CHAPTER 63

LONG–TERM CARE SERVICES

Authority

N.J.S.A. 30:4D–6a(4)(a)b(14); 30:4D–7, 7a, b and c; 30:4D–12; Section 1919 of the Social Security Act; 42 U.S.C. 1396r.

Source and Effective Date

R.1994 d.624, effective November 23, 1994.
See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Executive Order No. 66(1978) Expiration Date

Chapter 63, Long-term Care Services, expires on November 23, 1999.

Chapter Historical Note

Chapter 63, originally 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 Chapter 63 was repealed and a new Chapter 63, Long–Term Care Services Manual, was adopted as R.1979 d.126, effective March 29, 1979.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, and 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. 204(a), 16 N.J.R. 896(a); 16 N.J.R. 2484(a), 16 N.J.R. 3437(a). Pursuant to Executive Order No. 66(1978), Chapter 63 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 was readopted as R.1994 d.624. See: Source and Effective Date. As a part of R.1994 d.624, Subchapters 1, 2, 2A and 4, and Appendix I were repealed and new Subchapters 1 and 2, and Appendices A through Q were adopted; Subchapter 5 was recodified as Subchapter 4; effective January 3, 1995. See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a). See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:63–1.1 Scope

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medic-

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aid 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. Although the scope of the Long-Term Care Services chapter encompasses other long-term care facilities such as governmental psychiatric hospitals, inpatient psychiatric services/programs for the under 21 (residential treatment centers) and intermediate care facilities/mentally retarded (ICF/MRs), the following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement applies to all the above cited long-term care facilities.

Case Notes

Radioactive application of regulation valid. In re: Medicaid Long Term Care Services Bulletin 84-2, 212 N.J.Super. 48, 513 A.2d 967 (App.Div.1986), certification denied 526 A.2d 125, 107 N.J. 31.

Denial of request for reclassification from low to medium salary region assignment not inequitable. Rosewood Manor, Inc. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 20.

10:63-1.2 Definitions

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

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

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

"Case management" means a process by which the Division of Medical Assistance and Health Services Medical Social Care Specialist monitors the provision of nursing facility care to assure timely and appropriate provider responses to changes in care needs and delivery of coordinated services.

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

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

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

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

"Conventional nursing facility"—see nursing facility.

"Department of Health" (DOH) means the New Jersey State Department of Health.

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

"Division of Mental Health and Hospitals (DMH & H)" means the Division of Mental Health and Hospitals within the New Jersey State Department of Human Services.

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared by the Regional Staff Nurse during the Pre-Admission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

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

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

"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.

"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 evaluation team (MET)" means a team of Medicaid professionals consisting of a physician consultant, a regional staff nurse (RSN), a regional pharmaceutical consultant, a Medical Social Care Specialist I (MSCS I) and a Medical Social Care Specialist II (MSCS II) who are assigned to the Medicaid District Office (MDO). A MET has the responsibility to review medical, nursing, and social information as well as any other supporting data in order to evaluate the need for long-term care, determine the level of care needed, the feasibility of alternate care, the quality of care given and the outcome of service. Members of the MET may review each recipient or potential recipient as individual team members or may perform the review as a multidisciplinary team.

"Medical social care specialist (MSCS)" means a social worker employed by the Division of Medical Assistance and Health Services who performs case management as required by N.J.A.C. 10:63.

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

"Minimum data set (MDS)" means a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing facility resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24–hour basis to Medicaid recipients (children and adults) who, due to medical disorders, developmental disabilities and/or related cognitive and behavioral 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.

"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 recipients 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 the Regional Staff Nurse 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 annual resident review (PASARR)" means that process by which all individuals with mental illness (MI) or mental retardation (MR) are screened prior to admission to a NF and annually thereafter in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition.

"Prior authorization" means approval granted by the Division of Medical Assistance and Health Services through the appropriate Medicaid District Office (MDO) for payment for NF or before other Medicaid covered services are rendered to a Medicaid recipient, in accordance with this chapter.

"Regional staff nurse (RSN)" means a registered professional nurse employed by the Division of Medical Assistance and Health Services who performs health needs assessments as required by this chapter.

"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.

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

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

"Section Q" means the resident classification portion of the standardized resident assessment (SRA) instrument which identifies an individual NF resident's nursing service requirements based on the standards at N.J.A.C. 10:63–2.2(a).

"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 recipient 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 Division of Medical Assistance and Health Services to provide care to New Jersey Medicaid recipients who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. 10:63–2, Nursing Facility Services.

