CHAPTER 53A

HOSPICE SERVICES MANUAL

Authority

N.J.S.A. 30:40–3i(1) through (7); N.J.S.A. 30:40–6(b)(20); N.J.S.A. 30:40–7, 7a, b and c; 1814(i) of the Social Security Act, 42 U.S.C. 1395f(i); 1905(*o*) of the Social Security Act, 42 U.S.C. 1396d.

Source and Effective Date

R.1992 d.442, effective November 2, 1992.
See: 24 N.J.R. 2778(a), 24 N.J.R. 4036(a).

Executive Order No. 66(1978) Expiration Date

Chapter 53A, Hospice Services Manual, expires on November 2, 1997.

Chapter Historical Note

Chapter 53A, Hospice Services Manual, was adopted as new rules by R.1992 d.442. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:53A–1.1 Introduction

Reimbursement for hospice services provided by Medicaid was authorized pursuant to 1905(*o*) of the Social Security Act, codified as 42 U.S.C. 1396(d). N.J.S.A. 30:4D–6b(20) authorizes that the New Jersey Division of Medical Assistance and Health Services develop a program of hospice services. The Hospice Services Manual (N.J.A.C. 10:53A) sets forth the rules for the provision of hospice services to the terminally ill who are eligible for Medicaid. Room and board services are also available for those Medicaid recipients residing in a nursing facility that are eligible for hospice services. The Home Care Services Manual, N.J.A.C. 10:60, is applicable to hospice care as a waiver service provided under the AIDS Community Care Alternatives Program (ACCAP).

10:53A–1.2 Definitions

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

"Benefit period" means a period of time when an individual is eligible to receive hospice services. Hospice benefit periods are for the following periods of time: 90 days; 90 days; 30 days; and an unlimited fourth period.

"CAP" means a limitation on the payment amount or aggregate days of inpatient care as imposed by Medicaid on the hospice provider. The "CAP" year begins on November 1st of one year and ends on October 31st of the next year.

"Comprehensive hospice benefits" means the covered services provided by hospices and physicians for hospice care, room and board services provided to Medicare/Medicaid recipients residing in a nursing facility, and services unrelated to the terminal illness that may be provided by Medicaid as part of the hospice plan of care. The comprehensive hospice benefit does not include hospice services under ACCAP or any other waiver program.

"Dietician" or "dietary consultant" means a person who:

1. Is registered or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association; or

2. Has a bachelor's degree from a college or university with a major in foods, nutrition, food service or institution management, or the equivalent course work for a major in the subject area; and has completed a dietetic internship accredited by the American Dietetic Association or a dietetic traineeship approved by the American Dietetic Association or has one year of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting; or

3. Has a master's degree plus six months of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting.

"Division" means the Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

"Election of Hospice Benefits Statement" means a written document signed by a Medicaid eligible individual for hospice services, indicating the following: the identification of the particular hospice that will provide care to the individual; the scope of services and conditions under which hospice services are provided; which other Medicaid services are forfeited when choosing hospice services; the individual or his or her representative's acknowledgement that he or she has been given a full understanding of hospice care; and the effective date of the signing of the Election of Hospice Benefits Statement (FD–378) (incorporated herein by reference as Form # 1 in the Appendix).

"Hospice," for the purposes of the New Jersey Medicaid program (hereafter referred to as the Program), means a public agency or private organization (or subdivision of such organization) that is Medicare certified for hospice care and has a valid provider agreement with the Division to provide hospice services. A hospice is primarily engaged in providing supportive or palliative care and services, rather than curative care, to the terminally ill and/or bereaved. Hospice providers in New Jersey are hospital-based or free-standing home health agencies, or free-standing hospice agencies.

"Hospice indicator" means a unique date specific identifier in the Medicaid eligibility record which is used in the processing of hospice claims for eligible recipients.

"Hospice services," for the purposes of the Program, means services which support a philosophy and method for caring for the terminally ill emphasizing supportive and palliative rather than curative care, and includes services, such as home care, bereavement counseling, and pain control.

"Interdisciplinary group" means a group of professionals who are employees of the hospice, that provide and/or supervise hospice services. The interdisciplinary group, at a minimum, must be composed of a physician, a registered professional nurse, a medical social worker and a pastoral or other counselor.

