:85 Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative and the DDD shall 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/RC, the OCCO shall mail the approval letter in the form provided in N.J.A.C. 8:85 Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and shall transmit a copy of the approval letter to the CWA.

iv.In the case of an individual dually diagnosed with MI and MR/RC, 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/RC 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 OCCO, via the LTC-2 form, of the termination of NF services due to the beneficiary's:

1. Death while either in the NF or hospitalized;
2. Discharge to home or other community living arrangement;
3. Transfer to another NF; or
4. Ineligibility determination.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Former N.J.A.C. 10:63-1.8, Admission, transfer and readmission; general, repealed.

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Pre-Admission Screening (PAS), admission, and authorization". Rewrote the introductory paragraph of (a); in (a)3, substituted "an" for "a" and "MR/RC" for "MR", deleted a comma preceding "and HSDP", and inserted "N.J.A.C. 8:85"; added (a)4; in the introductory paragraph of (c), substituted "an" for "a" and "OCCO" for "LTCFO", and inserted "N.J.A.C. 8:85"; rewrote (d) and (e); in (h), substituted "MR/RC" for "MR"; in the introductory paragraph of (j), substituted "OCCO" for "LTCFO"; and recodified former (j)i through (j)iv as (j)1 through (j)4.

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N.J.A.C. 8:85-1.9

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.9 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In introductory paragraph (a), added "or transfer from another nursing facility"; in (a)2, substituted "LTCFO" for "MDO".

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.10 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Section was "Involuntary transfer initiated by the facility"; rewrote the section.

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N.J.A.C. 8:85-1.11

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 8:85-1.11. (Reserved)

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.11 and repealed by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Section was "NF authorization process".

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 8:85-1.12 Clinical audit and MDS verification

(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) In order to validate that the direct care component of the rate is supported by medical record documentation and accurately coded and submitted, the Department shall conduct a periodic MDS verification review, which shall:

1. Compare the MDS assessment coding with the corresponding medical record documentation to determine unsupported MDS assessments;
2. Determine the completeness and accuracy of the residents and MDS assessments identified on the resident roster; and
3. Determine the accuracy of the resident payment source listed on the resident roster.

(c) 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.

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

1. As a result of the clinical audits and MDS verifications, 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.

3.Findings from a clinical audit or an MDS verification shall be used to reduce an NF's per diem payment rate to reflect the audited costs, days, case mix index or other variables used in the rate setting process.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.12 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote introductory paragraph (b) and (b)1; in introductory paragraph (c), substituted "Department" for "Division".

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Clinical audit". Added new (b); recodified former (b) and (c) as (c) and (d); in (d)1, inserted "and MDS verifications"; and added (d)3.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.13 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Rewrote the section.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

History

HISTORY:

Amended by R.1997 d.231, effective June 2, 1997.

See: 29 N.J.R. 861(a), 29 N.J.R. 2561(b).

In (a)2, substituted "Effective July 1, 1996, reimbursement" for "Reimbursement", and inserted "90 percent of".

Recodified from N.J.A.C. 10:63-1.14 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.15 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Substituted "Department" for "Division" throughout; in (b), deleted "New Jersey State Department of Health and the".

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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:

i.For beneficiaries who are able to manage their funds, a family member must have authorization in writing from the beneficiary/authorized representative for a specific amount before funds are disbursed from the PNA.

ii.Beneficiaries who are unable to manage their funds should have representative payees appointed.

iii.Family members should withdraw funds only on presentation of receipts showing items purchased for the beneficiary, unless this appears to be a financial hardship for the family member.

iv.In cases where there is an outside representative payee, and the beneficiary appears to be denied access to his or her PNA funds, or personal items are not being purchased for him or her, the facility shall take steps to ensure that the beneficiary's right to his or her PNA benefits is restored. Such steps may include warning letters to the representative payee, use of the NF attorney, and/or

referrals to the Office of the Ombudsman for Institutionalized Elderly and the Social Security Administration. In such cases, the facility may wish to request representative payeeship.

9.When drawing checks or cash to make disbursements from the beneficiary's PNA account, either an original invoice or a signed receipt from the beneficiary or an authorized representative shall be retained by the facility and referenced to the beneficiary's account. The receipt must stipulate the use of the funds or specify the items purchased.

10.When the facility draws checks on behalf of a beneficiary or reimburses the petty cash fund, disbursements of PNA shall be segregated from the operating expenses of the facility. At the end of each month, the general ledger control account shall be charged for the total PNA disbursed and each beneficiary's subsidiary ledger account shall reflect the monthly disbursements on that beneficiary's behalf.

11.Accumulated interest is the property of the beneficiary. Although a beneficiary's PNA may not be used for banking service charges, interest from the account may be used for this purpose.

12.Upon discharge or transfer to another NF or other place of residence, the facility shall provide the beneficiary with a final accounting statement and a check in the amount of the beneficiary's close-out balance within seven working days of the transfer; however, a beneficiary transferred to another NF shall be given the option of authorizing the sending facility in writing to transfer any balance to the beneficiary's account at the receiving facility. The transfer of a PNA account from one facility to another shall be documented in writing, with a copy given to the beneficiary and/or his or her authorized representative. A beneficiary discharged or transferred shall have the right to the return of his or her personal property, such as, television, radio or other items.

13.Unclaimed PNA funds left behind by a discharged beneficiary who cannot be located or where the authorized representative cannot be located, shall be forwarded within 30 days to the Bureau of Administrative Control, Mail Code #6, PO Box 712, Trenton, New Jersey 08625-0712.

14.Within 10 days after the death of a Medicaid beneficiary, whether death occurred in the NF, in a hospital, or during a period of therapeutic leave, the NF shall send a written notice regarding the existence of PNA funds both to the CWA and the individual identified by the beneficiary as the person to contact. A NF shall exercise all reasonable efforts to locate and notify any family, representative payee or interested person acting on behalf of the deceased Medicaid beneficiary.

i.The facility shall advise the contact person or responsible person that any claims made for PNA funds must be directed to the NF. When no CWA claim exists, the executor(rix) or administrator(rix), upon presentation of a letter of administration from the County Surrogate's Office, must be issued a check made payable to the estate of the deceased Medicaid beneficiary for the PNA funds. A check for the funds shall not be issued unless a Surrogate's letter is presented, except when a beneficiary dies intestate, leaving no surviving spouse, and the total value of the

estate is less than \$ 5,000; in such case, an affidavit of administration in accordance with N.J.S.A. 3B:10-4 is acceptable.

ii.If there is an outstanding funeral bill which is deemed reasonable and there is no claim by the CWA or an executor/administrator, the NF may directly reimburse the funeral director from the PNA funds.

iii.If no claim for PNA funds is made to the NF within 30 days of death, a check made payable to the "Treasurer, State of New Jersey" shall be forwarded as follows:

Payee mail to:

Treasurer, State of New Jersey-Medicaid
Division of Revenue
Lock Box 656
160 S. Broad St. 1st Floor
Trenton, NJ 08625

Certified, courier, or FedEx to:

Treasurer, State of New Jersey-Medicaid
Division of Revenue
160 S. Broad St. 1st Floor
PO Box 656
Trenton, NJ 08628
Attn: Frank Clark.

The following information shall be included:

- (1)**An identification of the funds as unclaimed PNA funds of the deceased Medicaid beneficiary;
- (2)**Beneficiary's name;
- (3)**HSP (Medicaid) Case Number;
- (4)**Date of death; and
- (5)**Amount enclosed for that beneficiary.

iv.If a claim is received by the NF after the PNA funds have been forwarded to the Bureau of Administrative Control and within five years of the Medicaid beneficiary's death, the claim must be referred to the Bureau for processing. After five years, all claims received by the NF must be referred to the State Treasurer.

v.Any transactions involving distribution of a deceased Medicaid beneficiary's PNA funds must appear on the NF's record for audit purposes.

(g)Questions regarding personal needs allowance administration, for example, procedures, policy, or use of funds, should be directed to the Department:

Division of Long Term Care Services

PO Box 367

Trenton, New Jersey 08625-0367

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.16 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

Administrative change.

See: 44 N.J.R. 1701(a).

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85-1.17

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 8:85-1.17. Residents rights

(a)The NF shall ensure that each resident and his or her representative are informed of their rights upon admission and provided with a written statement of all resident rights, in accordance with 42 CFR 483.10 through 483.15, the Nursing Home Resident Rights Act, N.J.S.A. 30:13-1 et seq. and N.J.A.C. 8:39-4.1.

(b)The NF shall ensure that every resident who is entitled to Medicaid benefits shall receive a written statement of the services covered in the Medicaid per diem rate, those services required to be offered by the NF on an as-needed basis, and any charges not covered under the Medicaid program while in the facility.

(c)The NF shall notify each resident of his or her right under State law to make decisions concerning his or her medical care and his or her right to formulate an advance directive in compliance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., and the advance directive provisions of the Omnibus Reconciliation Act of 1990, effective December 1, 1991 and Department of Health and Senior Services licensing requirements at N.J.A.C. 8:39-9.5.

History

HISTORY:

Recodified from N.J.A.C. 10:63-1.17 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In (c), added "or her" following "his", substituted "N.J.S.A. 26:2H-53 et seq.," for "P.L. 1991, c.201", and added "and Senior Services".

End of Document

N.J.A.C. 8:85-1.18

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 8:85-1.18 Medicaid/Medicare

(a)The New Jersey Medicaid Program will reimburse for NF services provided to combination Medicare/Medicaid beneficiaries only after Medicare covered benefits have been fully utilized or when medically necessary services are not covered by the Medicare Program.

(Exceptions--see (f)1i below.)

1.A facility shall begin to bill Medicare for eligible residents immediately upon receipt of Medicare certification.

2.Failure by a facility to bill Medicare for Medicare/Medicaid eligible residents who meet the criteria for Medicare reimbursement for long-term care services, and who occupy Medicare certified beds may result in the termination of a facility's Medicaid provider agreement.

(b)Only skilled nursing facilities (SNFs), as defined in N.J.A.C. 8:85-1.2, certified by the Centers for Medicare & Medicaid Services (CMS) and the New Jersey Department of Health and Senior Services are eligible to be reimbursed by Medicare for services rendered consistent with all Medicare requirements.

(c)Medicare covers eligible beneficiaries needing post-hospital skilled nursing care when they are placed in Medicare certified facilities.

(d)Medicare-eligible residents shall be placed in Medicare certified beds. If no Medicare certified beds are vacant at the time a Medicare-eligible person is admitted, a nursing facility patient who is occupying a Medicare certified bed but who is not eligible for Medicare reimbursement, may be relocated to allow the newly admitted patient to occupy a Medicare certified bed. In accordance with 42 C.F.R. 483.10(o), such relocation shall only occur when the individual agrees to the relocation. The nursing facility shall provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer. If consent is not granted, Medicaid shall reimburse the nursing facility for a timely submitted claim reimbursable under Medicaid rules.

(e)When Medicare benefits are denied, terminated or exhausted, because of coverage limitations, Medicaid may be billed on behalf of eligible beneficiaries, provided that:

1.The services are allowable and provided within the standards and procedures established by the New Jersey Medicaid program as described in this manual. Medicaid shall reimburse a nursing facility if Medicare does not pay the claim and the claim is Medicaid reimbursable.

2.The certified facility provides written documentation of a denial of Medicare coverage:

i.The certified facility shall indicate for all Medicare eligible beneficiaries through status reports, that the effort was made to apply for Medicare reimbursement prior to Medicaid billing. Status reports affirming denial shall be obtained from the Medicare Fiscal Intermediary. Status reports shall consist of:

(1)A copy of form Inpatient Hospital and Skilled Nursing Facility Admission and Billing SSA-1453; or

(2)A notice of denial of coverage form Notice of Medicare Claim Determination SSA-1954 or form Notice of Medicare Claim Determination SSA-1955; or

(3)The facility statement of non-coverage, signed by an administrator or officer, which shall be accepted only under the limitation of benefits.

(f)Medicare Part A coinsurance may be paid by the New Jersey Medicaid Program, but the total combined Medicare/Medicaid reimbursement may never exceed the facility's Medicaid Nursing Facility rate. If the Medicaid beneficiary has available income during the coinsurance period of Medicare eligibility, it shall be used to offset the coinsurance charges, prior to billing Medicaid. New Jersey Medicaid will pay Part B Medicare insurance premiums for all eligible Medicare-Medicaid beneficiaries. Claims for Part B services shall be billed to Medicaid only after Medicare benefits have been exhausted. Medicare timely filing requirements shall be met prior to the reimbursement of coinsurance by Medicaid.

1.Coinsurance and deductible payment shall be made as follows:

i.Medicaid will not assume responsibility for payment of coinsurance for certain services under Part B Medical Insurance when the basis of payment is fee for service (for example, physicians or podiatrists). However, coinsurance is paid for certain other Part B Provider services where the basis for payment is not fee for service (for example, durable medical equipment), but only in those instances where the Medicare allowable reimbursement is less than the Medicaid established reimbursement for those items.

ii.Medicaid will assume responsibility for deductible payments for Part B Medical Insurance services.

History

HISTORY:

Amended by R.1998 d.177, effective April 6, 1998.

See: 29 New Jersey Register 4614(a), 30 New Jersey Register 1284(b).

In (a), made an internal reference change in the introductory paragraph, and added 1 and 2; inserted a new (d); recodified former (d) as (e), inserted a reference to denial of benefits in the introductory paragraph, and added a second sentence in 1; and recodified former (e) as (f).

Recodified from N.J.A.C. 10:63-1.18 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Substituted "beneficiary" for "recipient" throughout; rewrote (b).

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N.J.A.C. 8:85-2.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.1 Nursing facility services; eligibility

(a)Eligibility for nursing facility (NF) services will be determined by the professional staff designated by the Department, based on a comprehensive needs assessment that demonstrates that the beneficiary requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2.

1. Individuals requiring NF services may have unstable medical, emotional/behavioral and psychosocial conditions that require ongoing nursing assessment, intervention and/or referrals to other disciplines for evaluation and appropriate treatment. Typically, adult NF residents have severely impaired cognitive and related problems with memory deficits and problem solving. These deficits severely compromise personal safety and, therefore, require a structured therapeutic environment. NF residents are dependent in several activities of daily living (bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating).

i. Children requiring NF services exhibit functional limitations identified either in terms of developmental delay requiring nursing care over and above routine parenting or are limited in terms of specific age-appropriate physical and cognitive activities, functional abilities (ADL) or abnormal behavior, as demonstrated by performance at home, school or recreational activities.

(1) Children who have achieved developmental milestones within appropriate time frames and who require only well child care and/or treatment of acute, time limited illnesses or injuries shall not be eligible for NF services.

2. NF residents shall be those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse

treatment) unless the individual's clinical condition demonstrates that deterioration was unavoidable.

(b)All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health and Senior Services licensing rules at N.J.A.C. 8:39. Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

(c)NF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.1 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In introductory paragraph (a), substituted "professional staff designated by the Department", substituted "beneficiary" for "recipient" and changed reference to "N.J.A.C. 8:85-2.2"; in (a)1, added "(bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating)"; in (b), added "and Senior Services" and changed reference to "N.J.A.C. 8:85-3".

Amended by R.2007 d.391, effective December 17, 2007.

See: 38 N.J.R. 4795(a), 39 N.J.R. 5338(a).

In the introductory paragraphs of (a) and (a)1, substituted "that" for "which"; and in the introductory paragraph of (a)1, deleted the last two sentences.

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N.J.A.C. 8:85-2.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.2 Delivery of nursing services

(a)The NF shall provide 24-hour nursing services in accordance with the Department's minimum licensing standards set forth by the Standards for Licensure of Long-Term Care Facilities, N.J.A.C. 8:39, incorporated herein by reference, employing the service-specific case mix system to classify recipients with similar care requirements and resource utilization. The NF shall provide nursing services by registered professional nurses, licensed practical nurses and nurses aides based on the total number of residents multiplied by 2.5 hours per day; plus the total number of residents receiving each of the following services, as more fully described at (f) below:

| | | |
|----|--|--------------------|
| 1. | Wound care | 0.75 hour per day |
| 2. | Tube feeding | 1.00 hour per day |
| 3. | Oxygen therapy | 0.75 hour per day |
| 4. | Tracheostomy | 1.25 hours per day |
| 5. | Intravenous therapy | 1.50 hours per day |
| 6. | Respiratory services | 1.25 hours per day |
| 7. | Head trauma stimulation; and advanced neuromuscular or orthopedic care | 1.50 hours per day |

(b)The NF level of nursing care means services provided to Medicaid beneficiaries who are chronically or sub-acutely ill and require care for these entities, disease sequela or related deficits.

(c)The NF level of nursing care shall incorporate the principles of nursing process, which consists of ongoing assessment of the beneficiary's health status for the purpose of planning, implementing and evaluating the individual's response to treatment.

1. In his or her capacity as coordinator of the interdisciplinary team, the registered professional nurse, who has primary responsibility for the beneficiary, shall perform, beginning on the day of admission, a comprehensive assessment of the beneficiary to provide, communicate and record within the MDS: baseline data of physiological and psychological status; definition of functional strengths and limitations; and determination of current and potential health care needs and service requirements.

i. In addition to clinical observations and hands-on examination of the Medicaid beneficiary, the licensed nurse shall review the HSDP and any available transfer records. The assessment data shall be coordinated by the registered professional nurse with oral or written communication and assessments derived from other members of the interdisciplinary team and shall be consistent with the medical plan of treatment. The initial comprehensive assessment (MDS) shall be completed no later than 14 days after admission and on an annual basis thereafter. If there is a significant change in the beneficiary's status, the NF shall complete a full comprehensive assessment involving the MDS. The registered professional nurse shall analyze the data and utilize the resident assessment protocols (RAPs), or other screening tools as provided by the CMS RAI for completing the comprehensive assessment, to focus problem identification, structure the review of assessment information and develop an interdisciplinary care plan that documents specific interventions unique to the individual, which define service requirements and facilitate the plan of treatment.

2. The interdisciplinary care plan shall identify and document the beneficiary's problems and causative or contributing factors and is derived from the comprehensive assessment. The plan shall be coordinated and certified by the registered professional nurse with active participation of the Medicaid beneficiary and/or significant other. The scope of the plan shall be determined by the actual and anticipated needs of the Medicaid beneficiary and shall include: physiological, psychological and environmental factors; beneficiary/family education; and discharge planning. The care plan shall be a documented, accessible record of individualized care which reflects current standards of professional practice and includes:

i. Identified problems (needs) and contributing factors;

ii. Specific and measurable objectives (outcomes) which provide a standard for measurement of care plan effectiveness;

iii. The plan of care shall emphasize interventions which prevent deterioration, maintain wellness and promote maximum rehabilitation; and

iv. The initial interdisciplinary care plan shall be completed and implemented within 21 days of admission and shall be reviewed regularly and revised as often as necessary, according to all significant changes in a beneficiary's condition and to attainment of and/or revisions in objectives as indicated. Review and appropriate revision shall be done at least every three months and whenever the clinical status of the beneficiary changes significantly or requires a change in service provision.

3. Implementation of the interdisciplinary care plan and delivery of nursing care shall be documented within nursing progress (clinical) notes, which shall establish a format for recording significant observations or interaction, unusual events or responses, or a change in the Medicaid beneficiary's condition, which requires a change in the scope of service delivery. Specific reference shall be made to the beneficiary's reactions to medication and treatments, rehabilitative therapies, additional nursing services in accordance with N.J.A.C. 8:85-2.2(a), observation of clinical signs and symptoms, and current physical, psychosocial and environmental problems. Nursing entries shall

be made as often as necessary, based on the Medicaid beneficiary's condition and in accordance with the standards of professional nursing practice.

4.Assessment review is the process of ongoing evaluation of health service needs and delivery. Nursing actions shall be analyzed for effectiveness of care plan implementation and achievement of objectives. The registered professional nurse, along with the Medicaid beneficiary and/or significant other, shall participate with the team in the ongoing process of evaluation, reordering priorities, setting new objectives, revision of plans for care and the redirection of service delivery.

i.The assessment review process shall be conducted quarterly. Conclusions shall be documented on the MDS quarterly review, and the interdisciplinary care plan shall be updated to provide a comparison of the Medicaid beneficiary's previous and present health status, and to outline changes in service delivery and nursing interventions. The assessment review shall identify the effectiveness of, and the Medicaid beneficiary's response to, therapeutic interventions, and, whenever possible, the reason for any ineffectiveness in beneficiary responses.

(d)Restorative nursing is a primary component in the NF level of nursing care. Restorative nursing addresses preventable deterioration and is directed toward assisting each beneficiary to attain the highest level of physical, mental, emotional, social and environmental functioning. Restorative nursing functions shall include:

- 1.**Supervision, direction, assistance, training or retraining in all phases of activities of daily living to promote independence or growth, and to develop or restore function to the extent the individual is able (bathing, dressing, toileting, transfers and ambulation, continence, and feeding);
- 2.**Discharge planning which focuses on assessment of the caregiving potential of the resident, family or significant other. The nurse shall, along with other members of the interdisciplinary team, extend the assessment beyond the needs of the resident to include assessment of the caregivers' ability to provide long-term care and their need for information on normal growth, development or aging; care needs; medication and treatment; home safety and the need for additional supports, both formal and informal, in preparation for the resident's return to the community;
- 3.**Proper positioning of the individual in bed, wheelchair or other accommodation to prevent deformities and pressure sores;
- 4.**Program of bowel and bladder retraining for incontinence, in accordance with the individual's potential for restoration;
- 5.**Range of motion exercises, active and passive, as necessary;
- 6.**Follow-up care as required for physical therapy, occupational therapy and/or speech-language pathology services;
- 7.**Follow-up care as required for uncomplicated plaster care; assistance with adjustment to and use of prosthetic and/or orthotic devices;
- 8.**Routine care and maintenance of ostomies (that is, cleansing and appliance change and instruction for self care);

9.Resident education relative to health care, special diet, and, if ordered by the physician, self-administration of medication;

10.Encouragement of resident participation in, and monitoring resident response to, individual or group activities and therapies for psychosocial maintenance and restoration; and

11.In a NF providing care to children, the application of the principles of growth and development in planning, implementing and evaluating care needs; consideration of the child's physical and developmental functioning with respect to his/her need for recreational and educational stimulation and growth; and application of behavior modification techniques in the management of developmental and disability-related behavior problems.

(e)The 2.5 hours of nursing care provided shall also include, but not be limited to, the following nursing procedures, therapies and activities:

1.Safe and appropriate administration of medications;

2.Emergency care (for example, oxygen, injections, resuscitation);

3.Observation, recording, interpretation and reporting of vital signs, height and weight;

4.Intake and output recording, as clinically indicated;

5.Catheter care including intermittent or continuous bladder irrigations, intermittent catheterizations, and use of other drainage catheters;

6.Preparations for laboratory procedures and collection of laboratory specimens;

7.Telephone pacemaker or electrocardiogram checks;

8.Terminal illness management, when there is need for supportive services and intensive personal care;

9.Heat or cold treatments as ordered by the physician;

10.Risk determination for pressure sores using a standardized assessment instrument and implementation of necessary preventive measures as clinically indicated (for example, mattress overlays or cushions, positioning schedule, range of motion, nutrition support, skin care and skin checks);

11.Care of Stage I and II pressure sores, as follows:

i.A Stage I pressure sore is an area of redness which does not respond to local circulatory stimulation. It involves the epidermis. No break in the skin is evident;

ii.A Stage II pressure sore is a partial thickness, loss of skin layers with epidermis and possibly dermis involvement. A shallow ulcer or blister appears, and the site is free of necrotic tissue;

iii.An individual who enters the NF without pressure sores should not develop them unless the individual's condition demonstrates pressure sores were unavoidable. Treatment of superficial skin tears, wounds, excoriations and lesions shall be included in the 2.5 hours of care;

12.The long-term care of a simple stabilized tracheostomy with minimal care and supervision by licensed staff;

13.Uncomplicated administration of respiratory therapies requiring minimal staff assistance, direction, and supervision;

14.Protection of individuals through the appropriate use of universal precautions, in accordance with Centers for Disease Control guidelines published in the Morbidity and Mortality Weekly Report, volume 38, number 5-6 (Centers for Disease Control, Atlanta, GA 30333);

15.Appropriate use of restraints (physical and/or chemical), in accordance with the physician's order and N.J.A.C. 8:39 licensure standards, and clinically appropriate measures to guarantee the safety of individuals (for example, side rails);

16.Observation, supervision and recording of basic nutritional states for maintenance of current health status and prevention of deficiencies;

17.Observation, supervision and instruction concerning special dietary requirements during ongoing adjustment to treatment regimen for diagnosed medical conditions;

18.Nursing treatment, observation and/or direction of mental status impairment which necessitates nursing supervision and intervention (for example, marked confusion and/or disorientation in one, two, or three spheres (time, place and/or person), marked memory loss, severe impairments in judgment); and

19.Emotional support and counseling on an ongoing basis, and during adjustment to impaired physical and mental states, including observation for changes in affect and mood which may require special precautions and/or therapies.

(f)Nursing services requiring additional nursing hours pursuant to (a)1 through 7 above, in excess of those services included in NF level of nursing care as that term is described in (b) through (e) above, are described at (f)1 through 7 below. An individual beneficiary may require one or more additional nursing services, however, each category of additional nursing service may only be counted once for each individual beneficiary.

1.Wound care (0.75 hour per day), which includes, but is not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites. In this category are Stage II pressure sores encompassing two or more distinct lesions on separate anatomical sites, Stage III and Stage IV pressure sores.

i.Tube site and surrounding skin related to ostomy feeding is not to be counted as an additional nursing service unless there are complicating factors such as: exudative, suppurative or ulcerative inflammation which require specific physician prescribed intervention provided by the licensed nurse beyond routine cleansing and dressing.

ii.Stage III and Stage IV are defined as follows:

(1)Stage III. The wound extends through the epidermis and dermis into the subcutaneous fat and is a full thickness wound. There may be inflammation, necrotic tissue, infection and drainage and undermining sinus tract formation. The drainage can be serosanguinous or purulent. The area is painful.

(2)Stage IV. The pressure wound extends through the epidermis, dermis, and subcutaneous fat into fascia, muscle and/or bone. Eschar, undermining, odor and profuse drainage may exist.

(3)Other wounds which may be categorized under wound care as defined in (f)1 above include:

(A)Open wounds which are draining purulent or colored exudate or which have a foul odor present and/or for which the individual is receiving antibiotic therapy;

(B)Wounds with a drain or T-Tube;

(C)Wounds which require irrigation or instillation of a sterile cleansing or medicated solution and/or packing with sterile gauze;

(D)Recently debrided ulcers;

(E)Wounds with exposed internal vessels or a mass which may have a proclivity for hemorrhage when dressing is changed (for example, post radical neck surgery, cancer of the vulva);

(F)Open wounds, widespread skin disease or complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies; and

(G)Complicated post-operative wounds which exhibit signs of infection, allergic reactions or an underlying medical condition that affects healing.

2.Tube feeding (1.00 hour per day), which includes nasogastric tubes, percutaneous feedings and the routine care of the tube site and surrounding skin of the surgical gastrostomy, provided that all non-invasive avenues to improve the nutritional status have been exhausted with no improvement; NF staff shall document in the clinical record the non-invasive measures provided, the individual's poor response and the medical condition for which the feedings are ordered; and the feedings are providing the individual with either 51 percent or more calories per day, or 26 to 50 percent calories and 501 milliliters or more of enteral fluid intake per day.

i.Feeding tubes that do not meet the dietary administration and nutritional support criteria as stated in (f)2i or ii above are covered under NF level of nursing care and are not counted as an additional nursing service.

3.Oxygen therapy (0.75 hours per day), which includes the provision of episodic oxygen therapy to increase the saturation of hemoglobin (Hb) without risking oxygen toxicity in beneficiaries with airway obstructive conditions such as asthma, chronic obstructive pulmonary disease or heart failure. The beneficiary requires frequent, recurring, and ongoing pulse oximetry monitoring. The licensed nurses assess lung function and the beneficiary's symptoms that require intervention by the physician, physician assistant or advanced practice nurse.

4.Tracheostomy (1.25 hours per day), which includes:

i.New tracheostomy sites;

ii.Complicated cases involving either symptomatic infections or unstable respiratory functioning; or

iii.Frequent, recurring, and ongoing suctioning.

5.Intravenous therapy (1.50 hours per day), which includes (b)5i, ii, or iii below, provided that, when clinically indicated, intravenous medications are appropriately and safely administered within prevailing medical protocols; and, if intravenous therapy is for the purpose of hydration, NF staff shall document in the clinical record all preventive measures and attempts to improve hydration orally, and the individual's inadequate response.

i.The administration and maintenance of clinically indicated therapies by the NF, as ordered by the physician, such as total parenteral nutrition, clysis, hyperalimentation, and peritoneal dialysis;

ii.The administration of fluids or medications by the NF, as ordered by the physician, by means of lines or ports such as central venous lines, Hickman/Broviac catheters, or heparin locks and the flushing and dressing thereof; or

iii.The flushing and dressing of lines or ports such as central venous lines, Hickman/Broviac catheters, or heparin locks, by the NF, as ordered by the physician, for an identified treatment purpose and usage timeframe.

6.Respiratory services (1.25 hours per day), which includes the provision of respiratory services as to which the individual is dependent upon licensed nursing staff to administer, such as positive pressure breathing therapy, Bilevel Positive Airway Pressure (BiPAP), Continuous Positive Airway Pressure (CPAP) or aerosol therapy. The use of hand-held inhalation aerosol devices, commonly referred to as "puffers", is not included in this add-on service.

