

(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 clinical record or an abstract thereof, including the most recent HSDP, SRA and current copy of PASARR Specialized Service review for MI/MR individuals or the documentation which supports the diagnosis for individuals with 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 Division.

2. The facility shall establish and maintain appropriate and accurate records and accounts of all receipts and disbursements of Medicaid recipient funds, which shall be subject to review and fiscal audit by the State of New Jersey as may be required. A recipient 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 recipient's personal needs allowance accounts, income, cost studies, 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 a period of six months 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 recipient and which has been returned to the fiscal agent within the time limit specified. An adjustment form (FD999) or an MCNH-33 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".

10:63-1.14 Absence from facility due to hospital admission or therapeutic leave; bed reserve

(a) The bed reserve policy for hospital admission is as follows:

1. The NF shall reserve and hold the same room and the same bed of the Medicaid recipient 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 Division review, a justification for the action taken. Pending outcome of the Division'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.

2. Reimbursement, not to exceed 10 days, shall be at the rate the NF received prior to the transfer to the hospital.

i. The recipient's available monthly income shall be applied against the per diem cost of care.

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 recipient. The recipient's name shall be placed on the chronological listing of persons

waiting admission/readmission to the NF, and the recipient 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 recipient 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. 10:63-1.8) shall be followed when the Medicaid recipient has been readmitted following a period of hospitalization.

(b) Requirements concerning absence due to therapeutic leave are as follows:

1. The Medicaid program will reimburse NFs their per diem rate for reserving beds for Medicaid recipients 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 recipient's chart, for review by the Division.

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 recipient from the facility for the purpose of therapeutic leave shall be authorized in writing by the recipient's attending physician and shall be included in the recipient's plan of care.

4. In those instances where a recipient 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 recipient on a therapeutic home visit. Said bed shall not be occupied by another individual during the period of time in which the Medicaid recipient is on such leave.

6. Where a recipient's condition or situation requires more than 24 therapeutic leave days annually, as determined by the recipient's attending physician, prior authorization for the additional days shall be obtained from the MDO. The request for prior authorization shall be submitted in writing to the MDO Director, over the signature of the attending physician. A facility shall be reimbursed its per diem rate for reserving a bed for a Medicaid recipient for any additional days so authorized.

Case Notes

Bookkeeper's errors and lack of knowledge was exceptional case. *Leader Nursing and Rehabilitation Center v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 21.

Medicaid reimbursement; properly completed claims timely filed after rejection of improperly submitted claims. *Leader Nursing and Rehabilitation Center v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 21.

10:63-1.15 Complaints

(a) The Division will receive, document and investigate complaints from multiple sources and take appropriate corrective action as required. It is the Division'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 Division, 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 New Jersey State Department of Health and the Office of the Ombudsman for the Institutionalized Elderly for review and action. Any complaints or reports received by the Division indicating legal violations will be referred to the office of the Attorney General for review and action, as required.

10:63-1.16 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 recipient'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 recipient, recipient'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 recipients. Inquiries should be directed to the Division of Medical Assistance and Health Services, Bureau of Administrative Control, Mail Code # 6, CN-712, Trenton, New Jersey 08625-0712.

(1) Who has a beneficial interest of 10 percent or more in the net worth of the home; or

(2) Who has a beneficial interest of 10 percent or more in an entity related by (h)1i(2) or (3) above; or

(3) Who is a relative of an individual who is related by the definition in (h)1ii(1) or (2) above;

(4) Beneficial interest is cumulative, if it relates to spouse, parent or children.

(i) In related lease transactions, the rent paid to the lessor by the provider is not allowable as cost. The provider, however, would include in its costs the property expenses of ownership of the facility. The effect is to treat the facility as though it were owned by the provider. The treatment of these non-allowable costs is consistent with Federal regulations as they apply to costs to related organizations.

(j) Any legal expenses and related fees associated with any action initiated by the facility that is dismissed on the basis that no reasonable ground existed for the institution of such action will be excluded for reimbursement purposes.

(k) The cost of legal services for the appeal of reimbursement rates shall be excluded for reimbursement purposes.

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).

Case Notes

County hospital which did not participate in pre-adoption rulemaking proceedings is not entitled to an agency or court hearing. *Bergen Pines County Hospital v. New Jersey Dept. of Human Services*, 96 N.J. 456, 476 A.2d 784 (1984).

Unit staffing costs not reimbursable after case mix system became effective. *Matter of Seashore Gardens* October 1, 1990 Rates, 93 N.J.A.R.2d (DMA) 69.

Evidence failed to rebut presumption of reasonableness of agency's rate methodology. *Morris View Nursing Home v. Div. of Medical Assistance and Health Services*, 8 N.J.A.R. 561 (1983) affirmed per curiam Dkt. No. A-973-83 (App.Div.1985).

Rate reimbursement system challenged by facility utilizing minimum staffing report prepared for other purposes by the Department of Health. In re: *Preakness Hospital*, 8 N.J.A.R. 389 (1982).