"Specialized services for mental illness (MI)" mean those services offered, in accordance with 42 CFR 483.120, when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based on a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24–hour supervision for the individual, specific therapies and activities are prescribed, with the following objectives: to diagnose and reduce behavioral symptoms; to improve independent functioning; and as early as possible, to permit functioning at a level where less than specialized services are appropriate. Specialized services go beyond the range of services which a NF is required to provide.

"Specialized services for mental retardation (MR)" mean those services offered, in accordance with 42 CFR 483.120, when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills. Specialized services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an intermediate care facility for the mentally retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is required to provide.

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

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

"Track of care" means the designation of the setting and scope of Medicaid services determined by the PAS process conducted by the RSN following assessment of the Medicaid eligible or potentially eligible Medicaid recipient, as follows:

1. "Track I" means long-term NF care.

2. "Track II" means short-term NF care.

3. "Track III" means long-term care services in a community setting.

"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.

Case Notes

County hospital which did not participate in pre-adoption rulemaking proceedings is not entitled to an agency or court hearing to explore reasons underlying regulations prescribing methodology for fixing rates paid for Medicaid patient care at long-term care facility; regulations not arbitrary or unreasonable. Bergen Pines County Hospital v. New Jersey Dept. of Human Services, 96 N.J. 456, 476 A.2d 784 (1984).

Presumption of reasonableness of agency's rate methodology not rebutted by sufficient evidence; burden of proof improperly shifted to agency at hearing (Director's Final Decision). 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; 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).

10:63–1.3 Program participation

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

1. Be licensed by the New Jersey State Department of Health, in accordance with N.J.A.C. 8:39;

2. Be certified by the New Jersey State Department of Health and, in the case of both Medicare and Medicaid, by the Health Care Financing Administration (HCFA), which assures that the NF meets the Federal requirements for participation in Medicaid and Medicare;

3. Be approved for participation as a NF provider by the New Jersey Medicaid program. This includes the filing of a New Jersey Medicaid Provider Application FD–20 (see Appendix A, incorporated herein by reference), the signing of a Provider Agreement MCNH–38 (see Appendix B, incorporated herein by reference), and submittal of the HCFA–1513, Ownership and Control Interest Disclosure Statement (see Appendix C, incorporated herein by reference). The agreement for participation in the New Jersey Medicaid program stipulates that a NF shall provide all NF services required by N.J.A.C. 10:63. Continued participation as a New Jersey Medicaid provider will be subject to recertification by the New Jersey Department of Health and compliance with all Federal and State laws, rules and regulations. Upon recertification by the Department of Health, each NF will receive notification from the Provider Enrollment Unit, Division of Medical Assistance and Health Services, informing the facility that their provider agreement is being continued.

4. File a completed Cost Study for Long–Term Care Facility form MCNH–1 (see Appendix D, incorporated herein by reference) with the New Jersey State Department of Health and the Division of Medical Assistance and Health Services. After the initial cost study is filed, the provider shall file an MCNH–1 annually.

5. In accordance with 42 CFR 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; and

6. Accept as payment in full for covered services, the amounts paid in accordance with Medicaid policy defined at N.J.A.C. 10:49–9.3(a)2.

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).

10:63–1.4 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.

10:63–1.5 Occupancy level

(a) The NF Medicaid occupancy level shall be calculated by adding the total days for Medicaid and public assistance recipients 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 care beds.

1. A Special Care Nursing Facility (SCNF) which 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.

10:63–1.6 Termination of a NF provider agreement

(a) The Division shall terminate a NF's provider agreement if the Division:

1. Receives notice from the New Jersey State Department of Health or HCFA that the NF is no longer certified to provide NF services. In that case:

i. The provider agreement shall be terminated 23 days from the survey date if the New Jersey State Department of Health or the Secretary of the Department of Health and Human Services find 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 provider agreement shall be terminated ninety days from the survey date.

iii. The termination of provider agreement shall be rescinded if, prior to the effective date of termination, the Division is notified by the New Jersey Department of Health or the Secretary of the Department of Health and Human Services that the deficiencies have been satisfactorily corrected and the NF is certified to provide NF services; and

2. Determines that other good cause for such termination exists as cited at N.J.A.C. 10:49–11 or as a result of a pattern of aberrancies reported in a clinical audit as defined at N.J.A.C. 10:63–1.12.