7.Head trauma stimulation; and advanced neuromuscular or orthopedic care (1.50 hours per day), as follows:

i.Care of head trauma is directed toward individuals who are stable (have plateaued) and can no longer benefit from a rehabilitative unit or unit for specialized care of the injured head. Individuals shall have access to and periodic reviews by such specialists as a neurologist, neuropsychologist, psychiatrist and vocational rehabilitation specialist, in accordance with their clinical needs. There shall also be contact with appropriate therapies, such as physical therapy, speech-language pathology services and occupational therapy. The distinguishing characteristic for add-on hours for head trauma is the necessity for ongoing assessment and follow-up by licensed nursing personnel focusing on early identification of complications, and implementation of appropriate nursing interventions. Nursing protocols may be initiated which are specifically designed to meet individual needs of head injured individuals. The nurse may also supervise a coma stimulation program, when this need is identified by the interdisciplinary team.

ii.Advanced neuromuscular care needs will be identified by the physician for individuals during an unstable episode or where there is advanced and progressive deterioration in which the individual requires observation for neurological complications, monitoring and administration of medications or nursing interventions to stabilize the condition and prevent unnecessary regression.

iii.Advanced orthopedic care is the care of plastered body parts with a pre-existing peripheral vascular or circulatory condition requiring observations for complications and monitoring and administration of medication to control pain and/or infection. Such care also involves additional measures to maintain mobility; care of post-operative fracture and joint arthroplasty, during the immediate subacute post-operative period involving proper alignment; teaching and counseling and follow-up to therapeutic exercise and activity regimens. Individuals in this group shall be identified by the physician as needing advanced orthopedic care. If the requirement for advanced orthopedic care exceeds 30 days, clinical need must be demonstrated and clearly documented by the interdisciplinary team.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.2 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In the introductory paragraph of (c), inserted a comma following "process"; in the introductory paragraph of (c)1, and in (c)1i and (c)4i, substituted "MDS" for "SRA" throughout; and in (c)1i, inserted ", or other screening tools as provided by the CMS RAI for completing the comprehensive assessment,", and substituted "that" for "which".

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N.J.A.C. 8:85-2.3

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.3 Physician services

(a)General requirements for physician services shall be as follows:

- 1.Each Medicaid beneficiary's care shall be under the supervision of a New Jersey licensed attending physician chosen by, or agreed to by, the Medicaid beneficiary, or if the beneficiary is incompetent, by the family or legal guardian.
- 2.In a NF providing care to children, the attending physician shall be board certified/eligible by the American Board of Pediatrics or the American Board of Family Practice.
- 3.The NF shall maintain arrangements that assure that the services of a New Jersey licensed physician who can act in case of emergency, are continuously available.

(b)Requirements for a medical director shall be as follows:

- 1.The NF shall retain, pursuant to a written agreement, a physician licensed under New Jersey law to serve as Medical Director on a part-time or full-time basis as is appropriate for the needs of the residents and the size of the facility. The Medical Director shall be responsible for the overall development of medical policies and coordination of the medical care in the facility to ensure the adequacy and appropriateness of medical services provided to beneficiaries and to monitor the health status of employees.
 - i.In a NF providing care exclusively to children, the medical director shall be certified/eligible by the American Board of Pediatrics or the American Board of Family Practice.
- 2.The duties of the medical director shall include, but not be limited to, the following:
 - i.Participation in the development of written policies, rules and regulations which are approved by the governing body of the facility;
 - ii.Delineation of the responsibilities of the attending physician(s) and ensuring that visits by medical consultants occur as needed;
 - iii.Acting as liaison between administration and medical staff for improving services and ensuring the carrying out of responsibilities of the medical staff;

- iv.** Surveying the execution of resident care policies, which includes a periodic evaluation of the adequacy and appropriateness of the services of health professional and supporting staff and monitoring the health status of the facility's employees;
- v.** Participation in the review of incidents and accidents that occur on the premises to identify hazards to health and safety of employees and residents. The Medical Director is given appropriate information to help ensure a safe and sanitary environment for residents and personnel;
- vi.** Ensuring that the medical regimen is incorporated in the resident care plan;
- vii.** Participation in the facility's quality assurance program through meetings, interviews and/or preparation or review of reports regarding infection control, pharmaceutical services, credentials, resident care, etc.;
- viii.** Collaboration with administration in the planning of educational programs for facility staff;
- ix.** Reviewing written reports of surveys and inspection and making recommendations to the administrator;
- x.** Participation in special projects, such as medical evaluation studies;
- xi.** Negotiating and resolving problems with the medical community;
- xii.** Responding quickly and appropriately to medical emergencies that are not handled by another attending physician; and
- xiii.** Ensuring that, for each Medicaid beneficiary, there is a designated primary and alternate physician who can be contacted when necessary.

(c) Requirements for an attending physician shall be as follows:

- 1.** Initial medical findings and physician's orders;
 - i.** There shall be available to the NF, prior to, or at the time of admission, resident information that includes medical history, diagnosis, current medical findings, medical plan of care and rehabilitation potential.
 - ii.** If the resident is transferred from another health care facility, a transfer summary of the course of treatment including findings of diagnostic services shall accompany the resident. If the transfer summary information is not available in writing in the facility upon admission of the resident, it shall be obtained by the facility after admission.
 - iii.** There shall be orders from a physician for the immediate care of the resident, to include, at a minimum, medications, dietary needs, hygiene, level of activity, and special therapies, if applicable. A current health facility discharge summary containing the information is acceptable.
 - (1)** If medical orders for the immediate care of the resident are unobtainable at the time of admission, the physician with responsibility for emergency care shall give temporary orders.

(2)Each resident shall be examined by a physician within five days before, or 48 hours after admission.

2.The attending physician shall also be responsible for initial and ongoing medical evaluation, as follows:

i.The medical assessment of the Medicaid beneficiary shall begin at the time of admission to a NF and shall be the foundation for the planning, implementation, and evaluation of medical services directed toward the care needs of the resident.

ii.The medical assessment shall consist of the complete, documented, and identifiable appraisal (from the time of admission to discharge) of the Medicaid beneficiary's current physical and psychosocial health status. The medical assessment shall be utilized to determine the existing and potential requirements of care. The evaluation of the data obtained from the medical assessment shall lead to the development of the medical services portion of the interdisciplinary care plan. The assessment data shall be available to all staff involved in the care of the resident.

iii.The tools utilized in the assessment process shall include a complete history and physical examination, eliciting medically defined conditions and prior medical history, admission form(s), transfer form(s), HSDP, and data from other members of the interdisciplinary team.

iv.Other Medicaid recipient data utilized should include:

(1)Clinical physical and psychological symptoms and signs;

(2)Capabilities to perform functional activities of daily living;

(3)Sensory (hearing, speech, and vision) and physical impairments;

(4)Medical necessity of additional nursing services, in accordance with N.J.A.C. 8:85-2.2;

(5)Nutritional status and requirements;

(6)Special treatments or procedures (including laboratory and other diagnostic services);

(7)Psychosocial status;

(8)Dental condition;

(9)Activities potential;

(10)Rehabilitation potential;

(11)Cognitive status;

(12)Drug therapy;

(13)Safety requirements;

(14)Attention to comfort and dignity; and

(15)Plans of alternative care, when applicable.

v. In addition to the requirements in (c)2iv above, medical evaluations of children in a NF shall include the following:

- (1) Assessment of developmental status;
- (2) Measurement and recording of head circumference until the age of 24 months;
- (3) Measurement and recording of blood pressure, from age three;
- (4) Assessment of immunization status and administration of appropriate immunizations according to the recommendations of the Academy of Pediatrics;
- (5) Hemoglobin determination once during each of the following times: six to eight months, two to six years, and 10 to 12 years of age;
- (6) Urinalysis--a minimum of once between age 18 and 24 months and once between 13 and 15 years of age;
- (7) Tuberculin testing once during each of the following times: nine to 12 months, four to six years, and 10 to 15 years of age; and
- (8) Lead screening (EP Test) upon admission.

vi. As an active member of the interdisciplinary team, the attending physician shall:

- (1) Identify and document the medical needs of the Medicaid beneficiary;
- (2) Be attentive to and develop individualized preventive, maintenance, restorative and/or rehabilitative medical interventions in relation to the physical and psychosocial needs identified in order to prevent deterioration, maintain wellness and promote maximum development or restoration;
- (3) Be observant of clinical signs and symptoms of the Medicaid beneficiary;
- (4) Perform, annually, a complete physical examination, as the medical component of the comprehensive resident assessment;
- (5) Periodically evaluate and be cognizant of the Medicaid beneficiary's total clinical record including the interdisciplinary care plan and facilitate necessary changes as medically indicated;
- (6) Identify and document the effectiveness of, and the Medicaid beneficiary's response to, therapeutic intervention such as medications, treatment and special therapies, and, where possible, the reason for any ineffectiveness in the Medicaid beneficiary's responses.

3. Physician progress notes shall:

- i. Be maintained in accordance with accepted professional standards and practices as necessitated by the Medicaid beneficiary's medical condition;
- ii. Be a legible, individualized summary of the Medicaid beneficiary's medical status and reflect current medical condition, including clinical signs and symptoms; significant change in physical or mental conditions; response to medications,

treatments, and special therapies; indications of injury including the date, time and action taken; medical necessity for extent of change in the medical treatment plan; and

iii. Be written, signed, and dated at each visit.

4. Physician orders shall be completed as follows:

i. Orders concerning medications and treatment shall be in effect for the specified number of days indicated by the physician, but in no case shall exceed a period of 60 days. Vague and blanket orders shall not be acceptable. The physician shall review all orders and re-confirm in writing with signature and date, when any orders are continued.

ii. Stop orders shall conform with the standards of the Formulary Committee of the facility.

5. Physician visits shall be conducted as follows:

i. All required physician visits shall be made by the physician personally, or a physician assistant or nurse practitioner, as permitted by State law.

(1) For the first 90 days, the Medicaid beneficiary shall be visited and examined every 30 days. Thereafter, with written justification, the interval between visits may be extended for up to 60 days.

(2) Additional visits shall be made when significant clinical changes in the Medicaid beneficiary's condition require medical intervention.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.3 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.4 Rehabilitative services

(a)Rehabilitative services include physical therapy, occupational therapy and speech-language pathology services provided by a qualified therapist for the purpose of attaining maximum reduction of physical or mental disability and restoration of the resident to his or her best functional level. Rehabilitative services shall be made available to Medicaid beneficiaries as an integral part of an interdisciplinary program. Rehabilitative services shall not include physical medicine procedures administered directly by a physician, or physical therapy, which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a qualified therapist.

1.If the attending physician orders an evaluation for physical, speech-language pathology services or occupational therapy, an appropriately qualified therapist shall perform an assessment to determine the need for services. The therapist shall complete a written report of therapy recommendations within 14 days of the physician's order and shall include the report in the clinical record, for review by the attending physician.

2.Rehabilitative treatment shall be provided under the direct supervision and in the presence of a qualified therapist or physiatrist, only upon the written signed order of the physician who shall indicate modality and frequency and duration of treatments. The attending physician shall evaluate each resident's response to therapeutic services on a monthly basis. Continuance of said services shall be based on documentation of a potential for significant functional improvement within a reasonable time frame.

i.Rehabilitation therapy services shall be integrated with medical, nursing, recreational and social services to promote development or restoration of the resident to his/her maximum potential and reviewed in conjunction with other periodic reviews of the interdisciplinary care plan.

3.Rehabilitative services shall be provided by qualified therapists employed by or under contract to:

i.An approved home health agency;

- ii. A licensed or accredited general or special hospital;
- iii. An approved independent outpatient health facility; or
- iv. An NF.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.4 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In introductory paragraph (a), added "or her" following "his" and substituted "beneficiaries" for "recipients".

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In the introductory paragraph of (a), deleted a comma following "occupational therapy", and inserted a comma following "physical therapy"; in (a)3iv, substituted "An" for "A"; and deleted (a)4.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.5 Resident activities

(a)An ongoing resident activities program shall be established as an adjunct to the treatment program and an integral component of the interdisciplinary plan of care. The program shall be a planned schedule of appropriate social, physical, spiritual, psychological, leisure, cognitive, vocational and educational activities designed to meet the needs, interests, and behaviors of all residents, whether ambulatory, chair bound, or bedfast. In a facility providing care to children, activities programming shall be geared to the child's developmental and behavioral needs.

(b)Activities shall enable the residents to maintain a sense of usefulness and self-respect, and when possible, help to prevent regression. Activities shall encourage development or restoration to self-care and resumption of normal activities, stimulate and maximize the total functional ability of the resident and assist the resident to integrate into the social life of the facility. Families and friends of the resident shall be encouraged to accompany the resident to activities.

(c)Outside community resources, such as the Commission for the Blind, Office of Education, Divisions of Developmental Disabilities and Vocational Rehabilitation shall be accessed to develop needs-specific activities. Community outreach shall be done to encourage community groups to participate in programs in the facility. Residents also shall be encouraged to participate in programs in the community.

(d)Resident activities staffing requirements are as follows:

- 1.**The resident activities director shall meet the qualifications required by N.J.A.C. 8:39-7, Mandatory Patient Activities. In a facility providing care exclusively to children, the resident activities director who does not possess a baccalaureate degree shall have one year of the required three years of experience in a recreational program for children;

- 2.**The facility shall appoint a resident activities director who shall provide resident activity services in the facility on an average of 45 minutes per week per resident. Additional resident activity staff time shall be provided at a ratio of no less than 1:53 residents; and

3.The use of volunteers should be encouraged as adjuncts to staff. Volunteers should be trained and supervised in the performance of their duties by qualified staff.

(e)Scheduling requirements are as follows:

- 1.**A monthly schedule of activities in large print shall be conspicuously posted so that residents and staff are aware of daily programs;
- 2.**There shall be a diversity of activities seven days per week and during at least two evenings per week. Evening activities shall be scheduled after the evening meal; and
- 3.**The Residents' Council shall have the opportunity to meet at least monthly. All residents shall be given the opportunity to have input into programming.

(f)Space and equipment requirements are as follows:

- 1.**Sufficient space shall be provided for group activities and for each resident's individual use. Activity areas shall be accessible to all residents. Programs shall be provided on the resident units as well as general activity areas;
- 2.**Community social and recreational facilities shall be utilized for those able to do so. Transportation shall be provided to and from destinations in the community;
- 3.**Adequate indoor and outdoor recreational areas shall be provided with sufficient equipment and materials available to support ongoing programs as well as self-directed activities; and
- 4.**In a facility providing care to children, a safe, handicapped accessible outdoor play area shall be provided.

(g)Resident planning requirements are as follows:

- 1.**Activities staff shall be integral members of the interdisciplinary team and shall participate in all resident care conferences and quarterly reviews. Resident activities staff shall have input into the assessment;
- 2.**Activities staff shall conduct an initial assessment of activity needs within 14 days after the date of admission. The assessment shall include the resident's current functioning, past lifestyle, interests, skills, employment, hobbies, organizational memberships and religious preferences. This information shall form the basis for the activities component of the MDS;
- 3.**The activities staff shall be aware of each resident's physical and medical limitations and restrictions, so that activities participation is coordinated with the treatment plan;
- 4.**A plan for the resident's activities program shall be formulated, with the active participation of the resident, if possible. Resident goals shall be developed as an outcome of the MDS and in conjunction with the interdisciplinary care plan;
- 5.**Progress towards goals shall be evaluated with the resident at least quarterly in conjunction with the interdisciplinary review of the care plan. If a resident's functional status changes, resident activity staff shall review the activity plan and make revisions of goals, if necessary;

6. Residents shall be encouraged to participate in a variety of activities. Outreach efforts to involve residents in activities programs shall be the responsibility of all staff;

7. All staff of the facility shall be trained at least yearly in the value of an activities program for overall effective resident care and shall encourage participation in activities; and

8. On readmission after a period of hospitalization, an activities worker shall review the resident's functioning and shall participate in a reassessment, if a significant change has occurred.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.5 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In (d)1, (e)1, (f)1, (f)2, (g)1, (g)3, (g)4, (g)5, (g)6 and (g)7, substituted a semicolon for a period at the end; in (d)2, (e)2, (f)3 and (g)7, substituted "; and" for a period at the end; in (g)2, deleted a comma following "organizational memberships"; and in (g)2 and (g)4, substituted "MDS" for "SRA".

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.6 Social services

(a) Social work services shall have as their fundamental purpose the enhancement of a resident's sense of well-being and control over his life to the fullest extent possible. Social work interventions shall be geared to the resident's strengths, regardless of the extent of disability and shall be designed to enhance coping skills. Social work services shall help residents make the fullest use of nursing facility life, and shall assist residents in discharge to community living.

(b) Social workers shall assist residents with the emotional reactions to pain and functional loss, interpersonal conflicts, fear of death, and other issues impacting on the quality of life. Supportive intervention and encouragement shall be provided. The social worker collaborates with other staff to maximize opportunities for choice and individual expression. Social workers shall monitor a resident's concrete and personal needs and shall serve as primary advocates for the resident in the NF.

(c) Social work services shall not include:

1. Clerical or billing activity;
2. Public relations activity that does not relate to social work services; or
3. Medical records monitoring responsibilities.

(d) Social services staffing and qualifications shall be as follows:

1. Social work services shall be provided in accordance with accepted professional practice by persons who meet the qualifications for social worker as defined in the Social Workers' Licensing Act of 1991 N.J.S.A. 45:15BB-1 et seq. and the licensure requirements of N.J.A.C. 8:39-39. In a NF providing care to children, it is recommended that social service staff receive consultation and training in social care for children; and
2. The facility shall provide a minimum of one full-time equivalent social worker for every 120 residents. In a facility with more than 120 residents, one social worker shall coordinate the work of the department.

(e) Social services assessment and care planning shall be as follows:

- 1.**The social worker shall meet with the resident and family prior to or following admission and shall conduct a social assessment. The social assessment shall be completed within 14 days of admission and shall provide the basis for social service input into the MDS. The assessment shall gather sufficient information to provide an accurate understanding of the individual and shall include the following:
 - i.**Current problem areas, factors that led to placement, and reactions to placement by the resident and family;
 - ii.**Lifestyle and living arrangements before placement;
 - iii.**Family composition, place of birth, marital history, number and location of children;
 - iv.**Social history, which includes personality factors, adaptation to change and disability, interest, religious ties, community activities, medical and psychiatric history, substance abuse; and
 - v.**Discharge criteria;
- 2.**As an integral member of the interdisciplinary team, the social worker shall have active input into the completion of the MDS. The social worker shall attend resident care conferences and quarterly reviews;
- 3.**Resident goals shall be developed as an outcome of the MDS and in conjunction with the interdisciplinary care plan. The resident and family shall be included in the development of goals, if possible;
- 4.**Reassessment of the resident's social needs shall be done annually in conjunction with the interdisciplinary team's review of the MDS. Any new social information shall be recorded in the progress notes;
- 5.**Expectations regarding potential discharge shall be discussed fully with all residents and families on admission. The special needs of residents identified as only needing short term placement (Track II) during pre-admission screening shall be discussed with the resident and family on admission. The family's criteria for discharge shall be fully explored and goals for discharge shall be incorporated into the interdisciplinary care plan;
- 6.**Progress towards goals shall be reviewed with the interdisciplinary team quarterly, or when significant changes occur. Residents and families shall be included in the interdisciplinary care plan review, if possible. Goals shall be based on a current review of resident and family needs and the existing problems to be addressed, as reflected in the current MDS;
- 7.**The social worker shall remain familiar enough with each resident to have an understanding of each resident's psycho-social function and to provide assistance as needed;
- 8.**The social worker shall document important or unusual events and other circumstances which require social service intervention;

9.The record shall reflect the resident's current psycho-social functioning and social work interventions;

10.On readmission of a resident after a period of hospitalization, the social worker shall review the resident's functioning and participate in a reassessment if a significant change has occurred. If a new chart is opened on readmission, a copy of the original social assessment shall be included; and

11.The resident's written consent (or that of a responsible person acting on his or her behalf) shall be obtained before social service information is transmitted to an outside agency or individual. The consent form shall be on the resident's chart. All personnel having access to the record shall be trained to appreciate its confidential nature.

(f)Social services consultation shall be as follows:

1.The social worker shall provide consultation services to residents and family members at the time of admission;

2.Consultation shall be given to the resident when the need arises, upon referral, or when the resident requests it. Situations which may require consultation include problems in adjusting to functional limitations and losses and decline in cognitive functioning involving loss of memory, confusion, and disorientation. Social work consultation may also be used to help residents deal with depression, anxiety, and lack of motivation and other problems affecting interpersonal relationships, such as aggressive or self-isolating behavior;

3.The social worker shall provide crisis intervention when medical or personal crises occur, or when there is a death of a family member or other significant person. Consultation shall also be offered when residents require assistance in mourning losses that occur within the NF;

4.Social work intervention shall be provided when residents exhibit behavior problems, resistance to care, roommate conflicts, or other adjustment difficulties;

5.The social worker shall encourage residents to participate in their treatment plans and activities within and outside the facility, and to form satisfying and appropriate friendships with other individuals in the NF; and

6.The social worker shall provide consultation to staff when interpersonal conflicts or behavior problems occur among residents or between residents and staff.

(g)Social work liaison services shall be as follows:

1.The social worker shall make frequent rounds in the NF, in order to maintain contact and to be accessible to residents who may require or be seeking assistance, and to maintain good communication with other staff;

2.Liaison contact with families shall be maintained by the social worker throughout a patient's stay. The frequency of contact shall depend on the resident's and family's needs;

- 3.**The social worker shall be active in interpreting facility policies and procedures to the resident and his family during the initial period following admission. Questions, problems and complaints shall be addressed promptly;
- 4.**The social worker shall act on a physician's order for a social service consultation within two working days;
- 5.**The social worker shall assist in identifying residents who may be in need of psychological or psychiatric intervention;
- 6.**The social worker shall assist staff in understanding the resident's personal situation and background in order to enhance the ability of staff to deal with the resident appropriately;
- 7.**The social worker shall deal with problems concerning family visitation and support; and
- 8.**The social worker shall serve as a resource to assist families with social service needs and to locate other agencies for assistance.

(h)Social work supportive services shall be as follows:

- 1.**The social worker shall ensure that the resident has sufficient clothing and other personal items and that the resident's basic needs are being met;
- 2.**The social worker shall ensure that the resident's rights are protected and that the Personal Needs Allowance (PNA) is properly utilized;
- 3.**The social worker shall assist residents in understanding and exercising their rights, including the right to make health care decisions;
- 4.**The social worker shall assist the resident in obtaining needed entitlements, community, or legal services;
- 5.**The social worker shall facilitate the acquisition of prosthetic and assistive devices if necessary;
- 6.**The social worker shall assist the resident and/or family in applying for Medicaid benefits, when appropriate;
- 7.**The social worker shall work with the Activities and/or Volunteer Services Departments to obtain visitors for residents who have no supportive family or are otherwise isolated, or who have communication difficulties due to a language barrier; and
- 8.**The social worker may develop support and education groups for residents and families, as appropriate. The social worker shall serve as coordinator or co-coordinator in family support groups held in the NF and shall participate actively in meetings of the Resident's Council.

(i)Social services discharge planning shall be as follows:

- 1.**The social worker shall be the primary staff member responsible for coordinating and carrying out discharge planning;

- 2.** Discharge planning is a process that begins on admission and continues throughout the resident's stay until discharge occurs or is no longer feasible. Discharge planning shall be a collaborative effort by the entire interdisciplinary team. The social worker shall work very closely with nursing staff and other therapists until discharge is accomplished;
 - 3.** All residents shall have the right to live in the least restrictive setting possible. The social worker shall, in concert with other members of the interdisciplinary team, identify residents who may have discharge potential;
 - 4.** The social worker shall consult the HSDP on admission to determine the recommendations of the professional staff designated by the Department concerning discharge and to identify Track II residents;
 - 5.** All residents who appear to be appropriate for discharge shall have their needs reviewed. This review shall include physical and social functioning, medical needs in the community, current and potential supports, resources needed for community living, and psychological readiness for discharge;
 - 6.** Discharge planning shall be carried out by means of an interdisciplinary care plan that includes goals and time frames. Social work intervention geared towards discharge shall be recorded as interim notes. The discharge plan shall include:
 - i.** The level of functioning which needs to be achieved by the resident prior to discharge;
 - ii.** Housing needs: the availability of prior living arrangements and the type of future housing needed for successful discharge (for example, apartment, family home, rooming or boarding home, residential health care facility, foster home and/or shared housing);
 - iii.** Any informal support systems available to the resident;
 - iv.** Specific financial assistance needed by the beneficiary; and
 - v.** Specific community resources needed for care in the community (for example, meals-on-wheels, day-care and/or home health assistance);
 - 7.** The social worker shall link the resident to necessary community resources and shall follow up to verify that services have been implemented;
 - 8.** The social worker shall assist in identifying the family's training needs for resident care in order to implement a successful discharge plan;
 - 9.** The social worker shall maintain active contact with the resident, his or her family, and significant others to support their involvement with the discharge plan; and
 - 10.** The social worker shall be acquainted with formal resources that are available in the community and shall maintain an up-to-date resource file.
- (j)** In a NF providing care to children, the social services department shall initiate contact with the local school district when a child is admitted. The social worker shall also continue to serve as the coordinator between the local school district and the NF to facilitate the best care for the child.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.6 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (i)4, substituted "professional staff designated by the Department" for "Medicaid RSN"; in (i)6iv, substituted "beneficiary" for "recipient".

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In (d) through (i), substituted a semicolon or "; and" for a period and "MDS" for "SRA" throughout; and in (i)9, inserted "or her".

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N.J.A.C. 8:85-2.7

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.7. Pharmaceutical services; general

(a) Prescribed legend drugs shall be supplied to each individual resident by a licensed pharmacy. Legend drugs may be supplied to individual residents by other than a licensed pharmacy when dispensed by NF medical professional staff from an emergency drug box, or the like, supplied by the NF's contracted pharmacy provider. Non-legend drugs, such as aspirin, milk of magnesia, etc., may be separately stocked in the drugroom or medication cart of the NF. This will permit the NF to maintain a supply of non-legend drugs to be administered as directed by the prescribing physician under the supervision of a NF professional staff in keeping with established stop order policies (see (b) below). Reimbursement for non-legend drugs (that is, drugs which by Federal law do not require a prescription) shall be included in the NF per diem rate.

1. The New Jersey Medicaid program shall not reimburse for Methadone when used for drug detoxification or addiction.

(b) "Stop orders" are internal policy regulations of the NF and unrelated to the New Jersey Medicaid program rules. Thus, such "stop orders" shall not supersede Program rules concerning the prescribing of drugs and pharmaceutical services as outlined in N.J.A.C. 10:61, Pharmacy Services.

(c) In NFs, if the quantity of drug or medication is not indicated in writing by the prescriber, the pharmacy provider shall dispense an appropriate quantity of medication not to exceed a one month supply.

1. In NFs, a written physician order shall be considered a prescription. A physician order written to continue medication administration shall be considered a new prescription and issued a unique prescription number by the NF contracted pharmacy provider.

(d) Pharmacies with Institutional Permits shall be reimbursed pro-rated capitation which shall equal 75 percent of the capitation rate approved by Medicaid for pharmacies with Retail Permits.

(e) Signed physicians' orders for medications, drugs, tests, diet, and treatment administered to Medicaid beneficiaries must be accurately recorded on the beneficiary's chart with review and update as required.

(f) All services required of a Consultant Pharmacist in NFs, as stipulated in Federal and State statutes, rules and regulations, including, but not limited to, those listed in this subsection shall be provided.

1. Responsibilities of the consultant pharmacist shall be as follows:

- i.** Assure that all drugs are dispensed, and in cooperation with the Director of Nursing, shall assure all drugs are administered in compliance with all State and Federal laws;
- ii.** Establish and monitor the implementation of written policies and procedures, through the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), to assure the safe use, storage, integrity, administration, control and accountability of drugs;
- iii.** Assure the drug records are in order and that an account of all controlled substances is maintained and reconciled;
- iv.** Assure that beneficiaries' medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physician's orders and established stop-order policies;
- v.** Assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same beneficiary, are monitored for potential adverse reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications, and that the physician is advised promptly of any recommended changes;
- vi.** Review the drug regimen (that is, the dosage form, route of administration and time of administration) of each beneficiary at least monthly and prepare a written report of any irregularities pertaining to medications to the attending physician, Medical Director or Director of Nursing, as appropriate. Irregularities in the administration of medications shall also be reported promptly to the Director of Nursing.
- vii.** Report in writing at least quarterly to the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a summary of the review of each beneficiary's drug regimen and clinical record and the consultant pharmacist's findings and recommendations;
- viii.** Assure there is maintained and available upon request of the Director of the New Jersey Medicaid program or his or her designee, documented records of the disposition, disposal or destruction of unused or discontinued drugs;

ix. Serve as an active member of the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), and Infection Control Committee of the facility;

x. Provide and document in-service programs for the complete nursing staff. This training shall include, but not be limited to, registered nurses, licensed practical nurses, and aides and shall be given at least quarterly; and

xi. Devote a sufficient number of hours to carry out these responsibilities, maintain a written record of activities, findings and recommendations.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.7 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Substituted "beneficiary" for "recipient" throughout; in (f)1vi, rewrote "and report any" as "and prepare a written report of any".

