

Case Notes

55-year-old male suffering with Down's Syndrome was entitled to nursing facility care. *W.M. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 46.

Rate reimbursement system challenged by facility utilizing minimum staffing report prepared for other purposes by the Department of Health; Division of Medical Assistance and Health Services not bound by Department of Health determinations; denial of increased rate reimbursement not unreasonable agency action. In re: Preakness Hospital, 8 N.J.A.R. 389 (1983).

10:85-1.4 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.

Recodified from N.J.A.C. 10:63-1.4 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).

8:85-1.5 Medicaid occupancy level

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

1. An SCNF that is an identifiable unit within a conventional NF shall calculate its occupancy level separate and apart from the occupancy level of the conventional NF beds using the same formula as cited in (a) above.

2. The NF shall submit the completed Provider Certification Statement for Long Term Care (see Appendix E, incorporated herein by reference), to report the actual calculation of the occupancy level determination of the NF. In addition to the occupancy level determination, the Certification Statement is also used to certify that the billing information is accurate, complete and in accordance with the rules of the New Jersey Health Services Program (Medicaid). The Certification Statement shall be submitted with the monthly Turn Around Document (TAD) (as set forth in Appendix Q, incorporated herein by reference) to the fiscal agent. Billing documents will be returned if the Certification Statement is not completed, signed and attached.

3. The calculation of the occupancy level shall include eligible bed reserve days in the determination of the Medicaid occupancy level.

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".

Case Notes

Conditions of blindness and profound retardation established appropriateness of residential long-term pediatric care placement. *N.C. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 34.

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.

Recodified from N.J.A.C. 10:63-1.6 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).

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

Case Notes

Conditions of blindness and profound retardation established appropriateness of residential long-term pediatric care placement. N.C. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 34.

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.

Recodified from N.J.A.C. 10:63-1.7 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).

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".

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

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

1. An individual who is financially and clinically eligible for Medicaid residing in a Medicaid-participating NF who is transferred to an acute care hospital shall not be subject to PAS prior to returning to the same or another NF.

2. If an individual who is financially and clinically eligible for Medicaid identified as having MI residing in a Medicaid-participating NF is admitted to a psychiatric unit for treatment for less than one year, the individual shall not be subject to PASRR prior to returning to the NF.

3. When a NF resident with MI or MR is transferred to another NF, the admitting NF shall be responsible for ensuring that a copy of the resident's current PASRR determination, MDS (see N.J.A.C. 8:39-11.2(e)), and HSDP (Appendix L, incorporated herein by reference) accompany the transferring resident.

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

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

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 accord-

ing 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 reconfirm 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.

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.

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