"Medical Director" means a physician (M.D. or D.O.) who assumes overall responsibility for the medical component of the hospice services as an employee of the hospice.

"Room and board services," as referred to in this chapter, means the performance of personal care services, assistance in activities of daily living, provision of patient social activities, the administration of medications, the maintenance of the cleanliness of a resident's room, and supervision and assistance in the use of durable equipment and prescribed therapies provided to hospice recipients in a nursing facility (identical to those provided to non-hospice recipients in a nursing facility).

"Terminal illness," as referred to in this chapter, means having a medical prognosis of a life expectancy of six months or less as certified or recertified, in writing, by a licensed physician (M.D. or D.O.).

"Unrelated services" means services provided that are necessary for the diagnosis and treatment of diseases or illnesses that are not in and of themselves related to or are not caused primarily by the terminal condition for which hospice services are provided.

SUBCHAPTER 2. PROVIDER REQUIREMENTS

10:53A–2.1 Hospice enrollment requirements

(a) To be approved by the Division as a hospice provider, a hospice must:

1. Be approved for Medicare (Title XVIII) participation by the federal Health Care Financing Administration (HCFA) as a hospice provider. A copy of the Medicare certification must be submitted to the Division of Medical Assistance and Health Services; and

2. Complete and submit the Medicaid "Provider Application" (FD–20); "Ownership and Controlling Interest Statement" (HCFA–1513); and the "Medicaid Provider Agreement" (FD–62).

i. The documents, referenced in (a)2 above, are located as Forms 8, 9, and 10 in the Appendix of the Administration Chapter, (N.J.A.C. 10:49–Appendix) at the end of the chapter, and may be obtained from and submitted to:

Paramax/Unisys Corporation
Provider Enrollment
CN 4804
Trenton, New Jersey 08650–4804

ii. Hospice provider agreements are approved by the:

Chief, Provider Enrollment Unit
Division of Medical Assistance and Health Services
CN–712
Trenton, New Jersey 08625–0712

iii. A change in the ownership of a hospice is not considered a change in the individual's designation of a hospice and requires no action on the Medicaid hospice recipient's part. The hospice shall notify the Division in writing of a change in ownership and shall submit a new application package.

(b) If the hospice is providing hospice services to a Medicaid recipient residing in a nursing facility (NF), the nursing facility must be a Medicaid-approved nursing facility. The hospice must also have a written contract with the nursing facility under which the hospice takes full responsibility for the professional management of the individual's hospice services and the nursing facility agrees to provide room and board services to the individual.

1. Room and board services include the performance of personal care services, assistance in activities of daily living, provision of patient social activities, the administration of medications, the maintenance of the cleanliness of a resident's room, and supervision and assistance in the use of durable equipment and prescribed therapies provided to hospice recipients in an NF (identical to those provided to non-hospice recipients in an NF).

(c) If the hospice is already a Medicaid ACCAP hospice provider, in lieu of the process listed in (a) above, the hospice shall send a letter citing its ACCAP provider status to the Provider Enrollment Unit of the Division whose address is listed in (a)2ii above, requesting approval as a hospice provider of room and board services and/or as a provider of the comprehensive hospice benefit.

(d) Upon approval as a hospice provider, the hospice shall be assigned a Medicaid provider number. In the event the hospice provider is also an ACCAP hospice provider, the hospice provider number will be the same for both programs.

(e) For the purposes of reimbursement, if a physician provides direct patient care services to a hospice recipient, he or she must be an approved Medicaid physician provider (see Physician Services Manual, N.J.A.C. 10:54).

(f) The fiscal agent shall furnish a provider manual and an initial supply of pre-printed claim forms.

10:53A–2.2 Changing from one hospice to another

(a) In order for a hospice recipient to change hospices, the hospice policies and procedures listed below shall be followed:

1. An individual may change hospices once in each benefit period. The change of the hospice is not considered a revocation of the election of hospice services.

2. In order to change the designation of the hospice, an individual shall file a signed statement, the Change of Hospice, FD–384 (6/92) form incorporated herein by reference as Form # 7 in the Appendix, with the hospice where the individual was initially enrolled and also with the newly designated hospice. The statement shall include the following information:

i. The name of the hospice from which the individual received hospice services; and

ii. The name of the hospice from which the individual will receive hospice services and the date the change is effective.