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85-2.8

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.8 Consultations and referrals for examination and treatment

(a) Certain services, such as medical and surgical specialties, chiropractic, dental, mental health, podiatric, and vision care, shall be initiated by the attending physician as either a request for a "consultation" or as a "referral for examination and treatment".

(b) A consultation shall be ordered when the attending physician wishes an appropriate practitioner to evaluate, through history and appropriate physical findings and other ancillary means:

1. The nature and progress of a disease, illness, or condition, and/or
2. To establish or confirm a diagnosis, and/or
3. To determine the prognosis, and/or
4. To suggest appropriate therapy.

(c) When a consultant assumes the continuing care of the resident, subsequent services rendered by the consultant are not considered a consultation and other appropriate procedure codes shall be utilized.

(d) A referral for examination and treatment shall be ordered by the attending physician when he or she wishes a practitioner to assume responsibility for a specific aspect of the resident's care; for example, the attending physician may order a referral for examination and treatment for dental services.

(e) For the initial consultation examination and subsequent examinations, the record shall document the following:

1. The date of service;
2. The chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures performed;
5. The diagnosis; and
6. The treatment.

(f)A request for either a consultation or a referral for examination and treatment shall be written and signed by the attending physician on the order sheet, and shall clearly indicate the reason for the request.

1.If the attending physician is unable to write the request on the order sheet, he or she may personally dictate, by telephone to an appropriate person at the facility, the order for the consultation or the referral for examination and treatment, indicating the supporting reason(s) for the request. The attending physician shall then, within seven days of requesting the consultation or referral for examination and treatment, countersign the order on the order sheet or sign and forward to the NF an identical order on a prescription form which will satisfy the requirements until the next visit, when he or she shall sign the order sheet.

2.In consideration of a resident's rights, a resident may request either a consultation or a referral for examination and treatment, provided it is consistent with medical necessity. The attending physician shall note the request on the order sheet and, if the physician so wishes, may note that it was made at the resident's request.

Example: Resident requests ophthalmologic consultation with Dr. Evans for significant refractive error.

Signed: A.B. Turner, M.D.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.8 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

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N.J.A.C. 8:85-2.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.9. Mental health services

(a)All facilities shall assist Medicaid beneficiaries to obtain mental health care through a licensed psychiatrist or psychologist, who shall provide, or make provision for, routine and emergency services.

(b)An initial consultation for mental health services shall be performed only upon a written order signed by the attending physician (on the order sheet) citing the reason(s) for the consultation in the progress notes.

(c)If the mental health services are recommended following initial consultation, the psychiatrist or psychologist may provide the mental health service upon the written order signed by the attending physician. If the individual who provides the mental health services is a psychiatrist, he or she shall comply with the Medicaid policies cited in N.J.A.C. 10:54 regarding the request for authorization requirements for mental health services. If the individual who provides the mental health services is a psychologist, he or she shall comply with N.J.A.C. 10:67 regarding the request for authorization requirements for mental health services.

(d)Therapeutic goals and outcomes shall be documented by the psychiatrist and/or psychologist in the clinical record and treatment provided only where there is potential for significant functional improvement within a reasonable time frame.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.9 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In (a), substituted "beneficiaries" for "recipients".

N.J.A.C. 8:85-2.10

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.10 Dental services

(a)All facilities shall assist Medicaid beneficiaries to obtain dental care through a licensed dentist, who shall provide, or make provision for:

1. Appropriate consulting services;
2. In-service education to the facility;
3. Policies concerning oral hygiene; and
4. Routine and emergency services.

(b)Dental examinations carried out to comply with the Department of Health and Senior Services' minimal requirements, as defined in N.J.A.C. 8:39-15.1, as well as regular dental examinations, shall not be considered consultations and need not be brought to the attending physician's attention except as a matter of courtesy. However, treatments which involve invasive procedures such as extractions or fillings, except in an emergency, shall be brought to the attention of the attending physician who acknowledges clearance for such treatment on the order sheet.

(c)The dentist shall establish a time frame for the next periodic examination, either at the time of examination, or at the completion of treatment. The time frame entered on the clinical record may be for six months, one year, or any other time period that the attending dentist has established in accordance with his or her knowledge of the recipient.

(d)Dental care of a child residing in a NF shall be provided according to the American Dental Association Pediatric protocol available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60611.

(e)Policy and procedures regarding the provision of dental services are listed in the New Jersey Medicaid Program Manual for Dental Services. Services requiring prior authorization are listed under 202.2 (N.J.A.C. 10:56-1.3).

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.10 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In introductory paragraph (a), substituted "beneficiaries" for "recipients"; in (b), substituted "Department of Health and Senior Services" for "Department of Health's" and added "as defined in N.J.A.C. 8:39-15.1".

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N.J.A.C. 8:85-2.11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.11. Podiatry services

(a)All facilities shall assist Medicaid beneficiaries to obtain podiatry care through a licensed podiatrist who shall provide, or make provision for:

- 1.Appropriate consulting services;
- 2.In-service education for the facility;
- 3.Policies concerning foot care; and
- 4.Routine and emergency services.

(b)Once the attending physician reviews the consultation and approves the treatment plan of the podiatrist, the physician shall not be required to sign a request every time the podiatrist treats the resident; however, the attending physician shall review and approve the need for the podiatric services for residents under treatment every six months, and if continuing service is indicated, complete a request for podiatric services for each resident under treatment at least once a year. This shall be accomplished by an order on the order sheet and not by repeated requests for consultation.

- 1.Podiatry services provided to children shall be prior authorized by MDO professional staff.

(c)Policies and procedures regarding the provision of podiatric services are outlined in the New Jersey Medicaid Program's Podiatry Services Manual (N.J.A.C. 10:57).

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.11 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In introductory paragraph (a), substituted "beneficiaries" for "recipients".

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N.J.A.C. 8:85-2.12

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.12. Chiropractic services

All facilities shall assist Medicaid beneficiaries to obtain chiropractic care through a licensed chiropractor who shall provide, or make provision for, routine and emergency services.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.12 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Substituted "beneficiaries" for "recipients".

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N.J.A.C. 8:85-2.13

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.13. Vision care services

(a)All facilities shall assist Medicaid beneficiaries to obtain vision care through a licensed ophthalmologist or optometrist who shall provide, or make provision for, routine and emergency services.

(b)Policies and procedures regarding the provision of Vision Care services are outlined in the New Jersey Medicaid Program's Vision Care Manual (N.J.A.C. 10:62).

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.13 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In (a), substituted "beneficiaries" for "recipients".

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This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.14. Laboratory; X-ray, portable X-ray and other diagnostic services

(a)A NF shall have written agreements with one or more general hospitals or one or more clinical laboratories so that the facility can obtain laboratory services, including emergency services promptly. If the facility has its own laboratory capabilities, the services may not be billed on a separate fee-for-service basis. A laboratory must be:

1. Licensed and/or approved by the New Jersey State Department of Health and Senior Services and the State Board of Medical Examiners, which includes meeting Certificate of Need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey Sanitary Code; and
2. Certified as an independent laboratory under the Title XVIII Medicare Program; and
3. Approved for participation as an independent laboratory provider by the New Jersey Medicaid program.

(b)A NF shall have written agreements with one or more general hospitals or one or more Board certified or Board eligible radiologists so that the facility can obtain radiological services, including emergency services promptly.

1. Portable X-ray may be used when medically indicated. The mechanical portion of the services (obtaining the films) may be done by personnel of either the hospital or radiologist, but the interpretation of the film will be by a Board certified or Board eligible radiologist only.
2. X-ray services offered directly by the facility must be in adherence with the standards of the New Jersey Radiological Society.

(c)A NF shall have written agreements with one or more general hospitals or one or more qualified providers so that the facility can obtain other diagnostic services, such as ECG, EEG, CAT scan, MRI and ultrasonogram, including emergency services, promptly.

1. All diagnostic services shall be ordered by a physician, who shall be promptly notified of the test results.
2. All findings and reports shall be recorded in the beneficiary's clinical record.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.14 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In (a)1, added "and Senior Services"; in (c)2, substituted "beneficiary's" for "recipients".

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This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.15 Medical supplies and equipment

(a)Medical supplies include incontinency pads, bandages, dressings, compresses, sponges, plasters, tapes, cellu-cotton or other types of pads used to save labor or linen, and other disposable items (for example, colostomy bags), hot water bags, thermometers, catheters, rubber gloves, and supplies required in the administration of medication including disposable syringes. Routinely used medical supplies are considered part of the institution's cost and cannot be billed directly to the program by the supplier.

(b)Equipment for administration of oxygen for residents in a NF is a required service. Oxygen itself must conform to United States Pharmacopoeia Standards in order to be used as a medicinal gas. (United States Pharmacopoeia Convention, 12601 Twinbrook Parkway, Rockville, MD 20852.)

(c)Routinely used durable medical equipment ordered for Medicaid beneficiaries in a participating NF (for example, walkers, wheelchairs, bed-rails, crutches, traction apparatus, intermittent positive-pressure breathing (IPPB) machine, electric nebulizers, electric aspirators, low-end pressure relief systems such as mattress overlays and mattress replacements, powered mattress systems and powered flotation beds) and other therapeutic equipment and supplies essential to furnish the services offered by the facility for the care and treatment of its residents shall be considered part of the NF's cost, and shall not be billed directly to the program by the supplier.

(d)When unusual circumstances require special medical equipment not usually found in a NF, such special equipment may be reimbursable, with prior authorization from the Medical Assistance Customer Center (MACC) serving the county where the facility is located.

1. When special medical equipment is authorized and purchased on behalf of a Medicaid beneficiary, ownership of such equipment shall vest in the Division of Medical Assistance and Health Services (DMAHS). The beneficiary shall be granted a possessory interest for as long as the beneficiary requires use of the equipment. When the beneficiary no longer needs such equipment, possession and control shall revert to DMAHS. The beneficiary shall agree to this when he or she signs the "patient's certification" section on the claim form. The NF shall notify the MACC in writing when such equipment is no longer in use.

2. Prior authorization requests for special medical equipment shall be accompanied by documentation from the attending physician, the registered professional nurse who has primary responsibility for the beneficiary, and appropriate rehabilitative therapy personnel, which relates the medical necessity for the equipment and describes the extraordinary requirements of the beneficiary.

3. Pressure relief systems shall be reimbursed in a NF under the following conditions:

i. Air Fluidized and Low Air Loss therapy beds, as defined in N.J.A.C. 8:85-1.2, shall be considered special medical equipment and shall be prior authorized for reimbursement in a NF only when all of the following criteria, indicating medical necessity, are documented by the physician.

(1) The beneficiary has two stage III (full-thickness tissue loss) pressure sores or a stage IV (deep tissue destruction) pressure sore which involves two of the following sites: hips, buttocks, sacrum.

(2) The beneficiary with coexisting risk factors (such as vascular irregularities, nutritional depletion, diabetes or immune suppression) presents post-operatively with a posterior or lateral flap or graft site requiring short-term therapy until the operative site is viable.

(3) The beneficiary is bedridden or chair-bound as a result of severely limited mobility.

(4) The beneficiary is receiving maximal medical/nursing care, prior instituted conservative treatment has been unsuccessful and all other alternative equipment has been considered and ruled out.

(5) The bed is ordered, in writing, by the attending physician based on his or her comprehensive assessment (which includes a physical examination) and evaluation of the beneficiary.

(6) Prior authorization in conditions other than those defined above shall be considered on an individual basis by the MDO.

ii. Air fluidized and low air loss therapy beds shall not be covered for reimbursement in a NF under any of the following circumstances:

(1) As a preventative measure;

(2) After healing to stage II has occurred or wound stability (no significant change or evidence of healing) has been achieved;

(3) If the facility structure cannot support the weight of the bed or the facility electrical system is insufficient for the anticipated increase in energy consumption, air fluidized therapy shall be considered inappropriate. Reimbursement for an air fluidized bed shall be limited to the equipment itself. Payment shall not be made for architectural adjustments such as electrical or structural improvement.

iii. Prior authorization of air fluidized or low air loss therapy beds, if approved, shall be granted for 30 days only. Continued use beyond the initial approval period shall

require prior authorization on a monthly basis. The following information shall be submitted to the MACC to obtain prior authorization:

- (1) A completed FD-354 prior authorization form;
- (2) The physicians' written prescription;
- (3) A medical history relating to the wound which includes previous therapy and pressure relief systems utilized and found unsuccessful;
- (4) Physician progress notes indicating medical necessity, plan of treatment and evaluation of response to treatment specific to the care of the wound;
- (5) The wound care flow sheet documenting weekly the site, size, depth and stage of the wound, noting also the presence and description of drainage or odor;
- (6) Laboratory values including a complete blood count and blood chemistries initially and on request thereafter;
- (7) A nutritional assessment by a registered dietitian initially on request thereafter; and
- (8) Photographs of the site upon permission of the beneficiary/family, after full due consideration is afforded to the beneficiary's right to privacy, dignity and confidentiality.

iv. After treatment with an air fluidized or low air loss therapy bed is initiated, the beneficiary shall:

- (1) Be examined by the physician on a monthly basis;
- (2) Remain on the therapy unit and be confined to bed, unless medically necessary. While confined to bed, due consideration shall be given to the beneficiary's need for social and sensory stimulation and recreational diversion by providing in-room visitation and social/recreational activities appropriate to the beneficiary's condition; and
- (3) Be repositioned on a turning schedule of not less than every two hours.

v. Professional staff from the MACC may, at their discretion, perform an onsite visit to evaluate the beneficiary prior to or after therapy has been instituted. Continued approval shall be contingent upon the facility's compliance with the criteria and conditions defined in (d)3i, ii, iii and iv above and cooperation of the beneficiary to the therapeutic modality.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.15 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.16. Consultant services; general

If the NF has significant, unresolved or recurring problems, the NF shall be required to provide appropriate consultation in any service area until the problems are corrected.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.16 by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.17. Transportation services

- (a)**The NF shall assist a Medicaid beneficiary in obtaining transportation when the beneficiary requires a Medicaid-covered service or care not regularly provided by the NF.
- (b)**If a transportation service is provided by the NF to an inpatient of the NF, no additional reimbursement shall be allowed. Reimbursement shall be included in the per diem rate.
- (c)**Ambulance service shall not require authorization from the MDO, but shall be reimbursable to the transportation provider only when the use of any other method of transportation is medically contraindicated. (See N.J.A.C. 10:50-1.3(c)2 for specific conditions for ambulance service reimbursement.)
- (d)**Invalid coach services shall not require prior authorization from the MACC.
- 1.Invalid coach services shall be provided by a transportation provider approved in accordance with N.J.A.C. 10:50, Transportation Services.
 - 2.An invalid coach may be utilized when a Medicaid beneficiary requires transportation from place to place for the purpose of obtaining a Medicaid-covered service and when the use of an alternative mode of transportation, such as a taxi, bus, livery, or private vehicle, would create a serious risk to life or health.
- (e)**Transportation by taxi, train, bus and other public conveyances shall not be directly reimbursable by the New Jersey Medicaid program. Inquiry should be made to the County Welfare Agency (CWA) for authorization and payment for such transportation.
- (f)**Policy and procedures regarding the provision of transportation services are outlined in the New Jersey Medical Transportation Services Manual (N.J.A.C. 10:50-1.3 through 1.6).

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.17 and amended by R.2005 d.389, effective January 17, 2006.
See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Substituted "beneficiary" for "recipient" throughout; in introductory paragraph (d), substituted "MACC" for "MDO"; in (e), added the abbreviation "(CWA)".

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End of Document

N.J.A.C. 8:85-2.18

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.18. Bed and board

(a)Beds are provided in rooms licensed by the New Jersey Department of Health and Senior Services. A NF providing care to children shall have available protective cribs for infants and small children, as well as appropriate furniture, sized and scaled for children.

(b)Board shall be provided to meet basic nutritional needs and shall include the provision of therapeutic diets as prescribed by the attending physician.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.18 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In (a), added "and Senior Services".

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N.J.A.C. 8:85-2.19

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.19. Housekeeping and maintenance services

(a) Housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment and laundering of personal clothing (excluding dry cleaning) shall be required.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.19 by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

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N.J.A.C. 8:85-2.20

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.20. Non-covered services

(a)Medicaid beneficiaries residing in NFs shall not be eligible to receive Medicaid reimbursement for the following services:

- 1.Admission or continued care primarily for diet therapy of exogenous obesity, bed rest, rest cure, or care of non-medical nature;
- 2.Private duty nursing;
- 3.Private attendant services;
- 4.Services and supplies not related to the care of the resident, such as guest meals and accommodations, television, telephone, and personal items;
- 5.Practitioner or therapy services furnished on a fee-for-service basis by an owner, partner, administrator, stockholder, or others having direct or indirect financial interest in the NF;
- 6.Partial care services in independent clinics; or
- 7.Medical/social day care.

History

HISTORY:

Recodified from N.J.A.C. 10:63-2.20 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Rewrote introductory paragraph (a) and added (a)7.

End of Document

N.J.A.C. 8:85-2.21

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 2. NURSING FACILITY SERVICES

§ 8:85-2.21 Special care nursing facility (SCNF)

(a)A special care nursing facility (SCNF) is a nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the Department of Health and Senior Services to provide care to New Jersey Medicaid beneficiaries who require intensive nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. 8:85-2. A SCNF or SCNF unit shall have a minimum of 24 beds.

- 1.The minimum bed requirement will be waived for SCNFs that were approved by DMAHS prior to November 23, 1994. In addition, the requirement will be waived in those instances where a SCNF's Certificate of Need stipulates a specific number of beds approved by the New Jersey Department of Health and Senior Services.
- 2.A SCNF receiving reimbursement through the Medicaid program shall not increase its total number of licensed beds for which a SCNF rate of reimbursement is received except upon approval from the Department.
- 3.A SCNF shall provide intensive medical, nursing and psychosocial management to the seriously ill individual who has potential for measurable and consistent maturation or rehabilitation, or has a technologically and/or therapeutically complex condition which requires the delivery of intensive and coordinated health care services on a 24-hour basis.

(b)A SCNF shall provide the services of an interdisciplinary team, under the direction of a physician specialist, who has training and expertise in the treatment specific to the medical condition and needs of the target population.

- 1.Within a focused therapeutic program, targeted, when appropriate, at timely discharge to alternative health care settings, such as conventional NF or community-based services, the SCNF shall provide:
 - i.Aggressive management and treatment to stabilize, improve and monitor current conditions;
 - ii.Appropriate, intensive rehabilitative therapies and counseling services; and
 - iii.Coordinated care planning and delivery of required services.

(c)A SCNF shall provide services to Medicaid beneficiaries who have been determined, through the PAS process, to require extended rehabilitation and/or complex care. The individual's progress and overall response to the therapeutic regimen shall determine length of stay.

- 1.**Extended rehabilitation shall be considered for a medically stable individual with a condition whose prognosis indicates the potential for rehabilitative progress which requires a prescribed period of therapeutic treatment and goal-directed services provided by a qualified interdisciplinary team to restore the individual to the highest practical level of physical, cognitive and behavioral functioning. The individual may remain for a period of up to 12 months, with a review after six months. Length of stay will be extended for periods of six months, if continued benefit from the service can be demonstrated.
- 2.**Complex care shall be considered for a medically stable individual judged to have plateaued who demonstrates the need for prolonged, technologically and/or therapeutically complex care. Although the rehabilitative component may be less intense, the individual continues to require focused assessment, coordinated care planning and direct services on a continuing basis provided by an interdisciplinary team with training and expertise in the treatment of the medical conditions and specialized needs of the resident population. The individual may remain for a period of up to two years with review every 12 months. Length of stay will be extended for periods of six months if continued benefit from the service can be demonstrated.
- 3.**Medicaid beneficiaries who are suitably placed in the community, receiving care in appropriate alternative placements or referred for social reasons only shall not be authorized for admission to a SCNF.

(d)Pursuant to N.J.S.A. 30:4D-6j, contingent upon CMS approval of Federal financial participation under Title XIX of the Federal Social Security Act (42 U.S.C. § 1396 et seq.), professional staff designated by the Department shall authorize clinical Medicaid eligibility for SCNF admission for an individual whom a physician diagnoses with HIV infection and HIV-related medical co-morbidities and/or HIV-related psychosocial co-morbidities and/or AIDS-defining illness, provided:

- 1.**The Department has approved the application of the SCNF pursuant to N.J.A.C. 8:85-1.3 to provide services for beneficiaries diagnosed with HIV infection resulting in HIV-related medical co-morbidities and/or HIV-related psychosocial co-morbidities and/or AIDS-defining illness, which approval shall be evidenced by the SCNF's execution of an agreement with the Department for program participation; and
- 2.**The individual meets the requirements in (c)1 or 2 above and professional staff designated by the Department determine that the individual:
 - i.**Is dependent in several ADL; or
 - ii.**Demonstrates at least intermittent dependency in ADL and has an unstable medical, behavioral, and/or psychosocial condition that affects the individual's ability to be consistently independent in ADL such that the individual requires specialized nursing services for HIV infection resulting in HIV-related medical co-

morbidities and/or HIV-related psychosocial co-morbidities and/or an AIDS-defining illness.

(e) Discharge procedures shall include utilizing Medicaid discharge protocols established by this chapter, and shall be in accordance with the following:

1. The beneficiary shall be discharged upon achievement of maximum benefit from the specialized programming and maximum level of functioning and when the individual's condition can be appropriately managed in either the community or other forms of institutional care.
2. Outpatient treatment and supported community services may be needed to assist in community integration.
3. When a beneficiary residing in a SCNF unit of a conventional NF is determined by Department staff to no longer require special programming, yet continues to require conventional NF services, the beneficiary shall be accepted for placement into a conventional NF bed in the facility. If a conventional NF bed within the facility is not available within a reasonable time, the SCNF shall assist the individual in finding placement in another conventional nursing facility. The SCNF shall be afforded 30 to 60 days from the date of the determination to effect transfer of the beneficiary to a bed within the facility's conventional bed allocation or arrange transfer to another conventional NF.

(f) The SCNF shall provide all required services, as defined in this subchapter.

1. A SCNF shall provide those medical services as defined in N.J.A.C. 8:85-2.3, with the following modifications and/or additions:

i. A freestanding SCNF shall have a designated medical director who is board eligible/certified in a medical specialty as targeted by the medical diagnoses, medical conditions and/or resident population of the SCNF. The medical director shall also function as a primary care attending physician. If a medical group provides medical services, a member of that group shall be designated as the medical director.

(1) In lieu of the requirements contained in (f)1i above, a freestanding SCNF may have a designated medical director who is a licensed physician and was serving as medical director prior to November 23, 1994.

ii. For each resident there shall be a designated primary care physician specialist who is board eligible/certified in a medical specialty determined by the medical diagnoses, medical conditions and or resident population;

iii. Responsibilities of the primary care physician include but are not limited to:

(1) History, physical exam and diagnosis on admission and a comprehensive physical exam conducted on a yearly basis;

(2) Medical assessment shall reflect a correlation of the staging of existing diagnosis and premorbid conditions to the prognosis for rehabilitation.

(3)Each resident shall be examined and evaluated as required by the individual's condition as designated by the medical care plan.

2.A SCNF shall provide those nursing services as defined in N.J.A.C. 8:85-2.2 with the following modifications and/or additions:

i.A freestanding SCNF shall have a director of nurses or a nursing administrator who is a registered professional nurse in the State of New Jersey and possesses a Master's Degree or a Baccalaureate Degree in Nursing and has a minimum of two years experience as a nursing administrator or who has at least two years of supervisory experience in either an acute or long-term care setting.

(1)In lieu of the education and experience requirements of (f)2i above, the director of nurses or nursing administrator shall have served in that capacity prior to November 23, 1994.

(2)A SCNF unit within a conventional NF whose director of nursing does not meet the qualifications of (e)2i above shall have a nurse manager who meets the qualifications assigned full time to the unit.

ii.Registered professional nurses certified in intravenous therapy shall be available on a 24 hour basis.

iii.Two and one-half hours of basic nursing services by registered professional nurses, licensed practical nurses and certified nurse aides as defined in N.J.A.C. 8:85-2.2 shall be provided per beneficiary per day. Additional nursing services in a SCNF up to a maximum of three hours may be provided due to technically complex nursing needs and/or intensive rehabilitative/restorative nursing care needs. A SCNF which is an identifiable unit within a conventional NF shall calculate the nurse staffing level separate and apart from the nurse staffing level of the conventional beds.

iv.Provision of additional nursing services as defined in N.J.A.C. 8:85-2.2 does not apply to nurse staffing rules in a SCNF. The additional nursing services described at N.J.A.C. 8:85-2.2(a) are included in the three hours.

(1)Sixty percent of the additional hours of care under iii above shall be provided by registered professional nurses, and forty percent shall be provided by licensed practical nurses. There shall be a minimum of one registered professional nurse, one licensed practical nurse and one certified nurse aide on each shift.

v.Responsibilities of the nursing staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1)Expertise and understanding of the physiologic impact, prognosis and treatment needs specific to the medical condition or specialized needs of the target population to enhance integration of the resident and family goals with adjustment and rehabilitation.

(2)Utilization and application of specialized equipment essential to provide services required for the care and treatment of the SCNF population.

(3)Comprehensive and coordinated program of restorative and rehabilitative nursing services to prevent complications and promote and/or restore the individual's physical, psychosocial function to a realistic level.

(4)Individual/family education and instruction of self care to promote optimum level of health in preparation for discharge to a less restrictive environment.

(5)Evaluation and management of moderate to extreme emotional and behavioral disorders related to illness.

3.A SCNF shall provide those social services as required by N.J.A.C. 8:85-2.6, with the following modifications and/or additions:

i.The social services coordinator shall possess a Master's Degree or Baccalaureate Degree in Social Work from a college or university accredited by the Council on Social Work and have at least two years of full time social work experience in a health care setting.

ii.An average of at least 50 minutes of social work services per week for each resident. This is equal to one half-time equivalent social worker for every 24 residents.

iii.In a SCNF with more than 48 beds, one of the direct care social workers shall be designated as the Director of Social Services.

iv.Responsibilities of the social service staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1)Knowledge of alternative care programs and resources in the community to assist the resident/family with appropriate discharge planning.

(2)Maintain a library of information and resources pertinent to the resident's diagnosis, educational/vocational training needs and applications to community based programs.

(3)Facilitate on-going collaboration and coordination among health care providers, the resident and the family to promote long-range social and health care planning.

(4)Coordinate programming with community-based resources to facilitate continuity of care and assimilation into community/family environment.

(5)On-going supportive intervention with the resident/family in dealing with the confusion, anger, fear, depression, guilt and conflict associated with illness.

4.A SCNF shall provide resident activities required by N.J.A.C. 8:85-2.5, with the following modifications and/or additions:

i.The director of resident activities shall possess a Master's Degree or Baccalaureate Degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, occupational therapy or therapeutic recreation. In addition, three years of experience in a clinical, residential or community-based therapeutic recreation program is required.

(1)In lieu of (f)4i above, the individual shall have served as director of resident activities prior to November 23, 1994; or

(2)In lieu of (f)4i above, hold current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, 520 Stewart, Park Ridge, Illinois 60068) or the National Council of Therapeutic Recreation Certification (National Council of Therapeutic Recreation Certification, P.O. Box 16126, Alexandria, Virginia 22302).

ii.An average of at least 100 minutes of resident activity services per week for each resident. This is equal to one full-time equivalent resident activities staff for every 24 residents. This staff person shall serve as the Director of Resident Activities.

iii.For each additional 24 beds, the facility shall provide the services of a full-time resident activities assistant.

iv.Responsibilities of the resident activities staff, in concert with other members of the interdisciplinary team, shall include, but are not limited to:

(1)Utilization of all possible community, social, recreational, public and voluntary resources to promote the resident's ties with community life.

(2)Provision of therapeutic resident activities which endorse the therapeutic plan of care.

(3)Incorporation of family-centered activities which provide a supportive, therapeutic environment to give residents and families an opportunity to work together toward achieving common goals.

5.A SCNF shall provide, directly in the facility, the rehabilitation services as required by N.J.A.C. 8:85-2.4 on an intensive level which are specifically targeted to meet the goals of the prescribed treatment plan.

i.Rehabilitative therapies shall include, but shall not be limited to:

(1)Physical therapy;

(2)Occupational therapy;

(3)Speech/language pathology; and

(4)Cognitive or remedial therapies (including neuropsychological treatment)

ii.Rehabilitation services shall focus on developing and/or restoring maximum levels of function within the limits of the resident's impairment. Through collaboration with other members of the interdisciplinary team, a comprehensive rehabilitation plan shall be developed which:

(1)Identifies rehabilitation needs and establishes realistic criteria for measuring the need for continued rehabilitative services;

(2)Projects targeted outcomes (goals) and defines the parameters to measure response to treatment goals; and

(3)Establishes realistic time frames to meet outcome criteria.

6. Mental health services provided by a licensed psychiatrist, psychologist or other appropriately credentialed professional shall be provided to residents with mental health disorders in accordance with N.J.A.C. 8:85-2.9.