10:63–1.7 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 Division letter proposing termination, a written request to the Chief, Office of Legal and Regulatory Liaison, Division of Medical Assistance and Health Services, Mail Code # 3, CN 712, Trenton, New Jersey 08625–0712.

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 HCFA, may request a hearing pursuant to 42 CFR 498.40 by submitting a written request to the Health Care Financing Administration, 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.

10:63–1.8 Admission, transfer and readmission; general

(a) Pursuant to P.L.1988, c. 97, a Medicaid participating NF shall not admit any individual who is Medicaid eligible or who may become Medicaid eligible within 180 days of admission to the facility, or an individual with mental illness (MI) or mental retardation (MR) subject to Pre–Admission Screening and Annual Resident Review (PASARR) requirements as defined at 42 CFR 483.102 regardless of payment source, unless that individual has been prescreened by the Medicaid District Office (MDO) registered professional nursing staff and determined appropriate for NF placement.

(b) A Medicaid eligible individual residing in a Medicaid participating NF who is transferred to an acute care hospital shall not require preadmission screening prior to returning to the same or another NF.

(c) A Medicaid eligible individual identified as MI residing in a Medicaid participating NF, who is admitted to a psychiatric unit for treatment, shall not be subject to PASARR requirements, prior to returning to the NF. However, if the resident's condition indicates a significant change in mental or behavioral status, the NF shall immediately secure an Annual Resident Review (ARR) as defined in N.J.A.C. 10:63–1.11(e).

(d) In cases of transfer of a NF resident with MI or MR to a hospital or another NF, the admitting NF is responsible for ensuring that copies of the resident's most recent PASARR resident assessment reports, SRA and current HSDP accompany the transferring resident.

13. Unclaimed PNA funds left behind by a discharged recipient 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, CN 712, Trenton, New Jersey 08625-0712.

14. Within 10 days after the death of a Medicaid recipient, 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 recipient 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 recipient.

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 recipient for the PNA funds. A check for the funds shall not be issued unless a Surrogate's letter is presented, except when a recipient 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 to the Bureau of Administrative Control, Mail Code # 6, CN-712, Trenton, New Jersey 08625-0712. The following information shall be included:

(1) An identification of the funds as unclaimed PNA funds of the deceased Medicaid recipient;

(2) Recipient's name;

(3) HSP (Medicaid) Case Number;

(4) Date of death; and

(5) Amount enclosed for that recipient.

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 recipient'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 recipient'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 Director of the Medicaid District Office serving the NF.

Case Notes

Department of health can restrict licensed health care facility, apart from Medicaid, in the involuntary transfer of indigent patients or patients who become indigent; validity of health regulation. New Jersey Assn. of Health Care Facilities v. Finley, 83 N.J. 67, 415 A.2d 1147 (1980), appeal dismissed, certiorari denied 101 S.Ct. 342, 449 U.S. 944, 66 L.Ed.2d 208.

10:63-1.17 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 medical care and his or her right to formulate an advance directive in compliance with the New Jersey Advance Directives for Health Care Act, P.L.1991, c. 201 and the advance directive provisions of the Omnibus Reconciliation Act of 1990, effective December 1, 1991 and Department of Health licensing requirements at N.J.A.C. 8:39-9.5.

10:63-1.18 Medicare/Medicaid

(a) The New Jersey Medicaid Program will reimburse for NF services provided to combination Medicare/Medicaid recipients only after Medicare covered benefits have been fully utilized or when medically necessary services are not covered by the Medicare Program. (Exceptions—see (e)2i below).

(b) Only skilled nursing facilities (SNFs), as defined in N.J.A.C. 10:63-1.2, certified by the Health Care Financing Administration (HCFA) and the New Jersey Department of Health 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) When Medicare benefits are terminated or exhausted because of coverage limitations, Medicaid may be billed on behalf of eligible recipients, 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.

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.

(e) 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 recipient 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 recipients. 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.

SUBCHAPTER 2. NURSING FACILITY SERVICES

10:63–2.1 Nursing facility services; eligibility

(a) Eligibility for nursing facility (NF) services will be determined by the RSN, based on a comprehensive needs assessment which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 10:63–2.2.

1. Individuals requiring NF services may have unstable medical, emotional/behavioral and psychosocial conditions which 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. Dependency in activities of daily living (ADL) may have a high degree of individual variability. Each separate ADL may be classified as either independent, requiring some assistance, or totally dependent.

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 licensing rules at N.J.A.C. 8:39. Reimbursement of NF services is discussed in N.J.A.C. 10:63–3.