3. The original hospice of enrollment and the new hospice must send the Hospice Eligibility Form, FD–383 (6/92) to the MDO, CWA or DYFS, as applicable, in order to change providers. (See Form # 6 in the Appendix in this manual incorporated herein by reference for the Hospice Eligibility Form, FD–383 (6/92) and N.J.A.C. 10:53A–3.2 for the application policy for medical and financial eligibility.)

10:53A–2.3 Physician certification and recertification

(a) The hospice shall follow these policies and procedures to obtain physician certification of the applicant's terminal illness and to certify that hospice services are reasonable and necessary for the palliation and management of the terminal illness or related conditions.

1. The attending physician, who must be a doctor of medicine (M.D.) or osteopathy (D.O.), is the one identified by the Medicaid applicant at the time the applicant elects to receive hospice services as the primary physician in the determination and the delivery of the applicant's medical care.

2. The written Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92) (Form # 8 in the Appendix incorporated herein by reference) shall be obtained within two calendar days after hospice care is initiated for the first period of hospice coverage.

i. If the hospice does not obtain written certification within two days after the initiation of hospice care, a

verbal certification may be obtained within these two days and a written certification no later than eight calendar days after care is initiated. If these requirements are not met, no payment can be made for any days prior to the certification.

ii. The signing of the written form shall be done by the hospice Medical Director, or physician of the interdisciplinary team and the attending physician (if the applicant has an attending physician), and shall include the statement that the applicant's medical prognosis is such that the life expectancy is six months or less.

3. If the hospice recipient revokes hospice benefit package and then reenters the hospice in any subsequent period, the hospice shall obtain, no later than seven calendar days after the beginning of that period, a written Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92) prepared by the Medical Director of the hospice or the physician member of the hospice's interdisciplinary group.

4. For subsequent recertifications, a written recertification must be obtained no later than two business days after the period begins (after the first 90–day benefit period, after the next 90–day benefit period, and after the third 30–day period). The Medical Director of the hospice or physician member of the interdisciplinary team shall recertify that the individual is terminally ill and that hospice services are reasonable and necessary for the palliation and management of the terminal illness or related condition, and, in addition, recertify the necessity of the continuing need for hospice services.

5. In addition, the individual's attending physician is required to recertify the terminal illness for the fourth unlimited benefit period, as described below:

i. An additional Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92) must be obtained prior to the fourth unlimited period but no later than two days after the period begins.

6. The hospice must retain the Physician Certification/Recertification for Hospice Benefits Form(s), FD–385 (6/92) on file for review by the Division in the recipient's medical record.

10:53A–2.4 Standards for staffing

(a) The Medical Director of the hospice shall assume overall responsibility for the medical component of the hospice services.

(b) The hospice shall designate an interdisciplinary group or groups composed of, at a minimum, the following individuals who are employees of the hospice and who provide and/or supervise the services offered by the hospice:

1. A physician (doctor of medicine or osteopathy);

2. A registered professional nurse;

3. A medical social worker (see N.J.A.C. 10:53A–3.4 for qualifications); and

4. A pastoral or other counselor.

(c) The interdisciplinary group shall be responsible for the following:

1. Participation in the establishment of the plan of care;

2. Provision or supervision of hospice services in coordination with the recipient's attending physician;

3. Periodic review and updating of the plan of care for each recipient receiving hospice services with the attending physician;

4. Establishment of policies governing the day-to-day provision of hospice services; and

5. In-service education for volunteer staff before he or she begins providing care for a hospice recipient.

(d) A hospice recipient, family members, and/or significant others shall participate in the formulation of the final plan of care.

(e) If the hospice has more than one interdisciplinary group, it shall designate, in advance, the group it chooses to execute the functions described above.

(f) The Medical Director or Director of Nursing of the hospice shall designate a registered professional nurse to coordinate the implementation of the plan of care for each recipient.

(g) Volunteer assistance is an integral part of hospice services. The hospice shall document and maintain a volunteer staff sufficient to provide administrative and patient care in an amount that, at a minimum, equals five percent of the total compensated patient care hours provided by all paid hospice employees and contracted staff regardless of the payment source.

10:53A–2.5 Administrative policy for admission and discharge from room and board services in a nursing facility

(a) If a recipient of hospice services is admitted to a nursing facility (NF) from any location, or is changed from nursing facility status to hospice status (while residing in a nursing facility), or is discharged from the hospice or dies, the NF shall submit to the CWA and the MDO, a completed Notification from Long–Term Care Facility of Admission or Termination of a Medicaid Patient (MCNH–33) (Form # 9 in the Appendix, incorporated herein by reference) to prompt a change in the recipient's status.

(b) If the recipient residing in an NF chooses hospice benefits, the NF shall submit to the fiscal agent, a completed Long Term Care Turnaround Document (TAD)(MCNH–117) (Form # 11 in the Appendix herein incorporated by reference) to remove the patient from the Long Term Care Facility billing system. The following information shall be placed on the MCNH–117 in the REMARKS column (Field # 38 on the bottom):

"DISCHARGED FROM NURSING FACILITY TO HOSPICE"

1. The hospice recipient is removed from the Long Term Care Facility billing system effective on the date the Election of Hospice Benefits Statement, FD–378 (6/92) (Appendix Form # 1) is signed. On that date and thereafter, the Medicaid fiscal agent will directly reimburse the hospice for services rendered to the hospice recipient and the NF will no longer be reimbursed for care beginning this date. The hospice shall be responsible for reimbursing the NF for room and board services provided under contract with the hospice.

2. If the recipient revokes hospice and returns to NF care, the NF shall complete and submit the Long Term Care Turnaround Document (TAD)(MCNH–117) form to the fiscal agent. The following information shall be placed on the MCNH–117 in the REMARKS column (Field # 38 on the bottom):

"ADMITTED TO NURSING FACILITY AND DISCHARGED FROM HOSPICE"

3. The effective date of the change from hospice care to NF care is the date the Revocation of Hospice Benefits, FD–381 (6/92) (Form # 4 in the Appendix incorporated herein by reference) is signed. The NF will be reimbursed for care provided on this date and thereafter, and the hospice will no longer be reimbursed for care beginning on this date.

10:53A–2.6 Recordkeeping

(a) The medical record of the hospice recipient maintained by the hospice shall be complete and accurate and reflect the services provided. The medical record shall include, at a minimum, the following information:

1. Identification information;
2. Certification/recertification documents;
3. Informed consent documents;
4. Election forms;
5. Hospice eligibility forms;
6. Pertinent medical history and physical examination data;
7. Test results;
8. Initial and subsequent assessments;
9. Plan of care and updates; and
10. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

(b) All medical records shall be signed and dated by the professional staff person providing the service.

(c) The medical record shall be maintained and made available, as necessary, to the Division of Medical Assistance and Health Services or its agent for audit and review purposes in accordance with State law (see N.J.S.A. 30:4D–12 and (N.J.A.C. 10:49–13.1).

10:53A–2.7 Monitoring

(a) On a random selection basis, the Division shall conduct post-payment quality assurance reviews based on Surveillance and Utilization Review System (SURS) reports and other sources to assure compliance with program, personnel, recordkeeping and service delivery requirements. Provisions shall be made to recover funds, when reviews by the Division reveal that overpayments to the hospice have been made. At the specific request of the Division, the hospice shall submit a plan of care and other documentation for those Medicaid recipients selected for a quality assurance review.

1. The review shall involve contact with the hospice and the recipient and will focus on the following areas:

i. Number of recipients;

ii. Cost per recipient including the "cap" requirements;

iii. Number of days of service per recipient and the quality of services;

iv. Comparative analysis between claim payments and the plan of care; and

v. Completion of forms necessary for eligibility for hospice services.

(b) On-site monitoring visits shall be made by the Division staff for the purpose of determining compliance with the provisions of the Medicaid hospice rules and for quality assurance purposes. The results of the on-site monitoring shall be reported to the hospice with a copy for the Division. When indicated, a plan of correction will be required. Continued non-compliance with requirements may result in such sanctions as: the curtailment of accepting new recipients for services; termination of the hospice's provider contract; and/or the suspension, debarment or disqualification of the hospice or hospice-related parties from participation in the Medicaid program.

10:53A–2.8 Provision for provider fair hearings

Pursuant to the N.J.A.C. 10:49–10, Notices, Appeals and Fair Hearings, providers with the New Jersey Medicaid program have the right to file for fair hearings.

10:53A–2.9 Advance directives

(a) All hospices participating in the New Jersey Medicaid program are required to comply with the provisions of the Federal Patient Self Determination Act (P.L. 101–108) and must notify Medicaid hospice recipients about their rights under State law to make decisions concerning their medical care and their right to formulate an advance directive.

1. All hospice providers are required by Federal law to:

i. Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the hospice agency about their rights under State law to make decisions concerning their medical care and the right to formulate an advance directive;

ii. Provide the New Jersey State Department of Health statement of New Jersey law (Your Right to Make Health Care Decisions in New Jersey) to recipients upon initial receipt of hospice care, regarding their rights to make decisions concerning their medical care. This includes the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive for their health care;

iii. Provide written information to recipients, upon initial receipt of hospice care, concerning the hospice agency's written policies on the implementation of such rights;

iv. Document in the recipient's medical record whether or not the recipient has executed an advance directive;

v. Not condition the provision of care or otherwise discriminate against a recipient based on whether or not the recipient has executed an advance directive;

vi. Ensure compliance with requirements of State law respecting advance directives; and

vii. Provide education for staff and the community on issues concerning advance directives.

2. The provisions in (b)1 above do not prohibit the application of a State law which allows a hospice to refuse to implement an advance directive based on conscientious objection. The New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, does allow private religious affiliated health care institutions to develop institutional policies and practices defining circumstances in which they will decline to participate in the withholding or withdrawing of specific measures to sustain life. Such policies and practices are to be included in the hospice's written policies.

SUBCHAPTER 3. RECIPIENT REQUIREMENTS

10:53A–3.1 Eligibility for covered hospice services

(a) For the purposes of this subchapter only, the term "applicant" refers to an individual applying for hospice eligibility who may or may not be Medicaid eligible at the time of application.

(b) In order to receive hospice services, an individual must be eligible for Medicaid either in the community or in an institution. Additionally, an individual is eligible for hospice services in the community if he or she would be eligible for Medicaid if he or she were institutionalized. Eligibility rules are found at N.J.A.C. 10:71. Parental and spousal deeming of income do not apply. Persons eligible only for the Medically Needy component of the New Jersey Medicaid program are not eligible for hospice services.

1. The transfer of resource provisions of N.J.A.C. 10:71–4.7 apply to persons seeking hospice services while residing in a nursing facility as well as to persons seeking eligibility for hospice services in the community but whose income disqualifies them from New Jersey Care ... Special Medicaid Programs.

2. Persons not already eligible for Medicaid but who express interest in hospice services should be referred to the county welfare agency for a determination of eligibility. Persons already residing in a nursing facility should be referred to a county welfare agency of the county in which the facility is located. Persons in the community or waiting for placement in a nursing home should be referred to the county welfare agency in their county of residence.

3. When providing services to members of the Garden State Health Plan (GSHP), an authorization number shall be obtained from the applicant's GSHP physician case manager prior to providing hospice services. Hospice agencies shall use this authorization number when billing for services provided to a GSHP member.

(c) In addition to financial eligibility, the individual applying for Medicaid hospice eligibility shall meet the following conditions:

1. He or she shall voluntarily elect the hospice services (see N.J.A.C. 10:53A–3.2);

2. If eligible for Medicare, he or she shall assign his or her Medicare Part A benefits for hospice care. For dually eligible Medicare and Medicaid hospice recipients, the hospice benefits election applies simultaneously under both the Medicare and Medicaid programs;

3. He or she shall be certified or recertified as terminally ill by the attending physician (see N.J.A.C. 10:53A–2.3) and be certified by the attending physician that hospice services are reasonable and necessary for the palliation or management of the terminal illness or related conditions by the completion of the Physician Certification/Recertification for Hospice Benefits Form FD–385 (6/92). A copy of this form shall be part of the medical record at the hospice agency;

4. He or she shall have a plan of care for hospice services established prior to and consistent with the provision of hospice services. (For information on the plan of care, see N.J.A.C. 10:53A–3.6); and

5. He or she shall waive all rights to the following:

i. Those hospice services provided by a hospice other than the one designated by the recipient (unless provided under written arrangements made by the designated hospice); and

ii. Any Medicaid services that are related to the treatment of the terminal condition for which hospice services were elected, or for a related condition, or for services equivalent to hospice care, except for the following services:

(1) Those provided (either directly or under arrangement) by the designated hospice; and

(2) Those provided by the recipient's physician or consulting physician in treatment of the terminal condition, if that physician is not an employee of the designated hospice receiving compensation from the hospice for those services.

(d) Applicants in the following categories may be eligible for hospice if the applicant meets the criteria listed in (b) and (c) above.

1. The aged;

2. The blind;

3. The disabled;

4. Children under 21 years of age including those under the supervision of the Division of Youth and Family Services (DYFS);

5. Caretaker relatives who have dependent children in their care; or

6. Pregnant women (up to 60 days postpartum).

10:53A–3.2 Application policy for medical and financial eligibility for hospice services

(a) The application policy for completion of the medical criteria for receiving hospice services is as follows:

1. Individuals requesting or initiating hospice eligibility should be referred to a Medicaid approved hospice to complete the hospice medical eligibility requirements for hospice services through the completion of the Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92) and the Election of Hospice Benefits Statement, FD–378 (6/92).

2. The hospice shall notify the agency (that is, the county welfare agency (CWA), the Division of Youth and Family Services (DYFS), or the Medicaid District Office (MDO) (for SSI recipients), as applicable), responsible for maintaining the hospice "indicator" (Special Program Number 15) of the completion of the medical eligibility requirements in (a)1 above. The notification must be done through the use of the Hospice Eligibility Form, FD–383 (6/92). The form shall also be sent to the address listed below to indicate to the Division of the completion and/or change in the medical eligibility:

Hospice Program
Division of Medical Assistance and Health Services
CN–712
Trenton, New Jersey 08625–0712

i. The date of the signing of the Election of Hospice Benefits Statement, FD–378 (6/92) determines the date of eligibility for hospice services if the applicant is eligible for Medicaid.

3. For those cases in which the disability determination for Medicaid eligibility is within the jurisdiction of the Disability Review Section, Division of Medical Assistance and Health Services, the determination of disability for the first six months of hospice services will be based solely on a physician's certification of terminal illness. (See also N.J.A.C. 10:71–3.11 through 3.13).

i. To ensure the continuity of hospice services after six months, the agency responsible for the eligibility determination (that is, the county welfare agencies (CWA's)), shall inform the Disability Review Section of the recipient's eligibility for hospice services based upon the physician's certification of terminal illness and the determination of financial eligibility.

ii. After the initial six-month period, if it appears that such a recipient will require and elects to continue to receive hospice services, the Disability Review Section of the Division shall require medical documentation to validate the disability status based on terminal illness as part of the medical recertification. This documentation is in addition to the Physician's Certification/Recertification for Hospice Benefits Form (FD–385) required under N.J.A.C. 10:53A–2.3.

(1) The required additional documentation consists of the following:

(A) A statement from the attending physician of the diagnosis(es), prognosis and the stage of illness;

(B) Copies of laboratory test results, biopsy and/or pathology reports, Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CAT) results; and

(C) Copies of any other objective medical documentation which supports the diagnosis(es).

(2) Individuals who are over 65 years of age, or receiving Medicare, or receiving Social Security Disability Insurance Benefits under Title II or Supplemental Security Income (SSI) under Title XVI, or who are on Aid to Families with Dependent Children (AFDC) are not required to be evaluated by the Medicaid Disability Review Section.

(3) The Disability Review Section will identify and track individuals who are required to be evaluated for continuing disability and will contact the provider to initiate the enhanced recertification process.

(b) The application policy for financial eligibility is as follows:

1. After medical eligibility has been determined, all applicants (whether previously eligible for Medicaid or not) should be referred to the CWA, DYFS or the MDO, as applicable, for hospice financial eligibility processing. If the applicant's Medicaid eligibility status has not been established, is not known, or is uncertain, the hospice agency shall contact the MDO to determine where to refer the potential applicant.

2. For the recipient who had been eligible for regular Medicaid benefits (such as through AFDC, Medicaid Only or New Jersey Care ... Special Medicaid Programs), the CWA is responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD–383) (6/92).

3. Exceptions: The instructions in (b)1 and 2 above do not apply if the applicant is eligible through DYFS or SSI. For instructions for those eligible through DYFS or SSI, see (b)4 or 5 below, respectively.

4. If the applicant for hospice services is under the supervision of DYFS, DYFS shall be responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of the Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD–383) (6/92).

5. If the applicant for Medicaid hospice services is SSI eligible, the MDO is responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of the Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD–383) (6/92). (See N.J.A.C. 10:49, Administration, (Appendix Form # 17), for the list of Medicaid District Offices.)

6. The medical eligibility materials (copies of the Physician Certification/Recertification for Hospice Benefits, FD–385 (6/92) form and the Election of Hospice Benefits Statement, FD–378, (6/92)) shall be forwarded by the hospice to the MDO, CWA or DYFS, as applicable.

7. All other applicants for room and board services, including those who would lose SSI because of monthly income shall be referred to the CWA. For individuals determined eligible, see (b)2 above for processing responsibilities.

(c) Rules for retroactive Medicaid eligibility in N.J.A.C. 10:49, Administration, apply to those recipients eligible for Medicaid, prior to their Medicaid application for hospice. In addition, the following retroactive eligibility rule applies:

1. No retroactive eligibility payment will be authorized for hospice services prior to the date the Election of Hospice Benefits Statement, FD–378 (6/92) is signed. Retroactive eligibility for hospice services may be established for up to three months prior to Medicaid eligibility provided the Election of Hospice Benefits Statement, FD–378 (6/92) had been signed. Such cases must be referred to the following address for determination of retroactive eligibility:

Retroactive Eligibility Unit

Division of Medical Assistance and Health Services

CN–712

Trenton, New Jersey 08625–0712

2. For an applicant who becomes initially eligible for Medicaid, solely because of his or her hospice status, Medicaid eligibility begins with the date the Election of Hospice Benefits Statement, FD–378 (6/92) was signed by the applicant, or his or her representative. In these cases, retroactive eligibility is not available prior to the date on the Election of Hospice Benefits Statement, FD–378 (6/92).

(d) The hospice shall notify the agency determining eligibility (MDO, CWA or DYFS) through a copy of the Hospice Eligibility Form, FD–383 (6/92) of a change in the recipient's status which could affect the eligibility for Medicaid and/or for hospice services, a change in the hospice provider status, or a change in a recipient's address.

(e) A limited access Medicaid Eligibility Identification Card (MEI) with the statement "Except for hospice and physician services, CHECK WITH HOSPICE PROVIDER for other services" shall be issued to a Medicaid recipient who is eligible for hospice services. The hospice shall provide the name and telephone number of the contact person within the hospice so that other providers may obtain approval from the hospice for other than hospice and physician services.

1. When the hospice applicant is also a Garden State Health Plan member, the following process shall be followed by the hospice:

i. A member of the Garden State Health Plan has a message on his or her Medicaid Eligibility Identification Card (MEI) which states, "HMO–Check GSHP ID Card". Each member of the GSHP will also have a gold-colored GSHP–ID card which lists the name and telephone number of the member's physician case manager. The hospice provider shall obtain from the member of the Garden State Health Plan who requests hospice services, a Garden State Health Plan Authorization Form (GSHP–7) (9/91) which is completed by the member's physician case manager and specifically authorizes hospice services.

ii. The hospice provider shall use the authorization number which is imprinted on the top right hand corner of the GSHP–7 form when billing for services provided to a member of the GSHP.

Amended by R.1994 d.508, effective October 17, 1994.
See: 26 N.J.R. 1283(a), 26 N.J.R. 4185(a).

10:53A–3.3 Benefit periods

(a) There are two 90–day benefit periods, one 30–day period, and a fourth unlimited period. The two 90–day periods must be used before the 30–day period and all three periods must be used before the fourth unlimited benefit period. The benefit periods shall be recorded on a Hospice Benefits Statement, FD–379 (6/92) Form # 2 in the (Appendix, incorporated herein by reference) and filed in the recipient's medical record.