7. A SCNF that provides ventilator management of New Jersey Medicaid eligible children or adults shall provide respiratory therapy services beyond the scope of N.J.A.C. 8:85-2, which shall include, but not be limited to:

i. A respiratory care practitioner who is currently licensed by the New Jersey State Board of Respiratory Care be available on the premises on a 24 hour basis.

ii. Respiratory life support systems must be provided inclusive of, but not limited to:

(1) Mechanical ventilators (pressure/volume/time cycled), (portable/stationary); and

(2) Oxygen therapy delivery systems.

iii. Administration of medically prescribed respiratory care which includes, but is not limited to:

(1) Nasopharyngeal aspiration;

(2) Maintenance of natural and mechanical airways;

(3) Insertion and maintenance of artificial airways;

(4) Aerosol treatment;

(5) Administration of nebulized bronchodilators;

(6) IPPB;

(7) Oxygen therapy;

(8) Mechanical ventilation with/without supplemental oxygen;

(9) Monitoring of blood gases;

(10) Under the direction of the pulmonologist, the respiratory therapist applies weaning parameters and provides direct supervision during the weaning process;

(11) Postural drainage and chest percussion; and

(12) Breathing exercise and respiratory rehabilitation.

iv. Medically prescribed respiratory therapy may be provided to non-ventilator dependent children or adults who, due to cardio-respiratory deficiencies and/or abnormalities, require:

(1) Apparatus for cardio-respiratory support and control;

(2) Respiratory rehabilitation/chest physiotherapy;

(3) Maintenance of natural airway patency;

(4) Insertion and maintenance of artificial airway;

(5) Measurement of cardio-respiratory volume, pressure and flow;

- (6) Drawing and analyzing samples of arterial, capillary and venous blood;
- (7) Administration of aerosolized respiratory medications such as nebulized bronchodilators or antiprotozoals;
- (8) Assessment, intervention, and evaluation by a registered professional nurse; and/or
- (9) Protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by the physician or advanced practice nurse.

History

HISTORY:

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Recodified from N.J.A.C. 10:63-2.21 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

Amended by R.2007 d.391, effective December 17, 2007.

See: 38 N.J.R. 4795(a), 39 N.J.R. 5338(a).

Added new (d); recodified former (d) and (e) as (e) and (f); in (f)1i(1), substituted "(f)1i" for "(e)1i"; in (f)2i(1), substituted "(f)2i" for "(e)2i"; and in (f)4i(1) and (f)4i(2), substituted "(f)4i" for "(e)4i".

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N.J.A.C. 8:85-3.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.1 Purpose and scope

(a)These rules describe the methodology to be used by the State of New Jersey, Department of Health and Senior Services (Department), to establish prospective per diem rates for the provision of nursing facility services to residents under the State's Medicaid program.

(b)The Department believes that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The Department recognizes, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c)Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the Department is prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d)On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the Department reserves the right to question and exclude any unreasonable costs, consistent with the provision of N.J.S.A. 30:4D-1 et seq.

(e)All rates established pursuant to these rules will be subject to onsite audit verification of costs and statistics reported by NFs.

(f)The nursing facility rate formulae contained in this subchapter have been developed to meet the following overall goals:

1. To comply with Federal requirements that rates are reasonable and adequate to meet the cost that efficiently and economically operated facilities must incur to provide care in conformity with applicable State and Federal laws, rules, regulations and quality and safety standards;

2.To provide rates that are sufficient for facilities to meet the needs of their Medicaid beneficiaries through a rate setting system based on the average needs of individuals in their care; and

3.To control unnecessary costs, avoid duplicative cost reporting requirements and prevent fraud and abuse.

(g)For dates of service on or after July 1, 2010, the rates for Class I proprietary and voluntary NFs and Class II governmental NFs shall be based on the prospective case mix system required by this chapter.

History

HISTORY:

Amended by R.1985 d.705, effective January 21, 1986.

See: 17 N.J.R. 2331(a), 18 N.J.R. 189(a).

Old 1 and 2 deleted; new 1 added; old 3 and 4 recodified to 2 and 3.

Petition for Rulemaking: Notice of receipt of petition on Medicaid reimbursement system for long-term care facilities.

See: 22 N.J.R. 672(d).

Recodified from Subchapter Foreword and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Recodified from N.J.A.C. 10:63-3.1 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote (a) and made technical changes in (b) through (d).

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In the introductory paragraph of (f), substituted "rate" for "reimbursement"; in (f)1, substituted a semicolon for a period at the end; rewrote (f)2 and (f)3; and added (g).

N.J.A.C. 8:85-3.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.2 Cost report preparation and timing of submission

(a)Nursing facilities shall furnish required cost reports to the Department of Health and Senior Services, Office of Nursing Facility Rate Setting and Reimbursement, by May 31 following the end of each calendar year for a cost reporting period ending December 31.

1.Effective for periods ending on or after December 31, 2010, the cost report form shall be the Medicare cost report and supplemental Medicaid schedules designated by the Department as N.J.A.C. 8:85 Appendix U, incorporated herein by reference.

2.A nursing facility shall file separate cost reports for each central/home office when costs of the central/home office are reported on the facility's cost report.

3.Prospectively determined payment rates will be redetermined at least annually by the Department.

(b)Where a properly completed cost report, and other required documents, are received beyond the filing requirements of (a) above, the following schedule of penalties will be applied to current and/or subsequent reimbursement rates as the particular circumstances dictate:

| Number of days after due date | Amount of penalty | Month(s) of penalty |
|--------------------------------------|--|----------------------------|
| 1-15 | .25 percent of the NF's rate per patient day | 1st month |
| 16-30 | .50 percent of the NF's rate per patient day | 1st month |
| 31-60 | .50 percent of the NF's rate per patient day | 1st month |
| | 1 percent of the NF's rate per patient day | 2nd month |

N.J.A.C. 8:85-3.2

| | | |
|-------------------|---|------------------------------|
| 61-90 | .50 percent of the NF's rate per patient day | 1st month |
| | 1 percent of the NF's rate per patient day | 2nd month |
| | 2 percent of the NF's rate per patient day | 3rd month |
| 91 and thereafter | .50 percent of the NF's rate per patient day | 1st month |
| | 1 percent of the NF's rate per patient day | 2nd month |
| | 2 percent of the NF's rate per patient day | 3rd month |
| | 3 percent of the NF's rate per patient day | 4th and subsequent months |

(c) Penalties will remain in force until such time that a properly completed cost report and all other required documents have been received. Penalties are not recoverable and are not allowable costs.

(d) The Assistant Commissioner, Division of Senior Benefits and Utilization Management, or a designee of the Assistant Commissioner, may mitigate or waive the penalties specified in (b) above, for "good cause" shown:

1. "Good cause" shall include but shall not be limited to, circumstances beyond the control of the nursing care facility, such as fire, flood or other natural disaster;
2. Acts of omission and/or negligence by the nursing facility, its employees, or its agents, shall not constitute "good cause" for waiving the penalty provisions;
3. All requests for mitigation and/or waiver of the penalty provisions must be submitted in writing, and accompanied by such documentation and/or supporting affidavits as the Assistant Commissioner may require.

(e) The penalty rates indicated in (b) above will be applied to cost reports commencing with the reporting periods ending December 31, 2010.

(f) A nursing facility cost report cannot be substituted or revised by an NF except if such substitution or revision would prevent an overpayment to the NF.

(g) Nursing facilities shall report allowable costs for cost report periods ending on or after December 31, 2010, using allowable cost criteria contained within the Medicare Provider Reimbursement Manual.

History

HISTORY:

As amended, R.1979 d.482, effective January 1, 1980.

See: 11 N.J.R. 552(a), 12 N.J.R. 42(b).

As amended, R.1980 d.211, effective May 14, 1980.

See: 12 N.J.R. 84(b), 12 N.J.R. 323(b).

As amended, R.1982 d.87, effective March 9, 1981.

See: 12 N.J.R. 702(a), 13 N.J.R. 227(a).

(a) Deleted "to be in effect for one full year" after "per diem reimbursement rates."

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Added in (a): "As required .. at least annually".

Recodified from 10:63-3.1 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-3.2 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Section was "Timing"; rewrote the section.

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Rewrote (a); in (b), inserted "a properly completed" and "of (a) above", substituted "report" for "studies", and deleted "90 day" preceding "filing"; rewrote the table in (b); in (c), inserted "properly completed" and "all", and deleted ", completed in accordance with 'Care' guidelines"; in (e), substituted "December 31, 2010" for "May 31, 1980", rewrote (f); and added (g).

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85-3.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.3 Rate classes

(a) For dates of service on or after July 1, 2010, Class I and Class II prospective rates will be case mix rates for two classes of NFs:

1. Class I Proprietary and Voluntary NFs.
2. Class II Governmental NFs. To qualify as a Class II Governmental NF, the NF shall meet all of the contractual requirements of the Department and be a governmental operation.

History

HISTORY:

Amended by R.1979 d.482, effective January 1, 1980.

See: 11 N.J.R. 552(a), 12 N.J.R. 42(b).

Amended by R.1983 d.74, effective March 21, 1983.

See: 14 N.J.R. 742(a), 15 N.J.R. 442(b).

(c) and (d) added regarding lease transactions.

Amended by R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Deleted "(a)4 and recodified (a)5-6 as (a)4-5.

Amended by R.1985 d.705, effective January 21, 1986.

See: 17 N.J.R. 2331(a), 18 N.J.R. 189(a).

The text "established at the . . . 3, 4 or" deleted from (a).

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Recodified from 10:63-3.2 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Recodified from N.J.A.C. 10:63-3.3 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a)2i, substituted "Department of Health and Senior Services" for "Division of Medical Assistance and Health Services"; in (a)3i, deleted "of the Division of Medical Assistance and Health Services" and substituted "Department" for "Division"; in (a)3ii, deleted "the following types for separate screening purposes"; in (g), changed reference to "N.J.A.C. 8:85-3.19".

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Rate components". Rewrote the introductory paragraph of (a); in (a)1, substituted a period for a colon at the end; and deleted (a)3 and (b) through (k).

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N.J.A.C. 8:85-3.4

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.4 Resident rosters and case mix index calculation

(a)An NF shall electronically transmit MDS assessment information in a complete, accurate and timely manner.

1.The Department shall provide a Preliminary Resident Roster to an NF based on the NF's transmitted MDS assessment information for a calendar quarter, when that information is transmitted by the 20th day following the end of the calendar quarter.

2.The Department shall provide a Final Resident Roster to an NF based on the NF's transmitted MDS assessment information for a calendar quarter, when that information is transmitted by the end of the second calendar month following the end of the calendar quarter.

3.The Department shall not consider MDS assessment information for the purpose of reimbursement rate calculations under this subchapter for a calendar quarter that is not submitted by the end of the second calendar month following the end of the calendar quarter, except as provided in (a)4 below.

4.The Department may only grant an exception to the electronic MDS assessment transmission due date for the following reasons:

i.A showing by the nursing facility that fraud may have occurred;

ii.An intervening natural disaster making timely compliance impossible or unsafe;

iii.Technical failure of the NF system used to encode and transmit MDS information;

iv.Technical failure of the central MDS data collection system; or

v.A new NF not previously certified by either the Medicare or Medicaid program that can substantiate to the Department circumstances that preclude timely electronic transmission.

(b)The Department shall use the resource utilization group to adjust direct care case mix costs and to determine each NF's direct care rate component.

1.The Department shall adjust a nursing facility's case mix reimbursement rates on a quarterly basis based on the change in case mix of each facility according to the following schedule:

- i.**Case mix measure obtained from January 1 through March 31 shall be used to adjust rates effective July 1 through September 30 of the same calendar year;
- ii.**Case mix measure obtained from April 1 through June 30 shall be used to adjust rates effective October 1 through December 31 of the same calendar year;
- iii.**Case mix measure obtained from July 1 through September 30 shall be used to adjust rates effective January 1 through March 31 of the following calendar year; and
- iv.**Case mix measure obtained from October 1 through December 31 shall be used to adjust rates effective April 1 through June 30 of the following calendar year.

(c)The Department or its designated contractor shall distribute preliminary and final resident rosters to Class I NFs, Class II NFs and SCNFs according to the following schedule:

| Resident roster quarter | Preliminary resident roster distributed | Final resident roster distributed |
|------------------------------------|--|---|
| January 1 through March 31 | May 10 for submissions through April 20 | June 20 for submissions through May 31 |
| April 1 through June 30 | August 10 for submissions through July 20 | September 20 for submissions through August 31 |
| July 1 through September 30 | November 10 for submissions through October 20 | December 20 for submissions through November 30 |
| October 1 through December 31 | February 10 for submissions through January 20 | March 20 for submission through February 28 |

(d)A nursing facility that has an SCNF unit shall notify the Department of the room numbers of the beds in the SCNF unit, so that the residents in these units may be identified separately on the resident roster.

(e)A nursing facility shall review preliminary resident rosters for completeness and accuracy.

1.If data reported on the preliminary resident roster is in error or if there is missing data, NFs shall have two calendar months following the end of the calendar quarter to transmit additional MDS records, inactivations or modifications needed to obtain a correct resident roster.

(f) For each resident roster quarter, the Department shall calculate a Statewide average case mix index and a Statewide average Medicaid case mix index from all final resident rosters from Class I and Class II nursing facilities.

History

HISTORY:

New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Former N.J.A.C. 8:85-3.4, Equalized costs, recodified to N.J.A.C. 8:85-3.5.

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N.J.A.C. 8:85-3.5

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.5 Fringed costs

(a) In order to equitably develop and calculate limits and prices, the following computation will be made for all cost reports effective for periods ending before December 31, 2010:

1. General fringe benefits will be allocated to function as a percentage of salaries reported to develop total compensation. General fringe benefits will include the raw food value of free and subsidized meals to employees;
2. The term "fringed costs" means the net amount of compensation costs (salary and fringe benefits) plus other expenses, less expense recoveries and nonallowable costs; and
3. For NFs that provide residential, sheltered or domiciliary care, fringed nursing facility costs will be determined by apportioning fringed cost in the same ratio as the apportionment of unfringed net expenses.

History

HISTORY:

The following annotations apply to N.J.A.C. 8:85-3.5 prior to its repeal by R.2011 d.121:

Amended by R.1979 d.482, effective January 1, 1980.

See: 11 N.J.R. 552(a), 12 N.J.R. 42(b).

Amended by R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

(c) added: "Accordingly, a credit...food cost excess".

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

(a)1 added.

Recodified from 10:63-3.4 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1999 d.74, effective March 1, 1999.

See: 30 N.J.R. 3191(a), 31 N.J.R. 678(b).

Rewrote (c).

Recodified from N.J.A.C. 10:63-3.5 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In introductory paragraph (a), substituted "that" for "which"; in (b), deleted "of Health, Health Facilities Inspection" and "be asked to".

The following annotations apply to N.J.A.C. 8:85-3.5 subsequent to its recodification from N.J.A.C. 8:85-3.4 by R.2011 d.121:

Amended by R.1990 d.428, effective August 20, 1990 (operative October 1, 1990).

See: 22 N.J.R. 118(a), 22 N.J.R. 2588(a).

Stylistic changes in referring to types of facilities.

Amended by R.1993 d.371, effective July 19, 1993.

See: 25 N.J.R. 433(a), 25 N.J.R. 3215(a).

Recodified from 10:63-3.3 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-3.4 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Recodified from N.J.A.C. 8:85-3.4 and amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Equalized costs". Rewrote the section. Former N.J.A.C. 8:85-3.5, Raw food costs, repealed.

N.J.A.C. 8:85-3.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.6 Inflation

(a)For the purpose of calculating the limit and price as set forth in N.J.A.C. 8:85-3.9 and for adjusting the operating and administrative price between rebasing years as set forth in N.J.A.C. 8:85-3.8(c)2, the Department shall calculate an index factor using the most recent index factor publication.

(b)The Department shall calculate the index factor in (a) above by dividing the index associated with the quarter ending on the midpoint of the rate year for which the index is being established by the index associated with the quarter ending on the midpoint of the cost reporting period for purposes of setting the limit and price in N.J.A.C. 8:85-3.9 or the midpoint of the prior rate year for purposes of adjusting the operating and administrative price in N.J.A.C. 8:85-3.8(c)2.

History

HISTORY:

As amended, R.1979 d.482, effective January 1, 1980.

See: 11 N.J.R. 552(a), 12 N.J.R. 42(b).

As amended, R.1980 d.42, effective January 23, 1980.

See: 12 N.J.R. 125(b).

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Amended by R.1985 d.705, effective January 21, 1986.

See: 17 N.J.R. 2331(a), 18 N.J.R. 189(a).

Deleted text under chart "Historical unscreened rates ...".

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Recodified from 10:63-3.5 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Administrative Correction.

See: 28 N.J.R. 2998(a).

Amended by R.1997 d.231, effective June 2, 1997.

See: 29 N.J.R. 861(a), 29 N.J.R. 2561(b).

In (b)2, substituted "Nursing Facility and Reimbursement" for "Health Facilities Rate Setting"; in (b)2i, inserted "effective July 1, 1996", changed the multiplier in the equation from "1.05" to "1.00", and deleted "1.05 = 5 percent uniqueness factor"; in (b)3, substituted "Effective July 1, 1996, limited to 100 percent" for "Limited to 105 percent"; in (b)5, inserted "effective July 1, 1996"; and in (b)5i through (b)5iii, substituted "100 percent" for "105 percent".

Amended by R.1999 d.74, effective March 1, 1999.

See: 30 N.J.R. 3191(a), 31 N.J.R. 678(b).

Rewrote the section.

Recodified from N.J.A.C. 10:63-3.6 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Removed incorrect punctuation from introductory paragraph (b); in (b)1, changed reference to "N.J.A.C. 8:85-3.5".

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "General services expenses".

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N.J.A.C. 8:85-3.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.7 Case mix rate components

(a)Effective for dates of service on or after July 1, 2010, for Class I and Class II NFs, each facility's rate shall be comprised of:

- 1.The facility's direct care case mix rate component and direct care non-case mix rate component;
- 2.The operating and administrative price;
- 3.The facility-specific fair rental value (FRV) allowance; and
- 4.The provider tax pass-through per diem provided by N.J.S.A. 26:2H-92 et seq. and N.J.A.C. 8:85-3.12.

(b)The NF's direct care case mix rate component shall be based on the following costs:

- 1.RN nursing salaries, payroll taxes and general benefits;
- 2.LPN nursing salaries, payroll taxes and general benefits; and
- 3.Nurse aides salaries, payroll taxes and general benefits.

(c)The NF's direct care non-case mix rate component shall be based on the following costs:

- 1.Medical director salaries, payroll taxes and general benefits;
- 2.Patient activities salaries, payroll taxes and general benefits;
- 3.Pharmaceutical consultant salaries, payroll taxes and general benefits;
- 4.Non-legend drugs;
- 5.Routine medical supplies;
- 6.Social services salaries, payroll taxes and general benefits; and
- 7.Routine oxygen.

(d)For purposes of (b) and (c) above for cost reports ending on or after December 31, 2010, if these services are acquired through a contract, only the actual wages, payroll taxes and general employee benefits associated with those individuals providing direct care services

for the nursing facility may be included in the direct care rate component, and all of the contracting entity's overhead, other costs and fees charged to the nursing facility shall be reported as other general services costs on the cost report. Such contracts shall include a requirement for a detailed breakdown of the costs as follows:

1. Wages paid to the contract staff performing the direct care services for the nursing facility;
2. Payroll taxes of the contract staff performing the direct care services for the nursing facility;
3. General employee benefit expense for the staff performing the direct care services for the nursing facility;
4. Special employee benefit expense for the staff performing the direct care services for the nursing facility; and
5. The contractor's costs for all other costs, including overhead related costs and service fees.

i. If the contractor is a related party, all other costs, including overhead related costs, shall be identified separately from service fees.

(1) Failure to provide these cost breakdowns shall result in the entire contract cost being disallowed for reimbursement purposes, and these cost breakdowns shall be part of the cost report when filed.

ii. If the contractor is not a related party, the costs listed under (d)1, 2 and 3 above may be reported as a lump sum for each contract, and costs listed under (d)4 above and this paragraph may be reported as a second lump sum for each contract.

(e) The operating and administrative price shall be based on all allowable costs that are not directly recognized in the direct care rate component, the provider tax pass-through or the FRV allowance and shall include the costs of the following listed items:

1. Management;
2. Administrator;
3. Assistant administrator;
4. Other administrative;
5. Home office and/or management company costs properly allocated to the NF;
6. Dietary;
7. Food;
8. Laundry and linen;
9. Housekeeping;
10. Other general services costs, including contract staffing costs other than those reported costs listed in (b) and (c) above;

11. Maintenance (non capital portion);
12. Utilities;
13. Property insurance;
14. Other property operating costs;
15. Property taxes for the land and building; and
16. All other allowable costs not directly recognized in the direct care case mix adjusted or non-case mix adjusted cost center or reimbursed through the FRV allowance.

(f) The facility-specific FRV allowance shall reimburse an NF on the basis of the estimated depreciated value of its capital assets in lieu of direct reimbursement for allowable depreciation, amortization, capital related interest, rent expenses and lease expenses.

1. The Department shall establish an NF's bed value based on the age of the NF re-aged to reflect replacements, major renovation or additions placed into service since the NF's facility was built, to the extent those replacements, renovations and additions are reported to the Department and documented by the NF.

2. A nursing facility shall provide documentation to the Department upon request for these items to be considered in the calculation of the initial effective age and annual re-age calculations.

3. The FRV allowance for dates of service July 1, 2010 through June 30, 2011, shall be based on the FRV Data Report, provided there is sufficient documentation to support the historical information.

4. The FRV allowance for dates of service after June 30, 2011, shall incorporate any capitalized assets placed into service during the prior year and submitted on the FRV Re-age Request.

i. A nursing facility shall submit a Fair Rental Value Re-age Request to the Department by June 15th to be considered in the next July 1st annual rate setting process.

ii. Requests received by the Department after June 15th shall be considered in the rate setting process the following year.

History

HISTORY:

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

(a)7: substituted "county" for "country."

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Recodified from 10:63-3.6 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Recodified from N.J.A.C. 10:63-3.7 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Made technical changes throughout; changed references N.J.A.C. 10:63 to N.J.A.C. 8:85.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Property operating expenses".

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N.J.A.C. 8:85-3.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.8 Limit and price database

(a)The Department shall establish the database used to derive the direct care limit and operating and administrative price used in rates for dates of service July 1, 2010 through June 30, 2011.

1.Each Class I NF and Class II NF in operation as a Medicaid certified NF as of May 1, 2010 shall be identified.

2.The most recent validated cost report for each identified Class I NF and Class II NF, or a prior owner of that NF, that is available on May 1, 2010, with a cost reporting period covering at least six months ending on or before November 30, 2007, shall be selected as the basis for establishing nursing facility rates under this chapter.

i.In the event of a change of ownership after November 30, 2007, and the new owner has a more recent validated cost report covering at least six months and that validated cost report is available on May 1, 2010, the more recent validated cost report shall be selected as the basis for establishing nursing facility rates under this chapter.

ii.If no validated cost report fitting the criteria in (a)2i above is available, the closest validated cost report covering at least a six-month period ending after November 30, 2007, shall be selected as the basis for establishing nursing facility rates under this chapter.

iii.If no validated cost report covering at least a six-month period is available for the identified Class I NF and Class II NF, that NF shall be excluded from the limit and price database.

(b)On an annual basis beginning for rates for dates of service after June 30, 2011, the Department shall establish the direct care limit using the most recent validated cost report as of May 1 preceding the rate year covering at least a six-month period for each Class I NF and Class II NF in operation as a Medicaid certified NF.

1.If no validated cost report is available for a Class I NF and Class II NF, that NF shall be excluded from the limit database.

(c) Every third year, beginning for rates for dates of service after June 30, 2013, the Department shall establish the operating and administrative price using the most recent validated cost report as of May 1 preceding the rate year covering at least a six-month period for each Class I NF in operation as a Medicaid certified NF.

1. If no validated cost report is available for a Class I NF, that NF shall be excluded from the price database.

2. For the second and third year between periods when the operating and administrative price is reestablished, the Department shall adjust by one year the operating and administrative price used for the prior rate year, prior to making any adjustments pursuant to N.J.A.C. 8:85-3.13(d)1, using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year, as identified in N.J.A.C. 8:85-3.6, from the midpoint of the prior rate year to the midpoint of the rate year for which the price is used to establish rates.

History

HISTORY:

Recodified from 10:63-3.1 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-3.8 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a) and (b), substituted "Department" for "departments".

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Special amortization".

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This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.9 Limit and price calculation

(a)The Department shall establish the direct care limit for each Class I and Class II nursing facility.

1. For each cost report identified in N.J.A.C. 8:85-3.8, the Department shall fringe the direct care case mix costs and direct care non-case mix costs, as set forth in N.J.A.C. 8:85-3.5, for all cost reports effective for periods ending before December 31, 2010.

i. For periods ending on or after December 31, 2010, the Department shall select the direct care case mix costs and direct care non-case mix costs from the version of the cost report form used for the cost reporting period.

2. The Department shall adjust the costs identified in (a)1 above using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year, as identified in N.J.A.C. 8:85-3.6, from the midpoint of each cost reporting period to the midpoint of the rate year for which the limit is used to establish rates.

3. The Department shall calculate a per diem adjusted cost as follows:

i. The adjusted direct care case mix costs shall be divided by the total resident days identified on the cost report to establish the adjusted direct care case mix cost per diem;

ii. The adjusted direct care non-case mix costs shall be divided by the total resident days identified on the cost report to establish the adjusted direct care non-case mix cost per diem; and

iii. The results of (a)3i and ii above shall be totaled to establish the adjusted total direct care cost per diem.

4. For each cost report, the normalization ratio shall be calculated as the Statewide average case mix index divided by the cost report period case mix index.

5. Each cost report's adjusted direct care case mix cost per diem shall be multiplied by the normalization ratio to arrive at the normalized direct care case mix cost per diem.

6. Each cost report's normalized direct care case mix cost per diem shall be added to the adjusted direct care non-case mix cost per diem established in (a)3ii above to arrive at the total normalized direct care per diem.

7. For each Class I NF, the cost report's Medicaid resident days shall be used in the array of per diem costs to calculate the Medicaid day weighted median of the total normalized direct care per diems.

8. The direct care limit for Class I NFs shall be 115 percent of the Medicaid day weighted median, and the direct care limit for Class II NFs shall be 105 percent of the Class I NF direct care limit.

(b) The Department shall establish the operating and administrative price for each Class I and Class II nursing facility.

1. For each Class I NF cost report identified in N.J.A.C. 8:85-3.8, the operating and administrative costs shall be fringed as set forth in N.J.A.C. 8:85-3.5 for all cost reports effective for periods ending before December 31, 2010.

i. For periods ending on or after December 31, 2010, the Department shall select the operating and administrative costs from the version of the cost report form used for the cost reporting period.

2. The costs identified in (b)1 above shall be adjusted using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year as identified in N.J.A.C. 8:85-3.6, from the midpoint of each cost reporting period to the midpoint of the rate year for which the price is being established.

3. Each cost report's adjusted operating and administrative costs shall be divided by the total resident days identified on the cost report to arrive at the operating and administrative per diem.

4. For each Class I NF, the cost report's Medicaid resident days shall be used in the array of per diem costs to calculate the Medicaid day weighted median of the operating and administrative per diems.

5. The operating and administrative price for Class I NFs shall be 100 percent of the Medicaid day weighted median, and the operating and administrative price for Class II NFs shall be 104.50 percent of the Class I NF operating and administrative price.

History

HISTORY:

Amended by R.1981 d.326, effective September 10, 1981 (operative October 1, 1981).

See: 13 N.J.R. 360(b), 13 N.J.R. 579(e).

(b)6: "115" was "110"; delete language concerning 10 percent latitude reduction.

Amended by R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(b).

Amended by R.1990 d.428, effective August 20, 1990 (operative October 1, 1990).

See: 22 N.J.R. 118(a), 22 N.J.R. 2588(a).

Revised (b)1, adding i.-iv. regarding minimum nursing requirements.

Amended by R.1993 d.371, effective July 19, 1993.

See: 25 N.J.R. 433(a), 25 N.J.R. 3215(a).

Recodified from 10:63-3.8 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Recodified from N.J.A.C. 10:63-3.9 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Routine patient care expenses".

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N.J.A.C. 8:85-3.10

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.10 Direct care and operating and administrative rate component

(a)For each cost report identified in N.J.A.C. 8:85-3.8, the Department shall establish the direct care rate component.

1.A case mix portion percentage shall be established by dividing the cost report's normalized direct care case mix cost per diem established in N.J.A.C. 8:85-3.9(a)5 by the total normalized direct care per diem established in N.J.A.C. 8:85-3.9(a)6.

i.A non-case mix portion percentage shall be calculated as 100 percent minus the case mix portion percentage.

2.A facility-specific direct care limit shall be established as follows:

i.Multiply each NF's case mix portion percentage by the direct care limit for the NF's Class designation established pursuant to N.J.A.C. 8:85-3.9(a) to determine the facility-specific direct care case mix portion of the limit; then

ii.Multiply the result from (a)2i above by the ratio of the cost report period case mix index divided by the Statewide average case mix index to determine the facility-specific direct care case mix portion of the limit adjusted to the cost report period case mix index; then

iii.Multiply each NF's non-case mix portion percentage by the direct care limit for the NF's Class designation to determine the facility-specific direct care non-case mix portion of the limit; then

iv.The results of (a)2ii and iii above shall be totaled to determine the facility-specific direct care limit.

3.For each rate year, the direct care rate component shall be the facility-specific direct care limit or the inflated total direct care cost per diem established in N.J.A.C. 8:85-3.9(a)3iii, whichever is less.