Challenge to Medicaid reimbursement rate on basis of failure to consider cost of related party lease denied. *Hudson Manor Skilled Nursing Facility v. Div. of Medical Assistance and Health Services*, 8 N.J.A.R. 283 (1983), affirmed per curiam Dkt. No. A-972-83 (App.Div. 1984).

10:63-3.4 Equalized costs

(a) In order to equitably develop and apply screens the following computation will be made:

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. Costs will be equalized to adjust for timing differences among NF's fiscal years.

3. The term "equalized costs" means the net amount of compensation costs (salary and fringe benefits) plus other expenses, less expense recoveries and nonallowable costs, adjusted for timing differences among NF's fiscal years.

4. For NFs which provide residential, sheltered or domiciliary care, equalized nursing facility costs will be determined by apportioning equalized cost in the same ratio as the apportionment of unequalized net expenses.

5. The equalized net routine expenses will be apportioned to residential/sheltered care and nursing facility care in the same ratio as unequalized net routine expenses are apportioned, except in the case of land and building related items (see sections 6 and 10, of this subchapter).

6. In the calculation of costs screens, the per diem median runs and the cost regression analysis for the administrator/management screen will be calculated using actual patient days excluding bed hold days.

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).

Case Notes

Administrator's salary as calculated using the N.J.A.C. 10:63-3.5 regression analysis formula was reasonable. In re: *Cranford Hall Nursing Home*, 8 N.J.A.R. 463 (1982), affirmed per curiam Dkt. No. A-1641-82 (App.Div.1984).

4. For NFs whose appraised value per plant square foot (as determined by an agent designated by the State) is greater than 110 percent of the median construction costs at 1977 price levels, the property taxes attributable to the excess will be excluded from the rate base unless the owners can demonstrate unusual circumstances. For screening new NFs, this figure will be revised each year for inflation and for effects of standards changes upon construction cost. (See N.J.A.C. 10:63-3.11 for the methodology for calculating this limit at 1977 price levels.)

5. Reasonable land area (and related taxes) is established as follows:

i. For urban NFs two acres;

ii. For nonurban NFs five acres;

iii. For this purpose, a city, town, and so forth is considered "urban" if its population exceeds 25,000 and its average population density exceeds 7,000 per square mile. All other areas are considered "nonurban" or rural.

6. Property taxes ascribable to unreasonable land area will be excluded from the prospective rate base, based upon the assumption that assessed values vary directly with area.

7. After making any adjustments per (a)6 above, taxes bases upon land appraisals in excess of 140 percent of the median appraisal value of five acres, rural and two acres, urban of all NFs in the county will also be considered unreasonable. In the case of counties with fewer than five NFs neighboring counties may be combined in determining the median value to be used.

8. The department will review on an individual basis any inequities which owners believe are brought about by unusual circumstances.

(b) As noted in the instructions for the submission of cost studies, where a lessor is paying the property taxes, the actual property taxes paid by the lessor are to be reported by the NF operator as a property tax expense and deducted from the amount reported as rent. The property tax component of such leases will be subject to the above screens.

(c) Utility costs will be screened for reasonableness as follows:

1. Base period utility costs per bed will be deemed unreasonable to the extent that they exceed 125 percent of the Statewide median cost per bed, as determined for each class type of NF indicated in N.J.A.C. 10:63-3.3.

i. The Department will upon request review any inequities which owners believe are brought about by unusual circumstances.

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).

Case Notes

Utility add-on rate adjustment denied on basis that increased fuel costs were not an unusual situation. *Lincoln Park Nursing and Convalescent Center v. Div. of Medical Assistance and Health Services*, 8 N.J.A.R. 475 (1982), affirmed per curiam Dkt. No. A-291-82 (App.Div. 1983).

10:63-3.8 Special amortization

(a) The departments will consider on an individual basis, the amortization of start-up costs and special expenditures in rates. Each case will be reviewed on its particular merits and, accordingly, no guidelines are specified herein. As a rule, however, provisions for special amortization would relate to expenditures of a capital nature that are mandated by changes in laws and regulations. The amortization period would generally range from 12 to 60 months, depending upon the nature and magnitude of expenses.

(b) In approving the amortization of special expenditures, the departments will also consider the extent to which a NF's rates are based on capital and cost levels of fully complying NFs, or, for capital items, a review of a minimum of three bids on the acquisition or project.

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).

Case Notes

Evidence failed to rebut presumption of reasonableness of agency's rate methodology. *Morris View Nursing Home v. Div. of Medical Assistance and Health Services*, 8 N.J.A.R. 561 (1983), affirmed per curiam Dkt. No. A-973-83 (App.Div.1985).

Rate reimbursement system challenged by facility utilizing minimum staffing report prepared for other purposes by the Department of Health. In re: *Preakness Hospital*, 8 N.J.A.R. 389 (1983).

10:63-3.9 Routine patient care expenses

(a) For reporting purposes (on schedule A) and for the application of the following guidelines, "routine patient care expenses" are defined as expenses relating to those services defined as includable in the per diem rates for routine care under the Medicaid program.

(b) Reasonableness limits for nursing services (RN's, LPN's and other) will be established as follows: