

attached when submitting the CMS 1500 claim to the fiscal agent.

(h) In addition, for dually eligible Medicare and Medicaid hospice beneficiaries, the hospice shall submit claims first to Medicare. Payment by Medicaid for unrelated services or for coinsurance requires an EOMB or EOB to be attached to the claim submitted to the Medicaid Fiscal Agent.

(i) The hospice shall not overlap from one calendar month to another in the billing process or bill for more than one calendar month's hospice benefit and/or room and board charges on each claim form.

(j) The amount of the Medicare coinsurance payment to be reimbursed to the hospice by Medicaid shall be submitted on a separate CMS 1500 claim from the other per diem charges.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

In (a)1, amended N.J.A.C. references; in (b)3iii, added the second sentence; and in (c)1i inserted the second sentence.

Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

Rewrote the section.

Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).

Substituted "CMS" for "HCFA" throughout; in (c)1i, inserted the second sentence; added new (d)2 and (d)3; recodified former (d)2 and (d)3 as (d)4 and (d)5; in (d)4, substituted "at which the hospice service is provided to the beneficiary" for "of the main business office of the hospice provider".

10:53A-4.3 Basis of payment—physician services

(a) The method of calculation of the basic per diem rates for hospice services listed in N.J.A.C. 10:53A-4.1 includes the costs of the administrative and general supervisory activities performed by physicians who are employees of the hospice provider or those working under financial arrangements with the hospice provider.

1. The administrative and supervisory activities are generally performed by the physician serving as the Medical Director and/or the physician member of the hospice interdisciplinary group.

i. Interdisciplinary group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and the establishment of governing policies.

(b) The Division shall pay the physician for only direct patient care services furnished to Medicaid/NJ FamilyCare FFS hospice beneficiaries by hospice physician employees, and for physician services furnished under arrangements made by the hospice, unless the services were provided on a volunteer basis. The cost of the direct patient care services of the physician who is employed by or under contract with the hospice agency shall be submitted on the CMS 1500 claim by the physician to the fiscal agent.

1. Physician services furnished on a volunteer basis are excluded from Medicaid/NJ FamilyCare FFS reimbursement.

2. The physician may bill for services which are not provided on a volunteer basis. However, the physician shall treat Medicaid and NJ FamilyCare FFS beneficiaries on the same basis as other beneficiaries in the hospice. For instance, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid and NJ FamilyCare FFS beneficiaries.

(c) The attending physician shall bill only for direct personal care services and not for other costs such as laboratory or X-rays, which are to be included in the hospice per diem rate.

1. The costs of attending physician's direct personal care services shall not be included in the hospice cap determinations.

(d) Attending physician services and other specialty physician services, including consultation services provided by physicians who are not employees of the hospice, are reimbursed as covered services on a fee-for-service basis under N.J.A.C. 10:54, Physician Services, separate from the method of calculation of the hospice per diem rates listed in N.J.A.C. 10:53A-4.2.

1. The hospice shall state the name of the physician who has been designated the attending physician (when-ever the attending physician is not a hospice employee) in the plan of care and on the Election of Hospice Benefits Statement, FD-378; and specify whether the attending physician services are either related or unrelated to the beneficiary's terminal illness.

Amended by R.1997 d.479, effective November 17, 1997.

See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

Amended by R.2003 d.320, effective August 4, 2003.

See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

Rewrote the section.

Amended by R.2008 d.226, effective August 4, 2008.

See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).

In the introductory paragraph of (b), substituted "CMS" for "HCFA"; and in (d)1, deleted "(2/02)" following "FD-378".

10:53A-4.4 Limitations on reimbursement for hospice services

(a) The Division limits aggregate payments to a hospice during a hospice "cap" period to the same degree, amount, and methodology as Medicare except the room and board per diem amounts reimbursed to hospice providers for services provided in a nursing facility are not subject to the "cap limitations" on the overall reimbursement to hospice providers.

1. Any payments in excess of the "cap" must be refunded by the hospice to the Division.

(b) The Division also limits payment for inpatient care according to the number of days of inpatient care furnished to hospice beneficiaries in the aggregate for that provider. The computation of the limitation is as follows:

1. During the 12-month period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid and NJ FamilyCare FFS beneficiaries during that same period.

i. The maximum allowable number of inpatient days shall be calculated by multiplying the total number of days of Medicaid/NJ FamilyCare hospice care by 20 percent.

ii. If the total number of days of inpatient care furnished to Medicaid and NJ FamilyCare FFS hospice beneficiaries is less than or equal to the maximum, no adjustment shall be made.

iii. If the total number of days of inpatient care exceeds the maximum allowable number, the amount of the limitation will be determined by: calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursed for inpatient care (general and respite reimbursement); multiplying the excess inpatient care days by the routine home care rate; adding the amounts determined in the calculations of (b)1iii(1) and (2) above; and comparing the amount in (b)1iii(3) above with interim payments made to the hospice for inpatient care during the "cap period."

(1) The aggregate number of inpatient days (both for inpatient general and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid/NJ FamilyCare beneficiaries during that same period.

(2) Any payments in excess of the "cap" must be refunded by the hospice to the Division.

Amended by R.1997 d.479, effective November 17, 1997.

See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

Deleted (c).

Amended by R.2003 d.320, effective August 4, 2003.

See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

Rewrote the section .

10:53A-4.5 Submitting claims for payment

(a) The hospice shall submit claims in accordance with policies and procedures set forth in N.J.A.C. 10:49-7.1, 7.2 and 7.3, incorporated herein by reference, regarding the timely filing of claims and the timeliness of claims submission and inquiry.

(b) Documents needed specifically for the administration of the Hospice Care Program are Forms #1 through #10

located in the Appendix at the end of this chapter and may be obtained by writing to the following address:

Division of Medical Assistance and Health
Services
General Services
Attention: Forms
PO Box 712, Mail Code #50
Trenton, New Jersey 08625-0712
(Fax: 609-584-4383)

New Rule, R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

SUBCHAPTER 5. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:53A-5.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare program adopted the Centers for Medicare & Medicaid Services' Healthcare Common Procedure Coding System (HCPCS). The HCPCS procedure codes as listed in this subchapter are relevant to certain Medicaid/NJ FamilyCare fee-for-service hospice services.

(b) For a complete description of the basis of payment for the HCPCS codes listed below, refer to N.J.A.C. 10:53A-4.2, Basis of payment-hospice providers in this chapter. Section 1814(i)(1)(C)(ii) of the Social Security Act authorizes the rates and provides for annual increases in payment rates for hospice services. The Federally predetermined prospective annual rates are calculated based on the annual hospice rates established by Medicare. Section 1814(i)(2)(B) of the Act provides for an annual increase in the hospice cap amounts. Hospice payment rates for care and services are in effect from October 1 of one year to September 30 of the following year. For the "cap" amounts, the fiscal year ends on October 31 of the calendar year. In addition, Section 1814(i)(2)(D) of the Act requires that providers submit their claim for hospice services provided at an individual's home only on the basis of the geographic location at which the services are furnished.

(c) States have the flexibility to establish hospice rates at amounts no lower than the Medicare allowable hospice rate. The New Jersey Medicaid/NJ FamilyCare program is setting hospice rates for the four "levels of care" at the prospective predetermined levels which are determined by CMS.

(d) The rates marked with an asterisk are adjusted for regional differences in wages, in accordance with 42 CFR 418.306, using indices based on regions listed initially in the Federal statute as referenced in (b) above. Specific directions for calculating individual hospice rates for the four levels of hospice care (routine, continuous, inpatient respite and general inpatient care); for the co-payment for inpatient respite care; and for the annual update of the rates and the wage indices, can be found in the Federal Register, published

annually, in accordance with 42 CFR 418.306, or by contacting the United States Department of Health and Human Services, Centers for Medicare and Medicaid Administration.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

In (d), rewrote the second sentence and deleted the third sentence.

Amended by R.2003 d.320, effective August 4, 2003.

See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

Rewrote the section.

Amended by R.2008 d.226, effective August 4, 2008.

See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).

In (a), substituted "Centers for Medicare & Medicaid Services' Healthcare" for "Health Care Financing Administration's (HCFA)" and inserted "fee-for-service".

10:53A-5.2 HCPCS procedure codes for hospice services

Note: The rates of the procedure codes marked with an asterisk (*) are subject to an adjustment based on regional differences in wages as set by Federal statute and current annual Federal Register updates as referenced in N.J.A.C. 10:53A-5.1(b) and (d).

- *T2042 ROUTINE HOME CARE RATE
Per diem rate, calculated as referenced in N.J.A.C. 10:53A-5.1(d) and 4.2(b)1 and (d)1.
- *T2043 CONTINUOUS HOME CARE RATE
Per diem rate, calculated as referenced in N.J.A.C. 10:53A-5.1(d) and 4.2(b)2 and (d)1.
- *T2044 INPATIENT RESPITE CARE RATE
Per diem rate, calculated and adjusted annually in N.J.A.C. 10:53A-4.2(d) and 4.4.

- *T2045 GENERAL INPATIENT CARE RATE
Per diem rate, calculated and adjusted annually and limited according to N.J.A.C. 10:53A-4.2(b)3 and (d).
- T2046 ROOM AND BOARD RATE
Per diem rate, calculated and adjusted annually as referenced in N.J.A.C. 10:53A-4.2(c) and (d).
- Y6337 THERAPEUTIC LEAVE DAYS
Per diem rate, calculated, and annually adjusted, as referenced in N.J.A.C. 10:53A-4.2(c)1ii and (d).
- Y6338 BED RESERVATION DAYS RATE
Per diem rate, calculated and adjusted annually as referenced in N.J.A.C. 10:53A-4.2(c)1ii and (d).
- Y6339 HOSPICE RESPITE CO-PAYMENT
Per diem rate, as referenced in N.J.A.C. 10:53A-4.2(g).
- Y6343 DRUG AND BIOLOGICALS CO-PAYMENT
Reimbursed as referenced in N.J.A.C. 10:53A-4.2(f).

Amended by R.1997 d.479, effective November 17, 1997.

See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

Amended N.J.A.C. references.

Amended by R.2003 d.320, effective August 4, 2003.

See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

In "ROUTINE HOME CARE RATE" and "CONTINUOUS HOME CARE RATE", revised N.J.A.C. references.

Amended by R.2008 d.226, effective August 4, 2008.

See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).

Rewrote the table.

APPENDIX A

- Form #1 Election of Hospice Benefits Statement (FD-378)
- Form #2 Hospice Benefits Statement (FD-379)
- Form #3 Representative Statement for the Election of Hospice Benefits (FD-380)
- Form #4 Revocation of Hospice Services (FD-381)
- Form #5 Termination of Hospice Benefits (FD-382)
- Form #6 Hospice Eligibility form (FD-383), with Instructions for Submitting the Hospice Eligibility form (FD-383)
- Form #7 Change of Hospice form (FD-384)
- Form #8 Physician's Certification/Recertification For Hospice Benefits Form (FD-385)
- Form #9 Notification From Long-Term Care Facility of Admission or Termination of a Medicaid Patient (LTC-2)
- Form #10 Statement of Available Income for Medicaid Payment (PR-1)
- Form #11 Long-Term Care Turnaround Document (TAD) (MCNH-117)

FORM #1

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
ELECTION OF HOSPICE BENEFITS STATEMENT

I, _____ elect to receive Medicaid/NJ
(Beneficiary's Name and Medicaid/NJ FamilyCare fee-for-service Eligibility Identification Number)
FamilyCare fee-for-service hospice benefits from: _____
(Name of Hospice Agency and Medicaid Provider Billing Number)
effective this _____ day of _____, 20 _____.

I am aware that I have a life threatening illness. I consent to the management of the symptoms of my disease by the above hospice agency. My family and I will help to develop a plan of care based on our needs. My care will be supervised by my attending physician, _____, and the Hospice Medical Director in conjunction with the hospice interdisciplinary group.

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aide/homemaker services, physical therapy, occupational therapy, speech-language pathology services, other items and services which are included in the plan of care and otherwise covered by Medicaid, inpatient care for acute symptoms and procedures ordered by my physician, and hospice and continuous nursing care in the home in medical crisis.

I may request volunteer services from the hospice.

In accepting these services, I relinquish my rights to regular Medicaid/NJ FamilyCare fee-for-service benefits, except for services of my attending physician, and for treatment for medical care unrelated to my terminal illness, except when the unrelated services are approved by the hospice interdisciplinary group, or provided in the case of accidental injury, or sudden or serious illness requiring treatment on an emergency basis.

I understand that I can revoke and terminate my hospice benefits at any time and resume regular Medicaid or NJ FamilyCare benefits if I am still eligible for Medicaid or NJ FamilyCare fee-for-service.

I understand that the hospice benefits consist of the following benefit periods: two 90-day periods, and an unlimited number of subsequent 60-day benefit periods. I may be responsible for hospice charges if I become ineligible for Medicaid or NJ FamilyCare.

I am aware that if I choose to revoke hospice benefits during a benefit period, I am not entitled to coverage for hospice services for the remaining days of that benefit period. I understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s).

I understand that, should I choose to do so, I may change the designation of the particular hospice once during the election period by filing a statement with the particular hospice from which care has been received and with the newly designated hospice. I understand that changing hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the hospice benefits, hospice coverage will continue for 180 consecutive days. After the 180 days of hospice benefits, my benefits will automatically expire unless I choose to request an unlimited number of subsequent benefit periods, upon physician recertification of my continued need for hospice services related to my terminal illness.

I understand that if I am a dually eligible Medicare and Medicaid or Medicare/NJ FamilyCare beneficiary, I must elect to use the Medicare and Medicaid or NJ FamilyCare fee-for-service hospice benefits simultaneously.

Check one:

[] I am a Medicare beneficiary and have elected to use the Medicare hospice benefits. My Medicare eligibility for hospice benefits begins on: _____ (Date)

[] I am not a Medicare beneficiary.

[] I am currently a nursing facility resident, residing at:

Facility Name/Address

Signature of the Applicant