4.For each rate quarter, a nursing facility's direct care rate component shall be adjusted for the facility average Medicaid case mix index.

i.If the direct care rate component is the inflated total direct care cost per diem established in N.J.A.C. 8:85-3.9(a)3iii, the inflated direct care case mix cost per diem established in N.J.A.C. 8:85-3.9(a)3i shall be multiplied by the ratio of the facility average Medicaid case mix index to the cost report period case mix index plus the inflated direct care non-case mix cost per diem established in N.J.A.C. 8:85-3.9(a)3ii.

ii.If the direct care rate component is the facility-specific direct care limit established in (a)2iv above, the facility-specific direct care case mix portion of the limit adjusted to the cost report period case mix index according to (a)2ii above shall be multiplied by the ratio of the facility average Medicaid case mix index to the cost report period case mix index average plus the facility-specific direct care non-case mix portion of the limit established in (a)2iii above.

iii.To prevent any aggregate increase or decrease in expected Medicaid program expenditures between July rate setting quarters, for resident roster quarters used in the October, January and April rate quarter, the facility average Medicaid case mix index for use in the quarterly rate adjustments for each NF shall be increased or decreased proportionately, so that the Statewide average Medicaid case mix index equals the Statewide average Medicaid case mix index for the resident roster quarter used in the July rate quarter.

5.Except for a new Class I NF or Class II NF, the following shall apply to each Class I NF and Class II NF not included in the N.J.A.C. 8:85-3.8 database and to each Class I NF and Class II NF included in this database but where the NF's cost report filing status subjects that NF to penalties pursuant to N.J.A.C. 8:85-3.2(b):

i.If an NF has had a validated cost report included in the database for rate setting purposes under this chapter, the direct care rate component shall be the lowest direct care rate for the applicable Class of NF for the rate quarter.

(1)The direct care rate in (a)5i above shall remain in effect until such time that a properly filed cost report is received and validated, and a direct care rate established using that validated cost report shall be used to retrospectively adjust the rate quarters in which the lowest direct care rate was used; or

ii.If an NF does not have a validated cost report included in the database for rate setting purposes under this chapter, the rate paid to the NF, including any applicable add-ons, shall be its reimbursement rate in effect on June 30, 2010.

(b)Each NF's operating and administrative rate component shall be the price established for the NF's class designation for the rate year.

History

HISTORY:

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Deleted (a)8 and recodified (a)9 to (a)8.

Recodified from 10:63-3.9 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Recodified from N.J.A.C. 10:63-3.10 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Substituted "Department" for "departments", changed references N.J.A.C. 10:63 to N.J.A.C. 8:85, and made grammatical changes throughout.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Property--capital costs".

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85-3.11

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.11 Fair rental value rate allowance

(a)The Department shall determine the facility fair rental value allowance for each Class I NF and Class II NF.

1.The new construction value per bed shall be \$ 89,000.

2.The age of each NF for the July 1, 2010 through June 30, 2011 rate year shall be determined using the FRV Data Report adjusted to calculate the initial effective age as of 2010.

3.If complete auditable FRV Data Reports are not available for each facility by June 15, 2010, the nursing facility shall be assigned an initial age of 40 years that can only be adjusted by a complete auditable FRV Data Report.

4.For years after 2010, the age of each facility shall be adjusted each July 1 to make the facility one year older to a maximum of 40 years, as well as to make the following adjustments for allowable capitalized costs and other data submitted on the FRV Re-age Request:

i.If an NF places new beds in service during the cost report period, these new beds shall be averaged into the adjusted age of the prior existing beds to arrive at the facility's re-age.

(1)New licensed beds that have allowable capitalized costs of at least the new construction value per bed as stated in (a)1 above shall be re-aged using zero as their age. Allowable capitalized costs in excess of the construction value per bed shall be considered for additional re-aging pursuant to (a)4ii below.

(2)New licensed beds that have allowable capitalized costs less than the new construction value per bed as stated in (a)1 above shall be considered to be the same age as the existing licensed beds for the purpose of the re-aging process described pursuant to (a)4ii below. Allowable capitalized costs in excess of the construction value per bed related to the calculated age of the beds prior to submission of the FRV Re-age Request shall be considered for re-aging pursuant to (a)4ii below; or

ii. If an NF completes a major renovation project or major replacement project, defined as a project with allowable capitalized costs equal to or greater than \$ 1,000 per bed in service during the cost report period, the cost of the project shall be represented by an equivalent number of new beds.

5. A major renovation or replacement project shall have been started within the 24 months preceding the completion date reported on an FRV Re-age Request for the reporting period used for the July 1 rate year and shall be related to the reasonable functioning of the NF.

i. Major renovations and replacement projects unrelated to either the direct or indirect functioning of the NF shall not be used to adjust the facility's age.

ii. Adjustments to a facility's age due to major renovations or replacement projects that result in fewer licensed beds at completion of the project shall be calculated using the number of licensed beds at the beginning of the project.

6. The equivalent number of new beds shall be determined by dividing the capitalized cost of the project, exclusive of the costs attributable to the construction of new beds, by the accumulated depreciation per bed of two percent per year of the facility's existing beds immediately before the project was completed.

7. The Department shall calculate an adjusted age of the facility by taking the equivalent number of new beds determined in (a)6 above plus the number of new beds aged at zero pursuant to (a)4i(1) above and the result shall be subtracted from the total licensed beds, and the result therefor shall be multiplied by the age of the facility, as adjusted for prior additions, major renovations and replacements. The product of this calculation shall then be divided by the number of licensed beds after the completion of the project to arrive at the adjusted age of the facility.

i. An example of the calculation follows:

Licensed Beds Before Re-aging - 100

Licensed Beds After Re-aging - 110

Number of New Licensed Beds - 10

Age of Beds Prior to Re-age - 10

Allowable Capitalized Costs - \$ 1,150,000

Calculations:

Are Allowable Capitalized Costs \geq New construction value?

10 beds [times] \$ 89,000 = \$ 890,000; Answer is "yes."

Additional re-aging:

\$ 1,150,000 - \$ 890,000 = \$ 260,000 (greater than \$ 1,000 per bed)

Current accumulated Depreciation per Bed: 10 Years @ 2% = 20%

Bed Value: \$ 89,000 [times] 20% = \$ 17,800 Depreciation per Bed

Equivalent New Beds: \$ 260,000 / \$ 17,800 = 14.61

Old Beds: 110 beds - 14.61 equivalent new beds - 10 new beds = 85.39 at 10 years old

24.61 beds zero years old - Accum. Age = 0 years

85.39 beds 10 years old - Accum. Age = 853.90 years

853.90 years / 110 licensed beds = 7.76 (Round to 8)

8. If an existing structure is converted for use as a nursing facility, the provider must submit a completed FRV data report.

i. If a complete auditable FRV data report is not submitted, that nursing facility shall be deemed to have an age of 40 years for the purposes of the FRV calculation.

9. For each nursing facility, the facility per bed value shall be calculated as the difference between the new bed value and the new bed value multiplied by the weighted age of the NF (not to exceed 40 years) multiplied by two percent depreciation.

10. The facility total value shall be calculated as the facility per bed value multiplied by the number of licensed beds for the nursing facility.

11. The fair rental value allowance shall be calculated by multiplying the facility total value by an eight percent rental factor and dividing that result by the higher of actual resident days or 95 percent of available days from the cost report used in the database established at N.J.A.C. 8:85-3.8 for the direct care limit.

i. For Class I NFs and Class II NFs not represented in the database established at N.J.A.C. 8:85-3.8 for the direct care limit, the fair rental value allowance shall be calculated by dividing the facility fair rental value by 95 percent of available days, calculated as licensed beds times 365 days.

History

HISTORY:

As amended, R. 1983 d.73, effective March 21, 1983.

See: 14 N.J.R. 743(a), 15 N.J.R. 443(a).

Language concerning financing through a governmental authority.

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

New (e); recodified (e)-(o) as (f)-(p).

Amended by R.1985 d.705, effective January 21, 1986.

See: 17 N.J.R. 2331(a), 18 N.J.R. 189(a).

(n)2 deleted; 3 recodified to 2.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Recodified from 10:63-3.10 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Amended by R.2001 d.120, effective April 2, 2001.

See: 32 N.J.R. 3710(a), 33 N.J.R. 1108(a).

In (a)2, inserted references to new and replacement NFs; in (c), inserted references to Class I, II and III NFs; rewrote (d); in (k), substituted "NFs" for "LCTF's", "that" for "which" and "costs" for "cots".

Recodified from N.J.A.C. 10:63-3.11 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Buildings and fixed equipment".

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N.J.A.C. 8:85-3.12

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.12 Adjustments and pass-throughs

(a)The provider tax pass-through per diem for the rate year shall equal the per diem tax paid by the nursing facility for the calendar year preceding the rate year divided by the total resident days, including all taxable and non-taxable days, as reported on the NHA-100s encompassing that calendar year.

(b)The Department shall approve an NF request for an interim adjustment to rates during a prospective rate period for financial hardship that is likely to reduce the ability of the facility to provide legally required resident care.

1. Interim adjustments, if approved by the Department, shall not apply retroactively unless, for reasons beyond the control of the NF, costs are affected retroactively.
2. Interim adjustments shall not be in effect for a period longer than 12 months.

History

HISTORY:

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

(d) added "re" to determined.

Recodified from 10:63-3.11 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.2001 d.120, effective April 2, 2001.

See: 32 N.J.R. 3710(a), 33 N.J.R. 1108(a).

Rewrote (a)6; in (c), substituted "and" for "through"; in (d), substituted "NFs" for "LTCFs" and substituted references to residents for references to patients.

Recodified from N.J.A.C. 10:63-3.12 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85 throughout.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Land".

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.13 Total adjusted case mix rate

(a)For each rate year, the total adjusted case mix rate for each Class I NF and Class II NF shall be the sum of the direct care rate component, the operating and administrative rate component, the fair rental value allowance, phase-in provisions identified in N.J.A.C. 8:85-3.16 and the provider tax pass-through per diem.

1.The Department shall compare the Statewide Medicaid day weighted average Class I NF, Class II NF and Class III NF July rate to a target rate calculated from the legislative appropriations for nursing facility Medicaid reimbursement according to (c) below.

2.To the extent that the Medicaid day weighted average comparison rate for all Classes exceeds the target rate, each Class I NF and Class II NF total adjusted case mix rate and Class III NF rate, exclusive of the provider tax pass-through per diem, shall be reduced in accordance with (d) below.

(b)The Department shall determine the Statewide Medicaid day weighted average comparison rate of Class I NF, Class II NF and Class III NF rate as follows:

1.The most recent full State fiscal year NF and SCNF paid claims days available on May 1 prior to the rate year shall be identified and bed hold days shall be included by weighting the days to reflect the percentage of the nursing facility rate paid for bed hold.

2.Each nursing facility's comparison rate identified in (a) above shall be multiplied by the nursing facility's paid claims days and the result shall be divided by the sum of the paid claims days to determine the Statewide Medicaid day weighted average comparison rate.

(c)The Department shall determine the target rate as follows:

1.The total amount of State legislative appropriations for nursing facility Medicaid reimbursement for the rate year July 1 to June 30, excluding the State share of funding for the provider tax pass-through per diems, shall be divided by one minus the

Federal Medical Assistance Percentage (FMAP) applicable for the NF rate year to determine the total amount available for nursing facility reimbursement.

i. If more than one FMAP is applicable for the rate year, these FMAPs shall be weighted for the rate year using the number of days each FMAP is effective during the rate year.

ii. If State legislative appropriations change subsequent to the initial calculation of the target rate, these changes shall be used to modify the subsequent quarterly target rate calculations.

iii. If an unanticipated change in the FMAP occurs subsequent to the initial calculation of the target rate, to the extent that FMAP passes on to the nursing facilities, the subsequent quarterly target rate shall be recalculated.

2. The amount calculated in (c)1 above shall be reduced by any legislative appropriation to remove nursing facility payments that are included in the legislative appropriation for NF reimbursement but are paid outside of the NF per diem rates addressed in this chapter.

3. The target rate calculated in (c)1 and 2 above shall be increased for expected resident contributions to Medicaid care provided by the Medicaid NF and SCNF residents and by other payers on their behalf, as follows:

i. The most recent four State fiscal years of Medicaid NF and SCNF paid claims data available on May 1 preceding the rate year for resident contributions shall be identified.

ii. For each year, the total resident contributions shall be totaled and divided by the sum of the Medicaid days to determine a Statewide resident contribution per day.

(1) Simple regression shall be used to trend the Statewide resident contribution per day for each year to the midpoint of the current rate year.

iii. Expected Medicaid days for the rate year shall be calculated from the most recent four years of Medicaid NF and SCNF paid claims data available on May 1 preceding the rate year.

(1) Simple regression shall be used to trend the Statewide Medicaid days to the midpoint of the current rate year.

iv. The trended Statewide resident contribution per day shall be multiplied by the expected Medicaid days for the rate year to determine the Statewide expected resident contributions for the rate year.

4. The combined State funds, Federal funds and Statewide expected resident contributions shall be divided by total expected Medicaid days calculated in (c)3iii above to determine the target rate.

(d) If the Statewide Medicaid day weighted average comparison rate exceeds the target rate, the Department shall make the following adjustments to the calculated rates:

1.The operating and administrative price shall be reduced by as much as is needed to have the Statewide Medicaid day weighted average comparison rate equal to the target rate up to a maximum reduction to 95 percent of the Class I NF median.

2.If the adjustment of the operating and administrative price to 95 percent of the Class I NF median still results in the Statewide Medicaid day weighted average comparison rate exceeding the target rate, the direct care limit shall be reduced by as much as is needed to have the Statewide Medicaid day weighted average comparison rate equal the target rate up to a maximum reduction to 112 percent of the Class I NF median.

3.If the adjustment of the operating and administrative price to 95 percent of the Class I NF median and the reduction of the direct care limit to 112 percent of the Class I NF median still results in the Statewide Medicaid day weighted average comparison rate exceeding the target rate, then a budget adjustment factor shall be calculated by dividing the target rate, exclusive of the Medicaid day weighted average provider tax pass-through per diem, by the Statewide Medicaid day weighted average comparison rate, exclusive of the provider tax pass-through per diem as adjusted for (d)1 and 2 above.

i.The budget adjustment factor determined in (d)3 above shall be multiplied by each nursing facility's rate as adjusted for (d)1 and 2 above and exclusive of the provider tax pass-through per diem.

ii.The adjusted rates as determined in (d)3i above shall be the rates paid during the rate year, as adjusted for changes in the facility average Medicaid case mix index recognized on a quarterly basis, plus the provider tax pass-through per diem.

4.The budget adjustment factor shall be determined annually effective July 1, and shall be utilized in all Class I NF, Class II NF and Class III NF rates during the entire year.

i.If new or improved data becomes available, subsequent to the budget adjustment calculation process and its use in rate setting, this new data shall be utilized in subsequent budget adjustment calculations, but it shall not be utilized to recalculate or otherwise adjust the current rate year budget adjustment factor.

History

HISTORY:

As amended, R.1974 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Recodified from 10:63-3.12 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-3.13 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (b), changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85; rewrote (c).

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Moveable equipment".

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.14 Full cost rates

For publicly owned or operated governmental NFs and SCNFs, the Department shall make a full cost rate calculation that is equal to 100 percent of the facility's allowable costs divided by total patient days as determined from the most recent validated cost report identified in N.J.A.C. 8:85-3.8 and inflated pursuant to N.J.A.C. 8:85-3.6.

History

HISTORY:

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

(a)1: Deleted old text and substituted new text.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Recodified from 10:63-3.13 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1996 d.147, effective March 18, 1996.

See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

Recodified from N.J.A.C. 10:63-3.14 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a), changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85 throughout.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Maintenance and replacements".

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End of Document

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.15 Special Care Nursing Facility (SCNF) rates

(a)Effective for dates of service between July 1, 2010 and June 30, 2011, the rates for a Class III NF, Special Care Nursing Facility (SCNF), shall be the facility rate as of June 30 preceding the rate year adjusted by the percent change allowed for in N.J.A.C. 8:85-3.13(c).

1.To qualify as an SCNF, the NF must meet all of the Department's contractual requirements and be approved by the Department as an SCNF in accordance with the requirements of N.J.A.C. 8:33, 8:33H, 8:39 and this chapter.

2.SCNFs shall be grouped by:

- i.Ventilator/Respirator;
- ii.TBI/Coma;
- iii.Pediatric;
- iv.HIV;
- v.Neurologically Impaired; and
- vi.Behavioral Management.

(b)Effective for dates of service on or after July 1, 2011, the Department shall calculate preliminary SCNF reimbursement rates based on the total allowable costs of providing SCNF services as identified on cost reports filed by SCNFs pursuant to N.J.A.C. 8:85-3.2.

1.The preliminary reimbursement rates shall be limited to the lesser of the rate in effect for each SCNF during the preceding year prior to the application of N.J.A.C. 8:85-3.13(c), or its rate based on total allowable costs determined pursuant to (b) above, and shall be subject to any amounts appropriated for the current rate year.

History

HISTORY:

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

Added text in (a)1 "A separate calculation will be made for governmental facilities."

Recodified from 10:63-3.14 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Recodified from N.J.A.C. 10:63-3.15 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a)3 and 4, changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Property insurance".

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N.J.A.C. 8:85-3.16

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.16 Phase in of case mix rates

(a)For dates of service from July 1, 2010 through June 30, 2011, for Class I NFs and Class II NFs, the total adjusted case mix rate, exclusive of the provider tax pass-through per diem, shall be no more than \$ 5.00 above the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010 and no less than \$ 5.00 below the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010.

1.The Department shall apply the rate change protection in (a) above after any reduction in the operating and administrative price and the direct health care limit pursuant to N.J.A.C. 8:85-3.13(d)1 and 2 before the requirements of N.J.A.C. 8:85-3.13(c) are applied.

(b)For dates of service from July 1, 2011 through June 30, 2012, for Class I NFs and Class II NFs, the total adjusted case mix rate, exclusive of the provider tax pass-through per diem, shall be no more than \$ 10.00 above the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010 and no less than \$ 10.00 below the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010.

1.The Department shall apply the rate change protection in (b) above after any reduction in the operating and administrative price and the direct health care limit pursuant to N.J.A.C. 8:85-3.13(d)1 and 2 but before the requirements of N.J.A.C. 8:85-3.13(c) are applied.

History

HISTORY:

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

"Target" substituted for "largest".

Recodified from 10:63-3.15 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Amended by R.1999 d.74, effective March 1, 1999.

See: 30 N.J.R. 3191(a), 31 N.J.R. 678(b).

Rewrote (c).

Amended by R.2004 d.99, effective March 15, 2004.

See: 35 N.J.R. 2627(a), 36 N.J.R. 1356(a).

Rewrote the section.

Recodified from N.J.A.C. 10:63-3.16 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a)5, changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Target occupancy levels".

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N.J.A.C. 8:85-3.17

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.17 Appeals process

(a)When an NF believes that, owing to an unusual situation, the application of these rules results in an inequity (except for the application of N.J.A.C. 8:85-3.2(f)), two levels of appeals are available: a level I appeal heard by representatives of the Department; and a Level II appeal heard before an administrative law judge.

1.A request for a Level I appeal should be submitted in writing to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, PO Box 715, Trenton, NJ, 08625-0715.

i.Requests for Level I appeals shall be submitted in writing within 60 days of the receipt of notification of the rate by the facility and shall include as follows:

- (1)**A letter requesting a Level I appeal from the facility and/or from the facility's designated representative;
- (2)**A specific description of each appeal issue; and
- (3)**Appropriate documentation that will be sufficient for the Department to understand the nature of each issue of the appeal. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

ii.Adjustments resulting from the Level I appeal submitted in accordance with (a)1i above shall be effective as follows:

- (1)**At the beginning of the prospective reimbursement period if either an error in computation was made by the Department or the appeal was submitted within the specified period.
- (2)**On the first day of the month following the date of appeal for non-computational matters if the appeal is submitted after the specified period.

iii.The date of submission shall be defined as the date received by the Department of Health and Senior Services.

2.If the NF is not satisfied with the results of the Level I appeal, the NF may request a hearing before an administrative law judge. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

i.Request for an administrative hearing must be submitted in writing to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, PO Box 715, Trenton, NJ 08625-0715.

ii.Requests for an Administrative hearing will be considered timely filed if they are submitted within 20 days from the mailing of the ruling in the Level 1 appeal.

iii.The Administrative hearing will be scheduled by the Office of Administrative Law and the facility will be notified accordingly.

iv.At the Level II hearing, the burden is upon the NF to demonstrate entitlement to cost adjustments under this chapter.

History

HISTORY:

The following annotations apply to N.J.A.C. 8:85-3.17 prior to its repeal by R.2011 d.121:

Recodified from 10:63-3.16 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Recodified from N.J.A.C. 10:63-3.17 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

The following annotations apply to N.J.A.C. 8:85-3.17 subsequent to its recodification from N.J.A.C. 8:85-3.21 by R.2011 d.121:

As amended, R.1983 d.11, effective February 7, 1983, operative March 1, 1983.

See: 14 N.J.R. 269(a), 15 N.J.R. 156(a).

Language added concerning Level II hearing being an Administrative Law hearing.

Recodified from 10:63-3.20 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Prior text at 10:63-3.21, Medicaid Occupancy Initiative, repealed by R.1994 d.213, effective May 2, 1994. See: 26 N.J.R. 1840(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-3.21 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

Recodified from N.J.A.C. 8:85-3.21 and amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

In the introductory paragraph of (a), substituted "an" for "a" preceding "NF"; in the introductory paragraph of (a) and of (a)2, substituted "administrative law judge" for "Administrative Law Judge"; and rewrote (a)2iv. Former N.J.A.C. 8:85-3.17, Restricted funds, repealed.

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N.J.A.C. 8:85-3.18

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.18 Transfer of ownership and new facilities

(a)For any facility that transfers ownership, the rate, cost reports and case mix indices established for the old owner shall pass to the new owner.

(b)New Class I NFs and Class II NFs shall be subject to the following:

- 1.The direct care limit for the applicable Class of NF shall be used to establish the direct care rate component;
- 2.The NFs' case mix portion percentage shall be the simple average of all Class I NFs' case mix portion percentages and the NFs' non-case mix portion percentage shall be 100 percent minus the simple average of all Class I NFs' case mix portion percentages;
- 3.For each rate quarter, the direct care rate component shall be the direct care limit for the applicable Class of NF multiplied by the simple average case mix portion percentage multiplied by the ratio of the facility average Medicaid case mix index to the Statewide average case mix index plus the simple average non-case mix portion percentage multiplied by the direct care limit.
 - i.Until the new NF has a final resident roster for the quarter, the Department shall use the Statewide average Medicaid case mix index for the quarter to establish the direct care rate component;
- 4.The operating and administrative rate component shall be the price established for that NF's class designation for the rate year; and
- 5.The Department shall calculate the FRV allowance using 40 years of age for the NF unless a verifiable FRV Re-age Request is submitted and has the effect of re-aging the NF for the purposes of the FRV calculation.

(c)For new Class III NFs, as defined in N.J.A.C. 8:85-3.15(a)1, the rate shall be the simple average rate of the SCNFs in the group for which the new Class III NF qualifies.

History

HISTORY:

As amended, R.1984 d.573, effective December 16, 1984.

See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Deleted (a)4 and recodified (a)5 to (a)4.

Amended by R.1986 d.69, effective March 17, 1986.

See: 17 N.J.R. 1736(a), 18 N.J.R. 561(a).

(a)4 added; old (a)4 renumbered to (a)5.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

(a)4 added.

Recodified from 10:63-3.17 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-3.18 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a)3 and 5, substituted "Department" for "departments".

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Adjustments to base period data".

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N.J.A.C. 8:85-3.19

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.19 Effect of Federal rules incorporated by reference

Any changes to the Federal MDS required by 42 CFR 483.20 and set forth in the Resident Assessment Instrument (RAI) published by CMS, and available at www.cms.gov, which are incorporated herein by reference, as amended and supplemented, shall only apply to rate quarters subsequent to the date of amendment and/or supplement.

History

HISTORY:

As amended, R.1980 d.377, effective September 5, 1980.

See: 11 N.J.R. 445(a), 12 N.J.R. 586(d).

(e) amended.

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

New (b) added; old (b)-(e) renumbered (c)-(f).

Recodified from 10:63-3.18 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-3.19 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote (b); in (f), changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Inflation".

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This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.20 Access to information

(a)The following information maintained by the Department for the purposes of rate-setting or administering other duties under this chapter shall not be considered "government records" subject to public access or inspection within the meaning of the "Open Public Records Act," N.J.S.A. 47:1A-1 et seq.:

- 1.Any information derived from an NHA-100 provided by the Division of Taxation in accordance with N.J.S.A. 54:50-8;
- 2."Information relating to medical . . . history, diagnosis, treatment, or evaluation" within the meaning of Executive Order No. 26 (2002);
- 3."Records concerning morbidity, mortality and reportable diseases of named individuals required to be made, maintained or kept by any State or local government agency" within the meaning of Executive Order No. 9 (1963).

History

HISTORY:

Amended by R.1980 d.377, effective September 5, 1980.

See: 11 N.J.R. 445(b), 12 N.J.R. 586(d).

(a)3 amended to include last sentence.

Amended by R.1985 d.705, effective January 21, 1986.

See: 17 N.J.R. 2331(a), 18 N.J.R. 189(a).

(a)3 deleted text "This working capital ... a CFA rate."

Amended by R.1987 d.6, effective January 5, 1987.

See: 18 N.J.R. 257(a), 19 N.J.R. 126(a).

(a)5 substantially amended.

Amended by R.1990 d.428, effective August 20, 1990 (operative October 1, 1990).

See: 22 N.J.R. 118(a), 22 N.J.R. 2588(a).

Deleted old (a)5 regarding rates and added new text as (a)5i-iii(1) and Appendix I.

Recodified from 10:63-3.19 and amended by R.1994 d.624, effective January 3, 1995.

See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Repeal and New Rule, R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Section was "Working capital provision and total rates".

Recodified from N.J.A.C. 10:63-3.20 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Total rates".

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N.J.A.C. 8:85-3.21

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.21 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 8:85-3.17 by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Appeals process".

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N.J.A.C. 8:85-3.22

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.22 (Reserved)

History

HISTORY:

New Rule, R.2001 d.1, effective January 2, 2001.

See: 32 N.J.R. 2859(a), 33 N.J.R. 54(a).

Recodified from N.J.A.C. 10:63-3.25 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85 throughout. Former N.J.A.C. 10:63-3.22, Transitional relief for salary region adjustment; State Fiscal Year 1993, repealed.

Repealed by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Section was "Transfer of ownership".

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N.J.A.C. 8:85-3.23

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.23 (Reserved)

History

HISTORY:

Recodified from N.J.A.C. 10:63-3.23 and repealed by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Section was, Transitional relief for salary region adjustment; State Fiscal Year 1994.

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This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 3. COST REPORT, RATE CALCULATION AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

§ 8:85-3.24 (Reserved)

History

HISTORY:

Recodified from N.J.A.C. 10:63-3.24 and repealed by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Section was, Transitional relief for salary region adjustment; State Fiscal Year 1995.

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85-4.1

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 4. AUDIT

§ 8:85-4.1 Audit cycle

(a) Any cost report submitted by a Medicaid participating nursing facility (NF) which is selected for audit on or after February 7, 1983 may be audited within three years of the due date of the cost report or the date it is filed, whichever is later. This requirement shall be satisfied if the on-site audit of the NF is initiated within the three-year period and completed within a reasonable time thereafter. If a NF audit is not initiated within this time limit, the appropriate cost report or cost reports shall be excluded from the audit, subject to the conditions set forth in the balance of this subsection and the waiver provisions set forth in (b) below. Exclusion is subject to the following conditions:

1. Failure to initiate a timely audit shall not preclude the Department from collecting overpayments, interest or other penalties if the overpayments are identified by an agency other than the Department.
2. When a timely audit is conducted and additional overpayments are discovered by another agency, the Department shall not be precluded from collecting such overpayments together with any applicable interest or other penalties.

(b) The Department shall not be precluded from waiving the three-year limitation for good cause, and good cause shall include, but not be limited to, the following circumstances:

1. The overpayments involved in the audit were generated as a result of fraudulent activity by the NF or NF-related party, whether or not that fraudulent activity has been the subject of a criminal investigation and/or prosecution;
2. The NF, its agents or employees have failed to cooperate in the initiation or conduct of the audit;
3. The Department could not have reasonably discovered by audit any evidence of the overpayment within the three-year period;
4. The audit could not be initiated within the three-year period because of delay or cessation of the audit resulting from a request by a law enforcement agency or an administrative agency with jurisdiction over the facility.
 - i. This provision shall not apply if the NF's records are available and no request for delay or cessation of the audit has been made by any of these agencies.

(c) Notice must be given to the NF when the three year requirement is waived together with the reasons for such action. The NF may request a hearing on any waiver by the Department to the extent authorized by applicable statutes, rules and regulations.

History

HISTORY:

Amended by R.1981 d.23, effective February 1, 1981.

See: 12 N.J.R. 701(b), 13 N.J.R. 146(a).

Administrative change, recodified from N.J.A.C. 10:63-1.21.

See: 24 N.J.R. 3728(b).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-4.1 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Substituted "Department" for "Division" throughout; substituted "report" for "study" throughout.

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N.J.A.C. 8:85-4.2

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 4. AUDIT

§ 8:85-4.2. Audits

(a)For the exclusive purpose of calculating interest, under N.J.S.A. 30:4D-17(f), "completion of the field audit" for nursing facility providers shall be defined in the following manner:

- 1.**For all such audits and audit recovery cases pending on February 7, 1983, it shall mean the date that field work is completed, or the date information requested from the provider during the course of that field work is received, whichever is later;
- 2.**For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other agency for criminal investigation, it shall mean the date the Division of Medical Assistance and Health Services (DMAHS), Office of Program Integrity Administration (OPIA), receives authorization to take administrative action.
- 3.**For all such audits initiated on or after February 7, 1983, it shall mean the date the exit conference is completed or the date information requested from the provider during the course of the exit conference is received, whichever is later.

(b)Notwithstanding any of the previous subsections, if after the screening of any nursing facility provider audit the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires additional field work, for the exclusive purpose of calculating interest under N.J.S.A. 30:4D-17, the field audit shall be considered completed when the additional field work is completed.

(c)Notwithstanding any of the previous subsections, if after the screening of any nursing facility provider audit the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall, for the exclusive purpose of calculating interest, be considered reopened and interest shall again accrue for the period beginning 20 days from the date that the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.

(d)Notwithstanding any of the previous subsections, if all or part of any nursing facility provider audit initiated on or after the effective date of this subsection is referred to the Division of Criminal Justice or other agency for criminal investigation:

1. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation;

2. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OPIA receives authorization to take administrative action.

History

HISTORY:

Amended by R.1983 d.5, effective February 7, 1983 (operative March 1, 1983).

See: 14 New Jersey Register 1031(a), 15 New Jersey Register 155(a).

Amended by R.1985 d.177, effective April 15, 1985.

See: 16 New Jersey Register 2413(a), 17 New Jersey Register 966(a).

(a)2 added; (a)2 recodified to (a)3.

Correction: (a)3 was inadvertently omitted from code. It has been added.

See: 18 New Jersey Register 1205(c).

Administrative change, recodified from N.J.A.C. 10:63-1.22.

See: 24 New Jersey Register 3728(b).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 New Jersey Register 281(a), 27 New Jersey Register 1307(a).

Recodified from N.J.A.C. 10:63-4.2 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

In (a)2, added "Division of Medical Assistance and Health Services (DMAHS)".

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N.J.A.C. 8:85-4.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 4. AUDIT

§ 8:85-4.3 Final audited rate calculation

(a)The Department will calculate final per diem rates based on audit adjustment reports.

(b)The final per diem rates determined based on (a) above cannot exceed the prospective rates previously paid.

(c)Settlement after final rate calculation will be for fraud and/or abuse collections or recoveries of payments when the final rate is lower than the original rate.

History

HISTORY:

Amended by R.1984 d.572, effective December 16, 1984.

See: 16 N.J.R. 2335(a), 16 N.J.R. 3436(b).

Administrative change, recodified from N.J.A.C. 10:63-1.23.

See: 24 N.J.R. 3728(b).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

Recodified from N.J.A.C. 10:63-4.3 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a), substituted "Department" for "Division of Medical Assistance and Health Services"; in (d), changed N.J.A.C. 10:63 reference to N.J.A.C. 8:85.

Amended by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

Deleted (d) and (e).

N.J.A.C. 8:85-5.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES > SUBCHAPTER 5. PROVIDER REIMBURSEMENTS

§ 8:85-5.1 Provider tax reimbursement

(a) Upon receipt, from the Director of the Division of Taxation in the New Jersey Department of the Treasury, or the Director's designee, of the total amount of provider tax monies available for reimbursement to nursing facilities effective July 1 of each year from the Nursing Home Quality of Care Improvement Fund created pursuant to N.J.S.A. 26:2H-95, plus the appropriate Federal matching funds, the Department shall determine the amount of those monies that are necessary to provide funding of the provider tax pass-through per diems in accordance with N.J.A.C. 8:85-3.12(a).

(b) The remaining portion of the provider tax monies after determining the portion that shall be reimbursed to NFs as the provider tax pass-through per diems as described in (a) above shall be included in the amount of total funding available to nursing facilities in accordance with N.J.A.C. 8:85-3.13(c)1.



N.J.A.C. 8:85, Appx. A

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX A

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix A, repealed.

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N.J.A.C. 8:85, Appx. B

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX B

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix B, repealed.

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N.J.A.C. 8:85, Appx. C

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX C

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix C, repealed.

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N.J.A.C. 8:85, Appx. D

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX D

(RESERVED)

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Former N.J.A.C. 10:63, Appendix D, repealed.

Repealed by R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

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N.J.A.C. 8:85, Appx. E

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX E

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix E, repealed.

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N.J.A.C. 8:85, Appx. F

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX F

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix F, repealed.

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N.J.A.C. 8:85, Appx. G

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX G

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix G, repealed.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX H

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix H, repealed.

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N.J.A.C. 8:85, Appx. I

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX I

PASRR PSYCHIATRIC EVALUATION

PASRR PSYCHIATRIC EVALUATION
NEW JERSEY DIVISION OF MENTAL HEALTH SERVICES

PLEASE PRINT

DMHS 1/09

CLIENT'S NAME: _____
LAST FIRST M.I.

SECTION 1 CLIENT LOCATION AND IDENTIFIERS (to be completed by person referring client for evaluation)

1.1 COUNTY WHERE CLIENT IS TODAY: _____

NOTE: FOR ANCORA, ENTER CAMDEN COUNTY.
FOR CLIENTS OUTSIDE NJ, ENTER COUNTY WHERE CLIENT WILL RESIDE.

1.2 NAME OF ORGANIZATION REFERRING CLIENT FOR A PSYCHIATRIC EVALUATION:

____ CHECK HERE IF CLIENT IS IN THE COMMUNITY NOW

1.3 TYPE OF ASSESSMENT: ____ INTIAL ____ RESIDENT REVIEW ____ OTHER *please specify* _____

1.4 MEDICAID NUMBER (12 DIGITS): _____

____ CHECK HERE IF NO MEDICAID NUMBER ASSIGNED

1.5 SOCIAL SECURITY NUMBER (9 DIGITS): _____

1.6 DATE OF BIRTH: ____ / ____ / ____ 1.7 ADMISSION DATE: ____ / ____ / ____
MM DD YYYY MM DD YYYY

1.8 DOES THE CLIENT USE A PRIMARY LANGUAGE OTHER THAN ENGLISH?

____ NO ____ YES *please specify*: _____

IF YES, DESCRIBE HOW LANGUAGE NEEDS WERE MET TO CONDUCT THE PSYCHIATRIC EVALUATION:

SECTION 2 HEALTH AND ILLNESS (to be completed by person conducting the psychiatric evaluation)

2.1 WHAT IS THE PRESENTING PROBLEM AND CHIEF COMPLAINT? (if additional space is needed, please attach separate page)

2.2 WHAT IS THE HISTORY OF THE PRESENT PSYCHIATRIC ILLNESS? (if additional space is needed, please attach separate page)

PASRR PSYCHIATRIC EVALUATION
NEW JERSEY DIVISION OF MENTAL HEALTH SERVICES

PLEASE PRINT

DMHS 1/09

CLIENT'S NAME: _____
LAST FIRST M.I.

SECTION 9 PSYCHOTROPIC MEDICATIONS

| 9.1 | NAME OF MEDICATION | DOSAGE | TYPE OF THERAPY (CHECK ONE) | | TYPE OF ADMINISTRATION (CHECK ONE) | |
|-----|--------------------|--------|---------------------------------|--------------------------------------|---------------------------------------|---------------------------------|
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |
| | _____ | _____ | <input type="checkbox"/> ACTIVE | <input type="checkbox"/> MAINTENANCE | <input type="checkbox"/> VOLUNTARY | <input type="checkbox"/> FORCED |

9.2 ARE MEDICATIONS GIVEN TO AUGMENT THE ACTION OF MEDICATION ABOVE?
 NO YES *list names and dosages* _____

9.3 HAS CLIENT EXPERIENCED ANY SIDE EFFECTS OF MEDICATION ABOVE (I.E. PARKINSONISM, WEIGHT SIDE EFFECTS GAIN)? IF YES, DESCRIBE SIDE EFFECTS BELOW.
 NONE ARE KNOWN

9.4 MEDICATIONS PRESCRIBED TO CONTROL SIDE EFFECTS

9.5 BASED ON THE SEVERITY OF SIDE EFFECTS, OR FOR OTHERS REASONS, SHOULD MEDICATION OR DOSAGES BE ADJUSTED?
 NO YES *please explain* _____

PASRR PSYCHIATRIC EVALUATION
NEW JERSEY DIVISION OF MENTAL HEALTH SERVICES

PLEASE PRINT

DMHS 1/09

NOTE: THIS PAGE SERVES AS A ONE-PAGE NOTIFICATION LETTER FOR OFFICIAL PURPOSES. NURSING FACILITIES RECEIVING THIS LETTER ARE REQUIRED TO PLACE A COPY IN THE RESIDENT'S MEDICAL RECORD.

SECTION A (to be completed by person referring resident for evaluation)

A.1 CLIENT'S NAME: _____ CLIENT'S DOB: _____

A.2 FOR PSYCHIATRIC EVALUATIONS: ENTER NAME OF COUNTY SELECTED ON PAGE 1 BELOW FOR RESIDENT REVIEWS ONLY; ENTER FULL NAME OF NURSING FACILITY WHERE CLIENT RESIDES.

A.3 PERSON REFERRING CLIENT FOR EVALUATION:

_____ NAME _____ ORGANIZATION OR RELATIONSHIP TO CLIENT _____

_____ VOICE PHONE NUMBER _____ FAX NUMBER _____

A.4 _____ CHECK HERE IF CLIENT USES PRIMARY LANGUAGE OTHER THAN ENGLISH specify _____

SECTION B (to be completed by person conducting the psychiatric evaluation)

HAVING ASSESSED THIS CLIENT AND THE AVAILABLE CLINICAL RECORDS, IT IS MY PROFESSIONAL OPINION THAT THE CLIENT:

B.1 _____ NO _____ YES HAS AN ACTIVE PSYCHOSIS

B.2 _____ NO _____ YES HAS A MAJOR MENTAL ILLNESS

B.3 _____ NO _____ YES HAS MENTAL HEALTH TREATMENT NEEDS THAT CAN BE MET IN A NURSING FACILITY

B.4 _____ NO _____ YES NEEDS "SPECIALIZED SERVICES" FOR BEHAVIOR SYMPTOMS THAT REQUIRE 24-HOUR PSYCHIATRIC INPATIENT CARE

NOTE: B.3 AND B.4 ABOVE CANNOT BOTH BE "YES" SINCE A NURSING FACILITY CANNOT PROVIDE "SPECIALIZED SERVICES"

B.5 FUTURE NEEDS FOR LESS THAN "SPECIALIZED SERVICES" (check all that apply):

_____ MEDICATION MONITORING _____ LABORATORY TESTING specify _____

_____ SUPPORTIVE COUNSELING _____ FOLLOW-UP FOR CHEMICAL DEPENDENCY OR ABUSE

_____ FOLLOW-UP CONSULTATION specify _____

Print Name and Title of Examiner: _____

Signature of Examiner: _____

Telephone # _____ Exam Date _____

SECTION C (to be completed by Psychiatrist/APN at NJ Division of Mental Health Services)

C.1 _____ NO _____ YES THIS CLIENT NEEDS "SPECIALIZED SERVICES" (SEE B.4 ABOVE)

C.2 _____ NO _____ YES THIS CLIENT NEEDS A RESIDENT REVIEW FOR SERIOUS MENTAL ILLNESS

Signature _____ Review Date _____

FAX THIS EVALUATION TO THE NJDMHS PASRR COORDINATOR AT (609) 777-0662
CONTACT PASRR COORDINATOR BY PHONE AT (609) 777-0725

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Former N.J.A.C. 10:63, Appendix I, repealed.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

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N.J.A.C. 8:85, Appx. J

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX J

AT-RISK CRITERIA FOR NURSING FACILITY PLACEMENT

**New Jersey Department of Health and Senior Services
Division of Aging and Community Services**

AT-RISK CRITERIA FOR NURSING FACILITY PLACEMENT

The following is a list of "at-risk" criteria to assist the hospital in determining if a referral for long term care services, either in a nursing facility or in the community, is indicated.

- I. **Medical** – Has the patient experienced any of the following:
 1. Catastrophic illness requiring major changes in lifestyle and/or living conditions, i.e. Multiple Sclerosis, Stroke, Multiple Trauma, AIDS, Amputation, Neurological Disease, Cancer, Birth Defect(s), End Stage Renal Disease.
 2. Debilitation and/or chronic illness causing progressive deterioration of self-care skills, i.e. Diabetes, Fractures, Progressive Pulmonary Disease, Severe Chronic Diseases, Spina Bifida.
 3. Multiple hospital admissions within the past six (6) months. (Do not refer patients admitted directly from nursing facilities.)
 4. Previous nursing facility admissions within the past two (2) years.
 5. Major health needs, i.e. tube feedings, special equipment or treatments, rehabilitative/restorative services.
- II. **Social** – In addition to the medical criteria, does patient meet any of the following social situations:
 1. Living arrangements are uncertain
 2. Lives alone and/or has no immediate support system
 3. Primary caregiver is not able to provide required care services
 4. Lack of adequate support systems
- III. **Financial (as of 1/1/09)** – Does the patient meet any of the following income/assets tests:
 1. Currently eligible for Medicaid
 2. Monthly income at/or below the current Medicaid institutional cap of \$2,022.00 and:
 - a. Has no spouse in the community and resources no greater than \$2,000.00 (plus \$1,500.00 burial fund), or
 - b. Has no spouse in the community and resources below \$39,930.00 (plus \$1,500.00 burial fund). This is an indication that the patient may become Medicaid eligible within the next six (6) months by spending down assets in a nursing facility as private pay, or
 - c. Has a spouse in the community with combined countable resources at/or below \$104,400 (plus \$1,500.00 burial fund). This allows for calculation of the community spouse's resources under the Medicare Catastrophic Coverage Act of 1988.
 3. Monthly income at/or below the current New Jersey Care Special Medicaid Programs maximum monthly income limit of \$903.00 and:
 - a. Has no spouse in the community and resources no greater than \$4,000.00 (plus \$1,500.00 burial fund), or
 - b. Has no spouse in the community and resources at/or below \$39,930.00 (plus \$1,500.00 burial fund). This is an indication that the patient may become Medicaid eligible within the next six (6) months by spending down assets in a nursing facility as private pay, or
 - c. Has a spouse in the community with combined countable resources at/or below \$104,400 (plus \$1,500.00 burial fund). This allows for calculation of the community spouse's resources under the Medicare Catastrophic Coverage Act of 1988.

LTC-D1
APR 09

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

N.J.A.C. 8:85, Appx. J

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Former N.J.A.C. 10:63, Appendix J, repealed.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

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N.J.A.C. 8:85, Appx. K

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX K

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History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix K, repealed.

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX L

APPENDIX L
HEALTH SERVICE DELIVERY PLAN (H.S.D.P) - Part I



Office of Long Term Care Options

Client Name: _____

Social Security Number: _____

Medicaid #: _____

Social Security #: _____ Medicaid (HSP)#: _____ Birthdate: _____ Female Male

Primary Diagnosis: _____

Secondary Diagnosis: _____

Allergies: _____

ASSESSMENT SUMMARY - IDENTIFY CARE NEEDS TO JUSTIFY SERVICE RECOMMENDATION

Large empty rectangular box for assessment summary.

SERVICE AUTHORIZATION

NF

YES 2.5 HOURS
ADDITIONAL NURSING SERVICES
DENIAL OF NF SERVICES
PASARR NO
MI MR EXEMPT

LOCUS OF CARE

TRACK I (LONG TERM PLACEMENT)
 TRACK II (SHORT TERM PLACEMENT)
 TRACK III (COMMUNITY PLACEMENT)

SPECIAL CARE NURSING FACILITY

Respirator
 Coma
 Neuro Impaired YA
 TBI
 Pediatric
 AIDS
 Behavioral
 Other: _____

WAIVER PROGRAMS

CCPED
 Model Waiver
 ACCAP
 AL/AFC
 Other: _____
 Community

Months: _____ Date: _____

Assessor: _____



Office of Long Term Care Options

HEALTH SERVICE DELIVERY PLAN (H.S.D.P) - Part I

Client Name: _____
Social Security Number: _____
Medicaid #: _____

I. FINANCIAL INFORMATION

Monthly Income
SSI: _____
Social Security: _____
Pension: _____
Other: _____
TOTAL: _____
Resources (bank accounts, stocks, bonds)
Total: _____
Life Insurance? [] Yes [] No
If yes, cash value of life insurance (if applicable): _____

II. PLACEMENT/SERVICE INFORMATION

Placement options discussed with individual:
ALR: [] ALP: [] AFC: [] CPCH: [] CCPED: []

Rank the individual's preferences among the options discussed (numerical preferences starting with #1):
ALR: ___ ALP: ___ AFC: ___ CPCH: ___ CCPED: ___

Family Present during interview? [] Yes [] No
If yes, please specify who was present:

Rate the likelihood of individual being placed in a NF within 6 months based on care needs and willingness of individual to be admitted to a NF and availability of family support:
[] HIGH [] MODERATE [] LOW

Comments: [Large empty text box for notes]

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

N.J.A.C. 8:85, Appx. L

Former N.J.A.C. 10:63, Appendix L, repealed.

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N.J.A.C. 8:85, Appx. M

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX M

APPROVAL LETTER



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

DIVISION OF AGING AND COMMUNITY SERVICES

PO BOX 807

TRENTON, N.J. 08625-0807

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

Date: _____

Reply to: _____
Regional Office of the
Office of Community Choice Options

Dear _____:

This notice advises you of the following decision regarding your clinical eligibility for nursing facility level of care and/or adult day health services and the placement and/or program you are approved for under the New Jersey Medicaid or JACC program.

Importante: Si usted no entiende este aviso, pongase en contacto con un representante de esta oficina.

1. You are clinically eligible for:

Nursing facility level of care in accordance with N.J.A.C. 8:85-2.1.

a. You are approved for:

- Long-term nursing facility placement (Track I).
- Short-term nursing facility placement (Track II) for _____ month(s).
- Home and Community-Based Waiver Services (Track III).

You indicated your interest in the following program. If you are enrolled in the program a Care Manager will contact you to arrange services.

- Global Options (GO).
- HCBS DDS (Specify Program): _____
 - The Home and Community-Based Waiver Services program you selected is unable to accept new clients at this time. You will be contacted once an opening is available for you.

b. You are approved for placement in _____, which is a special care nursing facility (SCNF), in accordance with N.J.A.C. 8:85-2.21.

c. You are approved for Jersey Assistance for Community Caregiving (JACC). If you are enrolled in the program a Care Manager will contact you to arrange services.

JACC is unable to accept new clients at this time. You will be contacted once an opening is available for you.

-2-

Client Name: _____ Date: _____

2. You are clinically eligible and approved for:

- Adult Day Health Services in accordance with N.J.A.C. 8:86-1.5.
- Pediatric Medical Day Care in accordance with N.J.A.C. 8:87-3.1.
 - The child is exempt from Prior Authorization in Pediatric Medical Day Care for 90 days as per N.J.A.C. 8:87-3.3, which addresses a child being discharged from a Neonatal Intensive Care Unit. Exemption from Prior Authorization is dependent upon the provider following all provisions in the cited regulation.

Additional Information:

- This notice confirms clinical eligibility only. Program enrollment will not occur until financial eligibility is determined.
- Approval for the service(s) or program(s) identified by this notice, which is under the New Jersey Medicaid program, Home and Community-Based Waiver Services, or Global Options, is contingent upon financial eligibility. Financial eligibility is determined by the County Welfare Agency/Board of Social Services in your county or through SSI, if applicable.
- Approval for the Jersey Assistance for Community Caregiving (JACC) is contingent upon financial eligibility, which is determined by Pharmaceutical Assistance to the Aged and Disabled (PAAD).
- Enrollment in one of the Home and Community-Based Waiver services, PACE, and the Jersey Assistance for Community Caregiving (JACC) is contingent upon compliance with the specific program enrollment requirements.
- Your clinical and financial eligibility will be re-evaluated at least annually; you must continue to meet the clinical and financial eligibility criteria in order to remain in the program.

Sincerely,

Name of Community Choice Counselor

Signature of Community Choice Counselor

- c: County Welfare Agency/Board of Social Services
 PACE Provider Organization

LTC-13
APR 10

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

N.J.A.C. 8:85, Appx. M

Former N.J.A.C. 10:63, Appendix M, repealed.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85, Appx. N

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX N

DENIAL LETTER



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

DIVISION OF AGING AND COMMUNITY SERVICES

PO BOX 807

TRENTON, N.J. 08625-0807

www.nj.gov/health

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

Reply to:

_____ Regional Office of the
Office of Community Choice Options

Phone #: _____

Date: _____

Dear _____:

This notice advises you of the decision regarding your clinical eligibility for the level of care and/or program under the New Jersey Medicaid Program identified below.

Importante: Si usted no entiende este aviso, pongase en contacto con un representante de esta oficina.

- 1. You are not clinically eligible for:
 - a. nursing facility level of care in a nursing facility or home and community-based services waiver in accordance with N.J.A.C. 8:85-2.1.
 - b. the Adult Day Health Services Program in accordance with N.J.A.C. 8:86-1.5.
 - c. the Pediatric Medical Day Care Program in accordance with N.J.A.C. 8:87-3.1.
- 2. You are no longer clinically eligible for:
 - a. nursing facility level of care in a nursing facility or home and community-based services waiver in accordance with N.J.A.C. 8:85-2.1.
 - b. the Adult Day Health Services Program in accordance with N.J.A.C. 8:86-1.5.
 - c. the Pediatric Medical Day Care Program in accordance with N.J.A.C. 8:87-3.1.

Medicaid payment will only continue for a maximum of 20 days from the date of this letter for (1) the services you receive that require nursing facility level of care and/or (2) your care under the Adult Day Health Services Program.

Participant Name: _____ Date: _____

3. You no longer require the level of care provided in the _____ special care nursing facility (SCNF) in accordance with N.J.A.C. 8:85-2.21. Medicaid payment for your care in the SCNF will continue until you are discharged from the SCNF or 60 days from the date of this letter, whichever is first.
- a. Although you no longer require the level of care provided by the SCNF, you are still clinically eligible for nursing facility level of care in accordance with N.J.A.C. 8:85-2.1. A letter authorizing services for that level of care is attached.

Sincerely,

Name of Community Choice Counselor

Signature of Community Choice Counselor

- c: County Welfare Agency/Board of Social Services
 PACE Provider Organization

Participant Name: _____ Date: _____

Fair Hearing Notice

You have the right to request a fair hearing regarding this action. You must request a fair hearing within 20 days of the date of this letter. If you have been receiving Medicaid benefits and request a fair hearing within the 20-day period, your Medicaid benefits may continue until a hearing decision is reached so long as you remain eligible in all other respects. However, if the fair hearing decision is not in your favor, you may be required to repay any Medicaid benefits to which you were not entitled.

Fair Hearing Request

You must submit a request for a fair hearing in accordance with N.J.A.C. 10:49-10.3. To request a fair hearing, complete the following section in full and send a legible copy of pages 1 and 2 of this notice to:

Office of Legal and Regulatory Liaison
Division of Medical Assistance and Health Services
Fair Hearing Unit
PO Box 712
Trenton, New Jersey 08625-0712

I am requesting a fair hearing because: _____

If you are requesting a fair hearing for Medicaid benefits that you are currently receiving, check one:

- Continue** my Medicaid benefits during the fair hearing process. I understand that if the fair hearing decision is not in my favor that I may be required to repay any Medicaid benefits I was not entitled to receive.
- Do not continue** my Medicaid benefits during the fair hearing process.

If someone other than the individual identified on page 1 of this notice completed this request, please complete the following information:

Name of Representative: _____

Relationship to Applicant/Recipient: _____

Telephone Number: _____

Address: _____

Participant Name: _____ Date: _____

Your Rights

1. Concerning the fair hearing, you have the right to:
 - Present your own case or have a relative, friend, or attorney make the presentation.
 - Submit any evidence or bring any witnesses that bear on your case.
 - Examine records or case files including the application form. You may also examine the case record in advance except for those records which are protected from release and which may not be introduced by the Department of Health and Senior Services as evidence.
 - Review a complete and up-to-date copy of N.J.A.C. 8:85, N.J.A.C. 8:86, and/or N.J.A.C. 8:87.
2. You have the right to have legal counsel represent you at the fair hearing. The following is information regarding legal services:
 - There are legal services organizations that provide free legal counsel to individuals who cannot afford a private attorney.
 - Legal Services of New Jersey (LSNJ) provides free legal information, advice and/or representation for low-income individuals who qualify for their services. For more information about the LSNJ Health Care Access Project or their local legal services offices, contact the LSNJ toll-free legal hotline at 1-888-576-5529.
3. You have the right to request another assessment to determine your clinical eligibility if you experience a change in your condition or circumstances.

Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the grounds of race, color, national origin, age or handicap in the administration of a program for which Federal funds are received.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Former N.J.A.C. 10:63, Appendix N, repealed.

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

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N.J.A.C. 8:85, Appx. O (RESERVED)

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX O (RESERVED)

History

HISTORY:

Appendix O, repealed by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85, Appx. P

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX P



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PA # _____

REQUEST FOR PRIOR AUTHORIZATION
SUPPLEMENTAL INFORMATION

Provider Information:

Name

Address

Provider Identification Number

Beneficiary Information:

Name

Eligibility Identification Number

Contact Person:

Name

Telephone Number

9a BRIEF CLINICAL HISTORY

10a PRESENT CLINICAL STATUS (to support request)

11a DIAGNOSIS AND CODE (must conform with ICD-9-CM) AND CURRENT MEDICATIONS

17 TREATMENT PLAN AND GOALS

18 ADDITIONAL CLINICAL INFORMATION (include all modifications of treatment/medication)

19. RESERVED FOR USE BY DMAHS CONSULTANT ONLY

FD-07A (rev. 09/01)

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

N.J.A.C. 8:85, Appx. P

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix P, repealed.

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85, Appx. Q

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX Q

Click here to view image.

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 New Jersey Register 4700(a), 37 New Jersey Register 1185(a), 38 New Jersey Register 674(a).

Former N.J.A.C. 10:63, Appendix Q, repealed.

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N.J.A.C. 8:85, Appx. R

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX R



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF AGING AND COMMUNITY SERVICES

PO BOX 807
TRENTON, N.J. 08625-0807

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

Date: _____

Dear _____:

During your Pre-Admission Screening Assessment for nursing facility placement, the staff from the _____ Office of Community Choice Options reviewed clinical documentation that indicates a diagnosis of mental illness as defined in 42 CFR 483.102. Therefore, you are being referred to the State Mental Health Authority for a Level II Pre-Admission Screen and Resident Review (PASARR) screening. This screening must be completed before you can be approved for admission to a nursing facility.

The reason for this additional screening is to determine if you require any specialized services for your mental illness.

If you have any questions, please call the _____ Office of Community Choice Options at _____.

Sincerely,

Community Choice Counselor

LTC-L6
MAR 10

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

N.J.A.C. 8:85, Appx. R

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

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N.J.A.C. 8:85, Appx. S

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX S



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

DIVISION OF AGING AND COMMUNITY SERVICES

PO BOX 807

TRENTON, N.J. 08625-0807

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

Date: _____

Dear _____:

During your Pre-Admission Screening Assessment for nursing facility placement, the staff from the _____ Office of Community Choice Options reviewed clinical documentation which indicates a diagnosis of mental retardation or a related condition as defined in 42 CFR 483.102. Therefore, you are being referred to the State Developmental Disabilities Authority for a Level II Pre-Admission Screen and Resident Review (PASARR) screening. This screening must be completed before you can be approved for admission to a nursing facility.

The reason for this additional screening is to determine if you require any specialized services for your mental retardation or related condition.

If you have any questions, please call the _____ Office of Community Choice Options at _____.

Sincerely,

Community Choice Counselor

LTC-L7
MAR 10

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

N.J.A.C. 8:85, Appx. S

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

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N.J.A.C. 8:85, Appx. T

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX T

HOSPITAL PREADMISSION SCREENING REFERRAL

New Jersey Department of Health and Senior Services
Division of Aging and Community Services
Office of Long Term Care Options
HOSPITAL PREADMISSION SCREENING REFERRAL*

PLEASE PRINT

Hospital _____ Date _____
Referred By _____
Telephone Number _____

PATIENT INFORMATION

Name _____ (Last) _____ (First) _____ (MI) _____ DOB _____
Sex Male Female
HSP # _____ SS# _____
Home Address _____
Responsible Party _____
Home Telephone No. () _____ Work Telephone No. () _____

ADMISSION INFORMATION

Date of Admission _____ Floor _____
Admitted From _____ Room # _____
Primary Admitting Diagnosis _____
Secondary Admitting Diagnosis _____
Date Referred to D/C Planner/Soc. Serv. _____
Date Pt. Met At-Risk Criteria _____

ELIGIBILITY STATUS

Currently Medicaid Eligible _____ Date Referred to CWA _____
 Application in Process
 180 Days Potentially Eligible

*Form may be used to FAX information or as written confirmation of telephone referral to LTCFO.

LTC-4
MAR 04

History

HISTORY:

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

N.J.A.C. 8:85, Appx. T

Repeal and New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX U

Cost Report Supplemental Schedules

Nursing Facility Rate Setting and Reimbursement

**Cost Report Supplemental Schedules
New Jersey Department of Health and Senior Services
Nursing Facility Rate Setting and Reimbursement
MEDICARE CROSSWALK**

WARNING: While the Medicare cost report may allow more than one option for classifying costs, Medicaid will only recognize costs in a rate component based on the case mix cross-walk shown below. If a facility chooses to classify costs on the Medicare cost report in a manner that excludes that cost from their direct care or operating and administrative rate component, then the cost will forever be excluded from the direct care and operating and administrative rate, unless adjusted at audit or desk review.

Medicare 2540-96 or 2552-96 Cost Center Crosswalk to New Jersey Case Mix Rate Components

| Cost Center Category | CMS Form 2540-96 or 2552-96 Cost Center | Rate Component | | | | | |
|--|---|-------------------|--------------------|-------------------------------|--------------------------|--------------|----------------|
| | | Fair Rental Value | Operating & Admin. | Direct Care Case Mix Adjusted | Direct Care Non-Case Mix | Pass-Through | Excluded |
| General Service Cost Centers | Capital Bldg. & Fixtures/Capital Moveable Equip. ² | X | | | | | |
| | Employee Benefits – allocated based on salaries | | X | X | X | | X ³ |
| | Administrative & General | | X | | | | |
| | Maint. & Repair | | X | | | | |
| | Operation of Plant | | X | | | | |
| | Laundry | | X | | | | |
| | Housekeeping | | X | | | | |
| | Dietary | | X | | | | |
| | Nursing Admin. | | | | X ⁴ | | |
| | Central Service | | | X ⁵ | X | | |
| | Pharmacy | | | X ⁵ | X ⁴ | | |
| | Medical Records | | | X | | | |
| | Social Service | | | X ⁵ | X ⁴ | | |
| | Activities | | | X ⁵ | X ⁴ | | |
| Routine Service Cost Centers | Skilled Nursing Facility & Nursing Facility-Salary | | | X ⁴ | | | |
| | Skilled Nursing Facility & Nursing Facility "Other" Cost | | X | | X ⁴ | | |
| | Other Routine | | | | | | X |
| Ancillary Service Cost Centers | Laboratory (Direct Cost) | | | | | | X |
| | Respiratory Therapy (Direct Cost) | | | | | | X |
| | Physical Therapy (Direct Cost) | | | | | | X |
| | Occupational Therapy (Direct Cost) | | | | | | X |
| | Speech Pathology (Direct Cost) | | | | | | X |
| | Med. Supplies Charged (Direct Cost) | | | | | | X |
| | Drugs Charged (Indirect & Direct Cost) | | | | | | X |
| | Radiology (Direct Cost) | | | | | | X |
| | Other Reimbursable Ancillary (Direct Cost) | | | | | | X |
| Other Non-Reimbursable Ancillary (Direct Cost) | | | | | | X | |
| Other Outpatient Services | Clinic | | | | | | X |
| Non-Reimbursable Cost Centers | Apartments/Residential | | | | | | X |
| | Gift, Flower, Coffee and Canteen | | | | | | X |
| | Other Non-Reimbursable | | | | | | X |

Medicare Cost Report Crosswalk to New Jersey Case Mix Rate Components (Specific Costs)

| Cost Center Category | From Medicaid Schedule C –Specific Cost | Rate Component | | | | | |
|--------------------------------|---|-------------------|--------------------|-------------------------------|--------------------------|--------------|----------------|
| | | Fair Rental Value | Operating & Admin. | Direct Care Case Mix Adjusted | Direct Care Non-Case Mix | Pass-Through | Excluded |
| Medicaid-Specific Cost Centers | Provider Fees ⁵ | | | | | | X ⁵ |

¹ Includes all direct cost excluding the portion allocated either directly or indirectly to non-reimbursable cost centers and other long-term care cost centers.
² Fair Rental Value calculation replaces the cost in these cost centers. The capital cost is not used in the development of the Fair Rental Value.
³ The only employee benefits excluded are those that are allocated directly or indirectly to non-reimbursable cost centers and other routine service cost centers, those allocated directly to ancillary cost centers and those allocated to pharmacy salaries in ancillary cost centers.
⁴ If contract direct care services are utilized only the actual wages, payroll taxes and general employee benefits associated with those individuals providing direct care services for the nursing facility will be included, the remainder of the fee will be considered admin and operating.
⁵ For rate-setting purposes, provider fee expense is removed from the provider's cost (A&G).
⁶ For activities, pharmacy, and social services only the associated wages and benefits will be included in the direct care non-case mix adjusted category, other costs will be considered operating and administrative. For the central service cost center only the costs of routine medical supplies, and non-legend drugs will be considered direct care non-case mix adjusted, the remaining costs will be operating and administrative.

Schedule D (Reserved)

New Jersey Department of Health and Senior Services
Nursing Facility Rate Setting and Reimbursement

SCHEDULE E – SCNF SERVICES

Facility Name: _____
 DHSS Number: _____
 Unisys Number: _____
 Cost Report FYE: _____

| Services | (A) | (B) | (C) | (D) |
|--|----------|------|----------------------------------|----------------------|
| | Salaries | Fees | Recoveries for Medicaid Patients | Net Routine Expenses |
| Respiratory Therapy | | | | |
| 1. Respiratory Therapists | | | | |
| Rehabilitative Services for Medicaid Patients Only * (Allocation shall be based on Rehabilitative Service Revenue) | | | | |
| 2. Physical Therapy | | | | |
| 3. Occupational Therapy | | | | |
| 4. Speech/Language Pathology | | | | |
| 5. Cognitive or Remedial ** | | | | |
| 6. Total Rehabilitative Services | | | | |

* As defined by N.J.A.C. 8:85-2.4

** Including Neuropsychological Treatment

**New Jersey Department of Health and Senior Services
Nursing Facility Rate Setting and Reimbursement
SCHEDULE F CERTIFICATION**

CERTIFICATION BY TRUSTEE, OWNER, OFFICER, PARTNER OR ADMINISTRATOR OF PROVIDER

Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
DHSS Number: _____
Unisys Number: _____
Cost Report FYE: _____

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report, supporting schedules, and financial information prepared for the facility with a Cost Report period beginning on _____ and ending on _____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with N.J.A.C. 8:85, and the CMS Provider Reimbursement Manual.

Printed Name: _____
Title: _____
Signature: _____
Date Signed: _____
Phone Number: _____
Email Address: _____

History

HISTORY:

New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

NEW JERSEY ADMINISTRATIVE CODE

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N.J.A.C. 8:85, Appx. V

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New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX V

New Jersey Medicaid Nursing Facility Fair Rental Value (FRV) Data Report

**New Jersey Medicaid
Nursing Facility Fair Rental Value (FRV) Data Report
Form Instructions**

General Instructions:

A. Purpose: The purpose of this worksheet is to collect information regarding additions or deletions to your nursing facility as well as major renovations or modifications by year to include the aggregate capital expenditures including improvements, replacements or additions to land, building and capitalized moveable equipment. This information, along with the original year of construction, will be used to determine your nursing facility's first FRV Allowance in the case-mix reimbursement system effective July 1, 2010.

B. Nursing facility operations that are combined with non-nursing facility business activities: If your nursing facility building is also used for other non-nursing facility business uses (for example adult day care services), you must apportion cost and square footage between the nursing facility operation and non-nursing facility operation. These apportionments should use the same square footage allocation statistics used when completing your cost report. Only record on the FRV Data Report the capital costs and square footage information that are related to the nursing facility operation. For example, if you replaced the roof of your building and eighty-percent of the building is associated with the nursing facility operation, eighty-percent of the roof replacement should be recorded on the worksheet in the year the roof was replaced. However, where "direct" capital expenditures are identifiable, there is no allocation.

C. Converting non-nursing facility use to nursing facility use: If your building (or portion of the facility) was used for non-nursing activities and you converted its use to nursing facility activities, you should record this addition using the year the capital assets were constructed. For example, if your building was built in 1980, and at that time 2,000 square feet were used for adult day care, and then in 1985 you converted that portion of your building to nursing facility services, the year these assets were acquired is 1980 (not 1985), and the cost should be the cost of the portion of the building that was originally used for adult day care services.

D. Combining a Building Addition with a Renovation Project: If you completed a capital project that combined a building addition (added beds and square footage), with a renovation of existing beds/square footage, record the project on the same line as the building addition.

E. Change of Ownership: If you are not the original owner/operator of the nursing facility, you may record capital projects that were performed by the prior owner(s). You must document the beds added/deleted, square footage changes, and capitalized cost of each project performed by the prior owner(s) to claim them for age adjustments. **Note that the date at the top of the worksheet on Line 200 is the date the building was built, not the date you started your nursing facility operation.**

F. Data Subject to Audit: The information you provide on this survey is subject to audit and adjustment.

G. Questions/Comments: If you need assistance completing your worksheet, please contact Myers and Stauffer as follows:

Myers and Stauffer LC
11440 Tomahawk Creek Parkway
Leawood, Kansas 66221
Phone: 800-374-6858
Fax: 913-234-1104
Email: PAHELPDESK@MSLC.COM

Steps to Following when Completing the Survey:

Step 1:

Complete the facility and contact information in Lines 100 through 106.

Step 2:

Complete Lines 200 through 205:

Year Building was Originally Constructed: In this field, enter the year your building was constructed. The data must be entered as a four digit number. For example, if your nursing facility was built and started operation in Dec. 1985, you would enter "1985."

Original Licensed Beds of the Nursing Facility: Enter the original licensed beds. This data should be entered as a two or three digit whole number. For example if your licensed beds were 75 when your facility opened, enter "75."

Original Square Footage of the Nursing Facility: Enter the size (total square footage) of your nursing facility. If your operation includes both nursing facility services and non-nursing home activities, record the portion of the building that is utilized for nursing facility services. The square footage amounts reported on this form should agree to square footage amounts reported on your Medicare SNF cost report, if you complete that form.

Original Cost of the Nursing Facility: Enter the original cost of your nursing facility. If your operation includes both nursing facility services and non-nursing facility activities, record the portion of the costs that is utilized for nursing facility services.

Current Licensed Beds: Enter the current licensed beds of the nursing facility.

Current Square Footage of the Nursing Facility: Enter the current size of your nursing facility. If your operation includes both nursing facility services and non-nursing facility activities, record the portion of the building that is utilized for nursing facility services.

Step 3:

Starting with the oldest year after your nursing facility was constructed (Line 300) and in which the nursing facility accumulated capital expenditures including improvements, replacements, or additions to land, building and capitalized moveable equipment, provide the following information for each year separately.

Column A - Year of Capital Project or Modification to Licensed Beds: Report the four digit year when the capital project for your nursing facility, or modification of your licensed beds, was completed. For example, if you completed a capital project in July 1988, enter "1988." These inputs must be in chronological order **starting with the oldest year and must begin at least the year after the building was originally constructed.**

Column B - Number of Beds Added/Deleted: For each year, indicate the change in licensed beds if the capital project resulted in bed changes. Enter additions as a positive number; enter deletions as a negative number. If you performed a renovation project not impacting the number of licensed beds, leave this field blank, or enter zero.

Column C - Change in Square Footage Related to Building Modification: For each year, indicate the change in total nursing facility square footage. If you performed a renovation project not impacting facility size, leave this field blank, or enter zero.

Column D - Total Capitalized Expenditures for the Year (Must Agree to Depreciation Schedule): For each year, enter the total documented, capital expenditures including improvements, replacements, or additions to land, building and capitalized moveable equipment.. These costs must be supported by historical depreciation schedules.

Step 4:

For each subsequent year record the four data elements related to that project (Lines 301 through 324). Each subsequent year must be recorded on the very next line of the form. **Do not leave blank lines between years since this will result in an error on your worksheet.**

Once you have recorded all applicable years, make sure your current licensed beds recorded in Line 204 and any additions or deletions recorded in Lines 300-324, Column B agree to Line 325. Make sure your current square footage recorded in Line 205 and any additions or deletions recorded in Lines 300-324, Column C agree to Line 326. **In the event Line 325 or Line 326 cannot be reconciled, submit an explanation of the discrepancy with your completed FRV worksheet.**

Step 5:

The completed worksheet (in electronic format) must be e-mailed to Myers and Stauffer at PAHELPDESK@mslc.com or alternatively, a CD may be mailed to the address below.

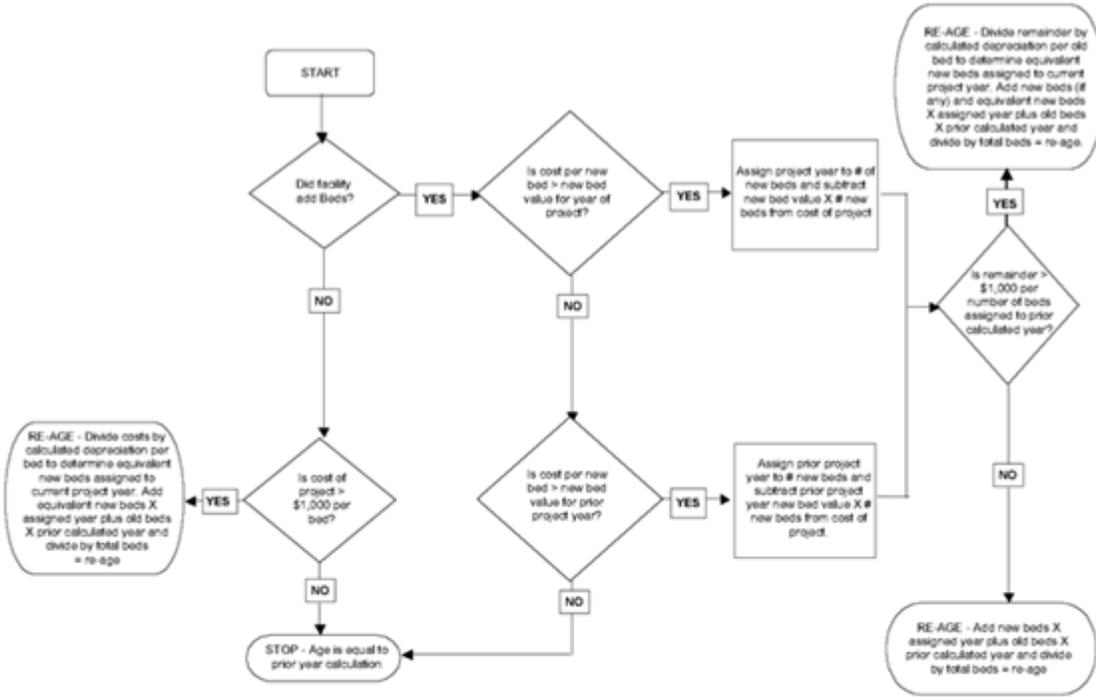
Mailing Address
Myers and Stauffer LC
Attention: NJ Capital Survey
6380 Flank Drive, Suite 100
Harrisburg, PA 17112

Email Address
PAHELPDESK@mslc.com

**New Jersey Medicaid
Nursing Facility Fair Rental Value Data Report**

| Ln. PROVIDER INFORMATION | | | | |
|---|---|---|---|---|
| 100 | Nursing Facility Name: | _____ | | |
| 101 | DHSS Provider Number: | _____ | | |
| 102 | Street Address, City: | _____ | | |
| 103 | Contact Name: | _____ | | |
| 104 | Contact Telephone Number: | _____ | | |
| 105 | Contact Email Address: | _____ | | |
| 106 | Date Completed: | _____ | | |
| ORIGINAL CONSTRUCTION INFORMATION | | | | |
| 200 | Year Building was Originally Construction (for example, 1975) | _____ | | |
| 201 | Original Licensed Beds of the Nursing Facility | _____ | | |
| 202 | Original Square Footage of the Nursing Facility | _____ | | |
| 203 | Original Cost of the Nursing Facility | _____ | | |
| 204 | Current Licensed Beds | _____ | | |
| 205 | Current Square Footage of the Nursing Facility | _____ | | |
| CAPITAL PROJECTS INFORMATION | | | | |
| Chronological Order of Bed Additions/Deletions or Major Renovation/Replacement Projects | Year of Capital Project or Modification to Licensed Beds | Number of Nursing Facility Beds Added/Deleted | Change in Square Footage Related to Nursing Facility Modification | Total Capitalized Expenditures from the Capital Project (Must Agree to Depreciation Schedule) |
| | Column A | Column B | Column C | Column D |
| 300 | Oldest Capital Project | | | |
| 301 | Next Oldest Project | | | |
| 302 | Next Oldest Project | | | |
| 303 | Next Oldest Project | | | |
| 304 | Next Oldest Project | | | |
| 305 | Next Oldest Project | | | |
| 306 | Next Oldest Project | | | |
| 307 | Next Oldest Project | | | |
| 308 | Next Oldest Project | | | |
| 309 | Next Oldest Project | | | |
| 310 | Next Oldest Project | | | |
| 311 | Next Oldest Project | | | |
| 312 | Next Oldest Project | | | |
| 313 | Next Oldest Project | | | |
| 314 | Next Oldest Project | | | |
| 315 | Next Oldest Project | | | |
| 316 | Next Oldest Project | | | |
| 317 | Next Oldest Project | | | |
| 318 | Next Oldest Project | | | |
| 319 | Next Oldest Project | | | |
| 320 | Next Oldest Project | | | |
| 321 | Next Oldest Project | | | |
| 322 | Next Oldest Project | | | |
| 323 | Next Oldest Project | | | |
| 324 | Newest Capital Project | | | |
| 325 | Calculated Current Licensed Beds | _____ | | |
| 326 | Calculated Current Nursing Facility Square Footage | | _____ | |

FRV Data Report Flow Chart



History

HISTORY:

New Rule, R.2011 d.121, effective April 18, 2011.

APPENDIX A

New Jersey Department of Health and Senior Services
Office of Provider Enrollment
PO Box 367
Trenton, NJ 08625-0367

PROVIDER APPLICATION

| | | | |
|--|--|-------------------------------------|----------------------|
| 1. Legal Name of Provider | | 2. Type of Business of Facility | |
| 3. Business Name, if Different from Above | | 4. Federal Employer ID Number / SSN | |
| 5. Street Address of Service Location Only | | 6. County | |
| 7. City State Zip Code | | 8. Length of Time at Address | |
| 9. Billing Address (for payments) | | | |
| 10. Mailing Address (for correspondence) | | | |
| 11. Name of Nursing Home Administrator, Chief Executive Officer or Other Responsible Official | | | |
| 12a. Nursing Home Administrator License No. | | 12b. Effective Date | 13. Telephone Number |
| 14. Indicate the legal status of your organization: <input type="checkbox"/> Profit <input type="checkbox"/> Private <input type="checkbox"/> Municipal <input type="checkbox"/> Charity <input type="checkbox"/> County <input type="checkbox"/> Non-Profit <input type="checkbox"/> Public <input type="checkbox"/> State <input type="checkbox"/> School Nurse <input type="checkbox"/> Other, Specify: | | | |
| 15. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program: | | | |
| 16. Do you operate from more than one location? | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all other subsidiary or affiliated organizations below: | | | |
| Name | | Service Address | |
| 1. _____ | | _____ | |
| 2. _____ | | _____ | |
| 3. _____ | | _____ | |
| <i>(Attach additional sheets if necessary.)</i> | | | |
| 17. Are you a member of a chain organization? | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate name: _____ | | | |
| 18. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health and Senior Services? | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate. | | | |
| 19. Does your business or facility require a license/permit? | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate type and number: _____ Attach a copy of the license/permit. | | | |
| 20. Do you require certification, accreditation or approval? | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Attach a copy of the certification, accreditation or approval. For example, New Jersey Department of Health and Senior Services (clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services). | | | |

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

NEW JERSEY ADMINISTRATIVE CODE

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End of Document



N.J.A.C. 8:85, Appx. W

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 50 No. 10, May 21, 2018

New Jersey Administrative Code > TITLE 8. HEALTH > CHAPTER 85. LONG-TERM CARE SERVICES

APPENDIX W

FAIR RENTAL VALUE (FRV) RE-AGE REQUEST

New Jersey Department of Health and Senior Services
Nursing Facility Rate Setting and Reimbursement
FAIR RENTAL VALUE (FRV) RE-AGE REQUEST

| | | |
|---------------|--------------------------|-----------------|
| Provider Name | Medicaid Provider Number | Date of Request |
|---------------|--------------------------|-----------------|

Note #1: Per N.J.A.C. 8:85-3.11(a)4i, in order to change the weighted age of a facility, the cost of a major renovation or replacement project must at least equal \$1,000 per bed.
 Note #2: The major renovation or replacement project must have been started within the 24 months preceding the Date Placed in Service and must be either directly or indirectly related to the functioning of the nursing facility.
 Note #3: All proceeds from insurance or other federal assistance payments (FEMA, etc.) must be offset against the capitalized cost of all renovations, additions, and replacements.

| ADDITIONS | | | | | | | | |
|-------------|--------------------------------------|---------------------------------|----------------------|-------------------|----------------------|------------------------|----|------------------------|
| Description | Licensed Nursing Facility Beds Added | Total Addition Cost Capitalized | | Square Feet Added | | Period of Construction | | Date Placed in Service |
| | | Nursing Facility | Non-Nursing Facility | Nursing Facility | Non-Nursing Facility | From | To | |
| | | | | | | | | |
| | | | | | | | | |

| MAJOR RENOVATIONS | | | | | | | |
|-------------------|-----------------------------------|----------------------|--|----------------------|------------------------|----|------------------------|
| Description | Total Renovation Cost Capitalized | | Square Feet Change (Removed Square Feet or Reallocated Existing Square Feet) | | Period of Construction | | Date Placed in Service |
| | Nursing Facility | Non-Nursing Facility | Nursing Facility | Non-Nursing Facility | From | To | |
| | | | | | | | |
| | | | | | | | |

| REPLACEMENTS | | | | | | | | |
|--------------|---|------------------------|----------------------|--|----------------------|------------------------|----|------------------------|
| Description | Licensed Nursing Facility Beds Replaced | Total Cost Capitalized | | Square Feet Change (Difference in New Location vs. Old Location of Beds) | | Period of Construction | | Date Placed in Service |
| | | Nursing Facility | Non-Nursing Facility | Nursing Facility | Non-Nursing Facility | From | To | |
| | | | | | | | | |
| | | | | | | | | |

- Documentation Checklist:
1. Attach copy of revised bed license..... Yes No
 2. Attach depreciation schedule showing date placed in service and capitalized cost..... Yes No
 3. Attach copies of revised floor plans with changes to square footage indicated..... Yes No
 4. Documentation of all insurance proceeds or government assistance payments (FEMA, etc.) received..... Yes No

Send this signed form and all supporting documents to the following address by June 15 preceding the rate year:

Attn: FRV Re-Age Request
 NJ Department of Health and Senior Services
 Nursing Facility Rate Setting and Reimbursement
 PO Box 723
 Trenton, NJ 08625-0723

Signature of Administrator/Management _____ Title _____ Date _____

History

HISTORY:

New Rule, R.2011 d.121, effective April 18, 2011.

See: 42 N.J.R. 1793(a), 43 N.J.R. 961(c).

NEW JERSEY ADMINISTRATIVE CODE

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End of Document

PROVIDER APPLICATION, Continued

| | |
|---|----------------------------------|
| Legal Name of Provider | Federal Employer ID Number / SSN |
| <p>21. Approved by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, indicate Medicare Provider Number: _____</p> <p>Attach a copy of your Medicare approval.</p> | |
| <p>22. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).</p> | |
| <p>23. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, explain.</p> | |
| <p>24. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, explain.</p> | |
| <p>25. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, explain.</p> | |

PROVIDER APPLICATION, Continued

| | |
|------------------------|----------------------------------|
| Legal Name of Provider | Federal Employer ID Number / SSN |
|------------------------|----------------------------------|

26. Do any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the other individuals named in response to Question 11 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid Program of any other state or jurisdiction?

Yes No

If yes, list provider name and nature of relationship.

27. Do you charge for goods and/or services?

To All To None To Certain Groups Only

If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule.

28. List days and hours of operation.

29. List the Name(s), Social Security Number(s), Date(s) of Birth, License/Permit Number(s) and Title(s) or Degree(s) for all professional staff in the organization. Include physicians, dentists, psychologists, pharmacists, registered nurses, licensed practical nurses, registered physical therapists, optometrists, etc. [NOTE: Not required for health care providers certified for Medicaid and/or Medicare participation by the New Jersey Department of Health and Senior Services and/or the Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA).]

| Name | Title/Degree (MD, DO, Ph.D, CPO, etc.) | SSN | Date of Birth | License Permit No. |
|----------|---|-------|---------------|-----------------------|
| 1. _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ | _____ |
| 6. _____ | _____ | _____ | _____ | _____ |
| 7. _____ | _____ | _____ | _____ | _____ |

(Attach additional sheets if necessary.)

CERTIFICATION

For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey Medicaid (Title XIX) Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me on this application are willfully false, I am subject to punishment, including but not limited to suspension, debarment or disqualification from the New Jersey Medicaid Program in accordance with N.J.A.C. 10:49-1.17(d)22. I agree to notify the New Jersey Department of Health and Senior Services, Office of Provider Enrollment, at least quarterly, of all future additions to any of those named in Questions 23 - 26, for whom the response to those same questions would be affirmative.

| | |
|---------------------------------|-------|
| Name of Provider Representative | Title |
|---------------------------------|-------|

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

FOR STATE USE ONLY

| | | | |
|----------------------------------|-------------------------------------|--------------------------------|-------------|
| <input type="checkbox"/> Approve | <input type="checkbox"/> Disapprove | <input type="checkbox"/> Other | |
| Provider Type(s) | Initial | Category of Service | Date |
| _____ | _____ | _____ | _____ |
| | Specialty | | |
| | _____ | | |

APPENDIX B

New Jersey Department of Health and Senior Services

New Jersey Medicaid Program
Title XIX (Medicaid)

PARTICIPATION AGREEMENT
BETWEEN

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
AND

(Nursing Facility)

| | |
|------------------------------|--------------------------|
| Name and Address of Facility | State License Number |
| | Medicaid Provider Number |

NJDHSS USE ONLY:

Agreement Begin Date: _____ Agreement End Date: _____

This contract, made and entered into by and between the Department of Health and Senior Services, hereinafter referred to as the Department, and the above-named facility, a provider of services, whose address is as stated above, hereinafter referred to as the Facility, Witnesseth:

WHEREAS, various persons eligible for benefits under the New Jersey Medicaid Program are in need of medical care in the form of skilled nursing care, or intermediate nursing care, as more specifically set forth in Program regulations and guidelines; and

WHEREAS, Section 1902(a)(27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or institution providing services under the State Plan for Medical Assistance (Title XIX); and

WHEREAS, pursuant to N.J.S.A. 30:4D-1 et seq., and the Executive Reorganization Plan AA#001-1996, the Department is responsible for the administration of parts of the Medicaid Program and is authorized thereunder to take all necessary steps for the proper and efficient administration of the New Jersey Medicaid Program;

WHEREAS, to participate in the New Jersey Medicaid Program, a Nursing Facility must:

- (1) be licensed under the laws of New Jersey;
- (2) be currently meeting on a continuing basis standards for licensure;
- (3) be administered by a licensed nursing facility administrator who holds a current license and who is not suspended, debarred or disqualified from participation in the New Jersey Medicaid Program;
- (4) meet on a continuing basis Federal requirements for participation in Title XIX; and
- (5) accept the terms and conditions of participation set out herein.

NOW, THEREFORE, in consideration of the mutual promises herein contained, it is agreed by and between the parties hereto as follows:

A. FACILITY AGREES:

1. That it will render all services which have been recognized as an element of cost as set forth in the cost survey report submitted;

NURSING FACILITY PARTICIPATION AGREEMENT, Continued

| Name and Address of Facility | Medicaid Provider Number |
|--|--------------------------|
| <p>2. That it will accept the payment approved under the Medicaid Program for a Medicaid recipient in semi-private accommodations, as payment in full and will not make any additional charges to the patient or others on his behalf for Medicaid-covered services. Payment shall be based on the net amount of the per diem rate times the number of patient days minus the patient's available income, the collection of which is the responsibility of the facility;</p> <p>3. That it will promptly initiate and terminate billing procedures, pursuant to applicable regulations, when individuals covered under this Program enter or leave the Facility or are assessed at a different level of care;</p> <p>4. That it will limit billing procedures under this Program to those authorized Medicaid recipients who reside only in those areas of this Facility which are certified for participation in the New Jersey Medicaid Program;</p> <p>5. That it will reserve beds for Medicaid recipients on therapeutic home leave in accordance with State and Federal regulations;</p> <p>6. That it will maintain all financial records for a period of at least one year after it is notified that such records will not be audited, or for a period of at least one year after they are audited, or for a period of one year after the conclusion of all hearings, appeals and/or other litigation with respect to such audits, whichever is later, and to make available to the appropriate State and/or Federal personnel or their agents, at all reasonable times and places in New Jersey, all necessary records, including but not limited to the following:</p> <ul style="list-style-type: none"> a. Medical records as required by Section 1902(a)(27) of Title XIX of the Social Security Act, and any amendments thereto; b. Records of all treatments, drugs, and services for which vendor payments are to be made under the Title XIX program, including the authority for and the date of administration of such treatments, drugs, or services; c. Documentation in each patient's record which will enable the Department to verify that each charge is due and proper prior to payment; d. Financial records of the Facility, including data necessary to determine appropriate reimbursement rates; and e. All other records as may be found necessary by the Department in compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the Department. <p>7. That it will comply with the provisions of N.J.S.A. 10:5-12.2 prohibiting any skilled nursing or intermediate care facility whose Medicaid occupancy level is less than the statewide occupancy level as established by the Commissioner of the Department of Human Services from denying admittance to a qualified Medicaid applicant when a nursing home bed becomes available;</p> <p>8. That it will place a Medicaid recipient only in a unit of the Facility approved as a Medicaid unit and covered by this agreement;</p> | |

NURSING FACILITY PARTICIPATION AGREEMENT, Continued

| Name and Address of Facility | Medicaid Provider Number |
|---|--------------------------|
| <p>9. That it will cooperate fully in permitting and assisting representatives of the Department to make assessments and evaluations of services provided to patients generally, and of the needs and circumstances of individual patients who are recipients of the Medicaid Program;</p> <p>10. That it will secure and arrange for other health services as may be available for Medicaid recipients pursuant to Medicaid Program regulations;</p> <p>11. That it will comply with State and Federal Medicaid laws, and rules and regulations promulgated pursuant thereto;</p> <p>12. That it will comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106;</p> <p>13. That it will comply with the provisions of the Patient Self Determination Act set forth in Section 4751 of the Federal Omnibus Budget Reconciliation Act of 1990 (OBRA 1990);</p> <p>14. That it will cooperate fully in permitting and assisting representatives of the Department in determining continuing conformity with the Federal and State standards applicable to Nursing Facilities;</p> <p>15. That it will notify the Medicaid Provider Enrollment, within five working days, of any change in the status of its license to operate as issued by the New Jersey Department of Health and Senior Services;</p> <p>16. That it will not initiate, request or otherwise cause the removal of a Medicaid recipient for the purpose of making an additional bed available for private paying or other non-Medicaid patients, other than in accordance with the Department's regulations on the involuntary transfer of Medicaid recipients;</p> <p>17. That it will give priority to the readmission of a Medicaid recipient who has been transferred from the Facility to a hospital for medical reasons;</p> <p>18. That it will provide the Department with written notice at least 90 days in advance of any change in ownership and/or operation of the Facility;</p> <p>19. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242(c) which makes it a crime and sets the punishment for persons who have been found guilty of making a false statement or representation of a material fact in order to receive any benefit or payment under the New Jersey Medicaid Program. (The Department of Health and Senior Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended);</p> <p>20. To notify the Department within 30 days of filing State or Federal Bankruptcy Proceedings, Receivership Proceeds, or Assignment for the Benefit of Creditors Proceedings;</p> <p>21. That it will not employ or engage any person who has been suspended, debarred or disqualified from participating in the Medicare and/or Medicaid program by either the Federal Government or any State, Territory or Possession in the U. S.;</p> | |

NURSING FACILITY PARTICIPATION AGREEMENT, Continued

| Name and Address of Facility | Medicaid Provider Number |
|--|--------------------------|
| <p>22. That breach or violation of any one of the above provisions shall make this entire agreement subject to immediate cancellation at the Department's discretion, in keeping with the procedures adopted by the Department in accordance with the New Jersey Administrative Procedures Act.</p> <p>B. DEPARTMENT AGREES:</p> <ol style="list-style-type: none">1. That it will pay for authorized services provided by the Facility in keeping with the availability of State appropriation, on the basis of the net amount of the per diem rate times the number of patient days minus the patient's available income, the collection of which is the responsibility of the Facility, for care required by the Medicaid recipient, including bed and board in semi-private accommodations, as determined by the Department acting under applicable regulations, but in no event will payment be made for any Medicaid recipient determined not to require nursing facility level of care;2. That it will reimburse the Facility through the use of rates that are reasonable and adequate to meet the cost that efficiently and economically operated facilities must incur to provide care in conformity with applicable State and Federal laws, regulations and quality and safety standards;3. That it will pay the Facility for reserving beds for Medicaid recipients on therapeutic home leave in accordance with State and Federal regulations;4. That it will make such payments in accordance with applicable laws and regulations as promptly as is feasible after a proper claim is submitted and approved. However, in the event the Department determines that irregularities, deficiencies, or other similar conditions exist, from any cause, it may withhold payments until such irregularities are adjusted;5. That it will make proper adjustment in the billing errors, as is indicated, to compensate for either overpayment or underpayment subject to existing time limitations;6. That it will give the Facility, (subject to Section A, Paragraph 22), 30 days notice of any impending changes in status as a participating Nursing Facility;7. That it will notify the Facility of any change in Title XIX rules and regulations and to work with the individual Facility with the view toward providing the best care available within the limitations of the law and available money;8. That the Facility may terminate its participation in the Medicaid Program with a written notice to the Department. The notice must be received 90 days prior to the termination. | |

NURSING FACILITY PARTICIPATION AGREEMENT, Continued

| | |
|---|--------------------------|
| Name and Address of Facility | Medicaid Provider Number |
| <p>C. DEPARTMENT AND FACILITY MUTUALLY AGREE:</p> <ol style="list-style-type: none"> 1. That, in the event the Federal and/or State laws should be amended or judicially interpreted so as to render the fulfillment of this agreement on the part of either party infeasible or impossible, or if the parties to this agreement should be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the Title XIX Program as the result of amendments or judicial interpretations, then, in that event, both the Facility and the Department shall be discharged from further obligation created under the terms of this agreement, except for equitable settlement of the respective accrued interests up to the date of the termination; 2. That this agreement shall be transferable and assignable upon a change in ownership and/or operation; 3. That, in the event a participating Facility is sold, the Department shall make no division of the reimbursable proceeds for services rendered to Medicaid recipients between the new and former owner, but rather will reimburse the owner of record as of the billing month for all services rendered. The new and former owner shall make the necessary adjustments; and 4. That this agreement may be terminated for any of the following reasons: <ol style="list-style-type: none"> a. upon decertification of the Facility by the Department or the Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA), b. by mutual consent of the parties, c. for cause under applicable clauses herein, d. without cause, by the Department, upon 90 days written notice to the Facility, or e. because of Federal and/or State government withdrawal from Program participation. | |

[Name of Authorized Representative of Facility (Print)]

(Title)

(Date)

(Signature of Authorized Representative of Facility)

[Name of Authorized Representative of NJDHSS (Print)]

(Title)

(Date)

(Signature of Authorized Representative of NJDHSS)

**INSTRUCTIONS FOR COMPLETING DISCLOSURE OF
OWNERSHIP AND CONTROL INTEREST STATEMENT (CMS-1513)**

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Secretary of appropriate State agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete part II (a) and (b) of this form. Only those title XX providers rendering medical, remedial, or health related home-maker services must complete parts II and III. Title V providers must complete parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V – 42CFR 51a.144
Title XVIII – 42CFR 420.200 – 206
Title XIX – 42CFR 455.100 – 106
Title XX – 45CFR 228.72 – 73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

- Item I** (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
(b) **For Regional Office Use Only.** If the yes box is checked for item VII, the Regional Office will enter the 5-digit number assigned by CMS to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV – VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ Yes No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ Yes No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ Yes No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ Yes No LB11

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
 Yes No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name _____ EIN # _____ Yes No LB13

Address _____ LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If yes, list Name, Address of Corporation, and EIN)
Name _____ EIN # _____ Yes No LB18

Address _____ LB19

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?
 Yes No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

| | |
|---|-------|
| Name of Authorized Representative (Typed) | Title |
|---|-------|

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

Remarks _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0086. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

PROVIDER CERTIFICATION STATEMENT
LONG TERM CARE
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

BILLING MM/YY:

I CERTIFY THAT THE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THAT THE ACCOMPANYING BILLING TRANSACTION FORMS CONTAIN ALL TERMINATIONS AND ADJUSTMENTS IN AMOUNTS DUE FOR PATIENTS THROUGH THE ENDING DATE OF THE BILLING MONTH. THOSE PATIENTS FOR WHOM PAYMENT IS REQUESTED WERE PROVIDED NURSING CARE IN THOSE AREAS ONLY OF THIS FACILITY WHICH ARE CERTIFIED FOR PARTICIPATION IN THE NEW JERSEY MEDICAID PROGRAM. I ALSO CERTIFY THAT FOR EACH MEDICAID PATIENT, A PHYSICIAN HAS ESTABLISHED/REVISED A WRITTEN PLAN OF CARE AND CERTIFIED/RECERTIFIED, IN WRITING, THE NEED FOR NURSING CARE IN ACCORDANCE WITH N.J.A.C. 10:60-1.5. I FURTHER CERTIFY THAT I AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED, AND TO FURNISH INFORMATION FOR SUCH SERVICES AS THE STATE AGENCY MAY REQUEST, AND THAT THE SERVICES COVERED BY THIS CLAIM AND THE AMOUNT CHARGED THEREFORE ARE IN ACCORDANCE WITH THE REGULATIONS OF THE NEW JERSEY MEDICAID PROGRAM AND THAT NO PART OF THE NET AMOUNT PAYABLE UNDER THIS CLAIM HAS BEEN PAID; AND THAT PAYMENT OF SUCH AMOUNT IS FROM FEDERAL AND STATE FUNDS AND WILL BE ACCEPTABLE AS PAYMENT IN FULL WITHOUT ADDITIONAL CHARGE TO THE PATIENT OR TO OTHERS ON HIS BEHALF. I ALSO CERTIFY THAT THE SERVICES HAVE BEEN FURNISHED IN FULL COMPLIANCE WITH THE NON-DISCRIMINATION REQUIREMENTS OF THE TITLE VI OF THE FEDERAL CIVIL RIGHTS ACTS AND SECTION 504 OF THE REHABILITATION ACT OF 1973.

NUMBER_OF_PRIVATE_PATIENTS_RECEIVING_ADDITIONAL_NURSING_SERVICES

TRACHEOSTOMY ----- RESPIRATOR ----- I.V. THERAPY -----
HEAD TRAUMA ----- OXY. THERAPY ----- N.G. TUBE FEEDING -----
WOUND CARE -----

NUMBER_OF_PRIVATE_PATIENTS_RECEIVING_THERAPIES

PHYSICAL ----- SPEECH ----- OCCUPATIONAL -----

***** CENSUS *****
**
** TOTAL GENERAL ASSISTANCE DAYS -----
** TOTAL MEDICAID DAYS ----- +
** TOTAL DAYS ----- =
** TOTAL NUMBER LICENSE BEDS -----

I UNDERSTAND THAT FRAUD OR CONCEALMENT WILL BE PUNISHABLE UNDER APPLICABLE FEDERAL OR STATE LAW OR BOTH AND THAT THE FACILITY IS NOT ELIGIBLE FOR PAYMENT WITHOUT TIMELY RECEIPT OF THIS CERTIFICATE.

SIGNED _____ DATE _____
(ADMINISTRATOR/EXECUTIVE OFFICER OR DESIGNEE)
NAME AND TITLE ----- PLEASE PRINT OR TYPE -----

APPENDIX F

**New Jersey Department of Health and Senior Services
STATEMENT OF AVAILABLE INCOME FOR MEDICAID PAYMENT**

HSP (Medicaid) Case Number _____ LAST, _____ FIRST _____ ELIG. EFF. DATE _____ PRINT DATE _____

SSA Number: _____ Redetermination Date: _____ (MMYY) _____ COUNTY CODE _____

Long Term Care Facility: _____ LTCF Provider No.: _____

Address: _____

| | LTCF | | # 1 | # 2 | # 3 | Remarks |
|--------------------------------|-------------------------|----|-----|-----|-----|---|
| Effective Date | | | | | | Admit, Change, Redetermination |
| Social Security Income | | | | | | Claim # |
| Buy-In Amount | | | | | | HIC # |
| Gross Social Security Benefit | | | | | | |
| Railroad/Veteran | | | | | | Claim # |
| Pension/Other Benefit | | | | | | Specify |
| Indemnity | | | | | | Specify |
| Total Other Income | \$ | \$ | \$ | \$ | \$ | Specify SSA # |
| Total Gross Income | \$ | \$ | \$ | \$ | \$ | M = Married couple same LTCF N = Medically Needy F = Foreign Pension G = VA A+A P = VA Improved Pension |
| PNA | | | | | | |
| Health Premium (Total \$) | | | | | | *Policy # |
| Other | | | | | | Specify |
| Maint./Home | | | | | | Specify |
| Month of Adm./ Disch. Exempt | | | | | | Specify |
| Med. Needy Spend Down | | | | | | Specify |
| Maint./Spouse Dependent | | | | | | Specify |
| Discretionary Income | | | | | | Specify |
| Total Exempt Income | \$ | \$ | \$ | \$ | \$ | |
| Available Income | \$ | \$ | \$ | \$ | \$ | R = Representative Payee |
| Resources Circle One Yes No | SPECIFY (i.e., address) | | | | | *Additional Health Insurance Policy Nos. |

Name and address of Representative Payee: _____

Signature: IM Worker _____

Date: _____

Supervisor: _____

Date: _____

APPENDIX G

New Jersey Department of Health and Senior Services
Division of Consumer Support
NOTIFICATION FROM LONG-TERM CARE FACILITY
OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT

I. PATIENT INFORMATION

1. Name: (Last) (First)
2. Social Security No.:
3. HSP (Medicaid) Case No.: Confirmed By: Medicaid Only SSI
4. Authorized By: LTCFO Date of Birth:

II. PROVIDER INFORMATION

1. Provider Number:
2. LTCF Name: 5. Long Term Care Field Office
3. Address: LTCFO Street Address:
4. City, State, Zip: City, State, Zip:

III. ADMISSION INFORMATION

1. Admission Date:
2. Admitted to Room Number: Bed Number:
3. Admitted from: Community/Boarding Home Medicare to Medicaid Psychiatric Hospital
4. Name of Hospital/LTCF: Admission Date:
5. If admitted from Hospital/LTCF, give the name/address of previous residence:

IV. TERMINATION INFORMATION

1. Discharge Date:
2. Discharged to: Own Home (check one): With Medicaid Services or Without Medicaid Services
3. Death (Date): In LTCF In Hospital

V. CERTIFICATION

The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program.

This form completed by:

Name: Title: Date:

VI. CWA USE ONLY

Medicaid Effective Date:
Medicaid ONLY (PA-3L Attached)
SSI Only (PA-3L Required, Contact DHSS)
Not Eligible
Transcript Requested - Date:
COUNTY WELFARE OFFICE
Street Address:
City and Zip:
Remarks:
Name of Case Worker: Date:

APPENDIX H

**New Jersey Department of Health and Senior Services
CERTIFICATION OF NEED FOR PATIENT CARE
IN FACILITY OTHER THAN PUBLIC OR PRIVATE GENERAL HOSPITAL**

| TO BE COMPLETED BY PUBLIC ASSISTANCE AGENCY | | | | |
|--|--|---|------------------------------------|------------------------------|
| Case Name | | County Registration No. | | Agency Name |
| Home Address | | | | |
| Health Services Program Case No. (10 digits) | | Person Number (2 digits) | | Date of Eligibility |
| Birthdate (or Age) | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Medicare No. (if applicable) |
| Describe Current Living Arrangement | | | | |
| If in an Institution, Name | | | | Admission Date |
| CERTIFICATION BY PHYSICIAN | | | | |
| This is to certify that the above-named individual requires patient care for the chronically ill because: | | | | |
| 1. Diagnosis (Complete): _____ | | | | |
| 2. Medication and/or Treatment:: _____ | | | | |
| 3. Other Therapy Contemplated: _____ | | | | |
| 4. Functional Capacity of the Patient | Inde- pendent | Needs Assistance | Potential for Inde- pendence | Comments |
| A. Bathing and Personal Hygiene | | | | |
| B. Dressing | | | | |
| C. Eating | | | | |
| D. Toiletry | | | | |
| E. Communication | | | | |
| F. Ambulation | | | | |
| G. Nursing Care | | | | |
| 5. Instructional Needs: | | | | |
| A. <input type="checkbox"/> Teaching for Independence in Activities of Daily Living | | E. <input type="checkbox"/> Understanding Medical Conditions | | |
| B. <input type="checkbox"/> Self-Administration of Drugs and Medications | | F. <input type="checkbox"/> Prevention Care and Treatment or Complication | | |
| C. <input type="checkbox"/> Diet and Nutrition | | G. <input type="checkbox"/> Counseling, Emotional and Motivation Support | | |
| D. <input type="checkbox"/> Self Care for Special Condition, e.g., Colostomy, etc. | | | | |
| 6. Emotional, Behavior or Social Problems (explain): _____ | | | | |
| 7. Characteristics of Major Disability: <input type="checkbox"/> Static or Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Improving | | | | |
| 8. Is patient now receiving any medication or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If yes, give details: _____ | | | | |
| 9. Is surgery or other therapy contemplated? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If yes, give details: _____ | | | | |
| 10. Is care in nursing home or public medical institution NOW necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 11. If Yes in Question 10, is future discharge contemplated? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 12. Could patient be adequately cared for now in a facility providing a lower level of care than that provided by a skilled nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 13. Could this patient be adequately cared for NOW, in: | | | | |
| -a boarding home? <input type="checkbox"/> Yes <input type="checkbox"/> No | | -his own home? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| -other facility (describe)? _____ | | | | |
| 14. I further certify that, in my opinion, this patient does not require treatment for: | | | | |
| <input type="checkbox"/> Active Tuberculosis; or | | | | |
| <input type="checkbox"/> A Mental Disease, Defect or Impairment in an Institution for the Mentally Ill or Mentally Deficient | | | | |
| Name of Physician (Print) | | | Signature | |
| | | | Date | |

APPENDIX K

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PREADMISSION SCREENING ASSESSMENT

| AUTHORIZATION LEVEL | MOS | LOCUS OF CARE | SPECIAL CARE SERVICES |
|---------------------|-----|-----------------------------------|---|
| 1 | --- | ___ TRACK I-LONG TERM PLACEMENT | ___ RESPIRATORY |
| 2 | --- | ___ TRACK II-SHORT TERM PLACEMENT | ___ COMA |
| 3 | --- | ___ TRACK III-COMMUNITY PLACEMENT | ___ NEUROLOGICALLY IMPAIRED YOUNG ADULT |
| | | ___ CCPED (MODEL WAIVER) | ___ PEDIATRIC LTC |
| | | ___ ACCAP | ___ AIDS/LTC |
| | | ___ COMMUNITY | ___ MR/MI |
| | | ___ DENIAL OF SERVICES | |

| | | | |
|---|-------------------------------|---|-----------------|
| APPLICANT'S NAME (Last, First, Middle) | | Date Ref. to DDD/DMH&H | |
| ADDRESS | | D.O.B | SEX |
| MEDICARE NUMBER | | MARITAL STATUS | |
| SSA NUMBER | TELEPHONE NUMBER | | |
| RACE/ETHNICITY CODE (For Data Collection Purposes Only) | | N.E.P. (Non-English) Case Number | |
| 1 = American Indian/Alaskan Native | 4 = Hispanic | | |
| 2 = Asian or Pacific Islander | 5 = White/Angle, Non-Hispanic | | |
| 3 = Black, Non-Hispanic Origin. | 6 = Other: | | |
| NAME OF FACILITY (Optional) | | DATE OF ADMISSION | FLOOR WARD BLDG |
| ADDRESS | | ROOM NUMBER | |
| INITIALLY ADMITTED FROM | NAME AND ADDRESS | | |
| Home () Facility or Other () | | | |
| ATTENDING PHYSICIAN, TITLE | TELEPHONE NO | RSN | ASSESSMENT DATE |
| ATTENDING PHYSICIAN, TITLE | TELEPHONE NO. | RSN | ASSESSMENT DATE |
| ATTENDING PHYSICIAN, TITLE | TELEPHONE NO | RSN | ASSESSMENT DATE |
| PRIOR HOSPITALIZATIONS. | | | |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| () Preadmission Level of Care Determination | | () Admission Level of Care Determination | |
| () Community Care Evaluation | | () Periodic Review for Level of Care | |
| () Psychiatric Hospital | | () Request for Change in Level of Care | |
| () ICF/MR (Developmental Disabilities) | | () Other: | |

II. CLINICAL ASSESSMENT

Recent Hospitalization Dates: _____
 Primary Diagnosis: _____
 Secondary Diagnosis: _____

Does patient have a history of any of the following?
 (Circle Appropriate).....

If YES, specify current treatments,
 compliance, unmet needs, problems.

| | |
|---|--|
| A. SKIN: Rashes, Bedsores, Lesions, Infection | |
| B. EYE: Glaucoma, Cataracts, Blindness, Glasses, Discharge, Pain, Itching, Acuvue | |
| C. EAR: Deafness, Hearing Aid, Discharge, Pain, Infection | |
| D. MOUTH/THROAT: Difficulty Chewing/Swallowing, Missing Teeth, Gum Disease | |
| E. BREAST: Lumps, Cyst, Pain, Discharge, Mammogram | |
| F. RESPIRATORY: Dyspnea, Asthma, Emphysema, TB, Apnea, Tracheostomy | |
| G. CARDIOVASCULAR: Heart Attack, Chest Pain, Irregular Rate, High Blood Pressure, Leg Ulcers, Edema | |
| H. G.I.: Ulcers, Bleeding, Diarrhea, Constipation, Liver/Gall Bladder Problems, Ostomy, Incontinency | |
| I. G.U.: Pain, Burning, Frequency, Urgency, Infection, Stones, Catheters, Ostomy, Incontinency | |
| J. GYN: Discharge, Abnormal Bleeding, Menzes | |
| K. MUSCULO-SKELETAL: Paralysis, Missing Limbs, Pain, Weakness, Broken Bones, Congenital/Acquired Impairments, Arthritis, Edema | |
| L. NEUROLOGICAL: Effects of a Stroke, Speech Impairment, Seizures, Headaches, Coma | |
| M. ENDOCRINE DISORDERS: Diabetes, Thyroid | |
| N. HEMATOLOGIC: Anemia, Transfusions, Bleeding | |
| O. ONCOLOGIC: Tumor, Cancer | |
| P. IMMUNE SYSTEM: Allergy (Drugs/Food), Chronic Infection, AIDS, ARC, HIV- | |
| Q. MENTAL ILLNESS: (Schizophrenia, Paranoid, Major Affective) | |
| R. MENTAL RETARDATION | |
| S. DEVELOPMENTAL DISABILITIES: (CP, Epilepsy, Spine Bifida) | |
| T. PROSTHESIS: Limb, Joint, Dental, Eye | |
| U. SURGERIES: Type, Date | |
| V. ACCIDENT/INJURY: Recent | |
| W. SUBSTANCE ABUSE: Alcohol, Drugs, Tobacco | |
| X. OTHER DISABILITIES-HEALTH PROBLEMS | |

III. PEDIATRIC ASSESSMENT

A. Name of Parents/Foster Parents: _____

B. Address: _____ City/Town _____ St _____ Zip _____

C. Telephone Number: () _____

D. BIRTH HISTORY: Gestational Age at Birth _____
 APGAR Score: 1 Min. _____ 5 Min _____ Unknown _____
 Birth Weight: _____ Head Circumference: _____

E. Prenatal Problems (Specify): _____

F. Neonatal Problems (Specify): _____

G. ACQUIRED INFECTIOUS DISEASES:
 Chicken Pox () Measles () Mumps () Rubella ()
 Meningitis () Hepatitis () AIDS () Whooping Cough ()
 Other (Specify): _____

H. IMMUNIZATION STATUS: (Refer to Approved Schedule)

| TYPE | DATES |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I. GROWTH & DEVELOPMENT:
 Current Wt. _____ Current Ht. _____ Current Head Circumference _____
 Wt % For Age _____ Ht % For Age _____ H.C. % For Age _____

J. MILESTONES (Refer to Growth and Developmental Charts):
 On Time () Delayed () (Specify): _____

K. Sleep Pattern & Environment: _____

L. Appearance/Dress: _____

M. Potential Risks/Safety: _____

COMMENTS (if required): _____

IV. TREATMENTS AND DIAGNOSTIC STUDIES

**A. RESULTS & DATES OF LAB AND OTHER
DIAGNOSTIC STUDIES**

B. MEDICATION (Administered by Self or Other _____)
Drugs Dose Sig.

**C. TREATMENTS, REHABILITATIVE THERAPIES
SPECIAL EQUIPMENT**

Type and Frequency:

O.T.

S.T.

P.T.

Other — e.g., Chest Therapy, Percussion/
Postural Drainage, Psychosocial, Skin Care

D. NUTRITIONAL STATUS

Diet (Specify: _____)

Current Weight: _____

Weight Gain/Weight Loss _____

Appetite: Good () Fair () Poor ()

Describe Nutritional & Hydration Status

Naso-Gastric Feedings _____

Gastrostomy _____

TPN _____

V. MENTAL AND BEHAVIORAL STATUS

| CHECK (X) APPROPRIATE STATUS | YES | NO | SOME TIME | COMMENTS |
|---------------------------------------|-----|----|-----------|----------|
| A. MENTAL - BEHAVIORAL | | | | |
| 01. Disoriented | | | | |
| 02. Confused | | | | |
| 03. Withdrawn | | | | |
| 04. Lethargic | | | | |
| 05. Fearful | | | | |
| 06. Anxious | | | | |
| 07. Suspicious (more than reasonable) | | | | |
| 08. Bizarre Behavior | | | | |
| 09. Inappropriate Behavior | | | | |
| 10. Agitated | | | | |
| 11. Assaultive | | | | |
| 12. Verbally Abusive | | | | |
| 13. Noisy | | | | |
| 14. Wanders | | | | |
| 15. Ritualistic | | | | |
| 16. Compulsive | | | | |
| 17. Delusional | | | | |
| 18. Hallucinatory | | | | |
| 19. Depression | | | | |
| 20. Sundowning | | | | |
| 21. Other | | | | |

B. COGNITIVE FUNCTIONS

| | INTACT | IMPAIRED |
|---------------------|--------|----------|
| 1 Long-Term Memory | | |
| 2 Short-Term Memory | | |
| 3 Judgement | | |
| 4 Insight | | |

COMMENTS (if required):

VI. FUNCTIONAL ASSESSMENT

| | INDE- PENDENT | PARTIAL ASSIS- TANCE | TOTAL ASSIS- TANCE | COMMENTS RECENT CHANGES IN STATUS |
|-----------------|------------------|----------------------------|--------------------------|--------------------------------------|
| A. ADL | | | | |
| 1. Eat/Feed | | | | |
| 2. Bathing | | | | |
| 3. Dressing | | | | |
| 4. Toileting | | | | |
| 5. Grooming | | | | |
| 6. Oral Hygiene | | | | |

| | YES | NO | COMMENTS INCLUDE RECENT CHANGES IN STATUS |
|------------------------|-----|----|--|
| B. INCONTINENCE | | | |
| 1. Bladder | | | |
| 2. Bowel | | | |

| | INDE- PENDENT | PARTIAL ASSIS- TANCE | TOTAL ASSIS- TANCE | COMMENTS RECENT CHANGES IN STATUS |
|--------------------------------|------------------|----------------------------|--------------------------|--------------------------------------|
| C. MOBILITY | | | | |
| 1. Walking With/Without Aids | | | | |
| 2. Transfers | | | | |
| 3. Climbing | | | | |
| 4. Climb Stairs | | | | |
| 5. Change Position | | | | |
| 6. Distance/Walks | | | | |
| 7. Can Be Transported In A Car | | | | |
| 8. Wheelchair In Room | | | | |
| 9. Wheel/Walker In Hall | | | | |

| | YES | NO | COMMENTS INCLUDE RECENT CHANGES IN STATUS |
|------------------------------|-----|----|--|
| D. IMPAIRMENT | | | |
| 1. Hearing With/Without Aids | | | |
| 2. Vision With/Without Aids | | | |
| 3. Speech | | | |
| 4. Communications | | | |
| 5. Contractures | | | |
| 6. Paralysis | | | |
| 7. Amputation | | | |
| 8. Memory | | | |
| 9. Swallowing | | | |
| 10. Chewing | | | |

| | INDE- PENDENT | PARTIAL ASSIS- TANCE | TOTAL ASSIS- TANCE | COMMENTS RECENT CHANGES IN STATUS |
|----------------------------------|------------------|----------------------------|--------------------------|--------------------------------------|
| E. IADL'S | | | | |
| 1. Handles Own Finances | | | | |
| 2. Can Bank and Shop | | | | |
| 3. Can Prepare Simple Meals | | | | |
| 4. Can Do Own Light Housekeeping | | | | |
| 5. Personal Laundry | | | | |
| 6. Can Do Own Heavy Housekeeping | | | | |
| 7. Can Use Telephone | | | | |
| 8. Takes Own Medication | | | | |

VII. SOCIAL ASSESSMENT

A. Caregiver/Friend

Name _____ Relationship _____

Address _____

Telephone Number: Home () _____ Work () _____

Employment: _____ Full Time _____ Part Time _____ Not Employed

Days/Hours Assisting: _____

Caregivers' health problems/limitations/concerns. (Please describe any problems or questions the caregiver has.)

B. Client's/Family's Perception of Care Needs:

() Patient wants to return home

() Household members want patient to return

() Unwilling to return, specify: _____

() Unable to return, specify: _____

() Willing to go to nursing facility

() Willing to return — environment unsafe

C. Identify Services/Social Support Client Family Requires:

ASSESSMENT CONCLUSION

APPENDIX Q

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agency Billing Supplement, write to:

UNISYS
P.O. Box 4801
Trenton, New Jersey 08619-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
Post Office Box 049
Trenton, New Jersey 08622-0049