(b) Contents of the Election of Hospice Benefits Statement, FD–378 (6/92) (Appendix Form # 1) shall include the following:

1. The identification of the particular hospice that will provide the care to the applicant;

2. The applicant's or his or her representative's acknowledgment, that he or she has been given a full understanding of hospice services;

3. The applicant's or his or her representative's acknowledgment that he or she understands that the regular Medicaid services other than hospice services are waived by the signing of the Election of Hospice Benefits Statement, FD–378 (6/92) and/or the Representative Statement for the Election of Hospice Benefits, FD–380 (Form # 3 in the Appendix, incorporated herein by reference), unless the services are prior authorized;

4. The effective date of the election statement; and

5. The signature of the applicant or the applicant's representative.

(c) The hospice applicant is eligible for three benefit periods of hospice services (90 days, 90 days, and 30 days, totaling 210 days) and a fourth unlimited benefit period with the approval of the hospice provider, if the applicant or his or her representative files an Election of Hospice Benefits Statement, FD–378 (6/92) with a particular hospice.

1. A hospice recipient shall designate an effective date for the beginning of hospice services which shall not be earlier than the date the election is made.

(d) Revocation of election of hospice services shall be as follows:

1. The recipient may choose at any time to institute a "break" (a time period when care other than hospice care is given) between benefit periods or by a revocation of hospice services.

2. The Election of Hospice Benefits Statement, FD–378 (6/92) shall be considered to be valid through subsequent benefit periods if there is no "break" in care.

3. A new Election of Hospice Benefits Statement, FD–378 (6/92) is required to be filed following a break or revocation of hospice service.

i. The recipient or his or her representative shall file a signed statement with the hospice provider that indicates the recipient revokes the election for Medicaid coverage of hospice services for the remainder of the election period with the date that the revocation is to be effective.

ii. When revoked, the recipient forfeits hospice services for any remaining days in the benefit period. A recipient may not receive hospice services later than the effective date that the revocation is signed.

iii. The hospice shall immediately notify the agency that determined hospice eligibility (either CWA, DYFS or the MDO) of the revocation of hospice, verbally if possible, and also by filling out and submitting the Hospice Eligibility Form, FD–383 (6/92) to the eligibility source (CWA, MDO or DYFS, as applicable) so that the recipient's hospice eligibility may be terminated. The hospice shall also fill out the Termination of Hospice Benefits, FD–382 (6/92) (Form # 5 in the Appendix, incorporated herein by reference) and retain this form in the recipient's medical record.

(e) Entitlement to all other Medicaid services may be restored if the recipient continues to be Medicaid eligible, under the following circumstances:

1. When the 210 days of hospice entitlement has expired, and the recipient does not choose the fourth unlimited benefit period; or

2. When the recipient revokes hospice services.

(f) When a hospice recipient residing in a nursing facility revokes the hospice benefits and returns to the status of a patient of the NF, the hospice shall proceed as follows:

1. The Hospice Eligibility Form, FD–383 (6/92) shall be completed and submitted to the MDO after the recipient has signed the Revocation of Hospice Benefits, FD–381 (6/92) form indicating he or she has revoked the Medicaid hospice benefit.

2. The nursing facility shall conform to the nursing facility rules in the Long Term Care Facilities Services Manual, N.J.A.C. 10:63 for admission and placement for this recipient similar to any admission to the NF.

i. Upon discharge from the hospice, the recipient, upon admission or readmission to the NF, is counted in the "occupancy rate" by the NF. The recipient is not counted as part of the NF census or "occupancy rate" if he or she is a hospice patient residing in the NF.

10:53A–3.4 Covered hospice services

(a) The amount, character, and scope of New Jersey Medicaid hospice services shall be the same for all hospice recipients and shall not be less than the hospice services provided under Medicare (Title XVIII) (Section 1861(dd) et seq. of the Social Security Act, codified as 42 U.S.C. Section 1395x(dd)1).

(b) The Division reimburses for covered hospice services that are reasonable and necessary for the palliation and management of the terminal illness, and which are provided to a hospice recipient consistent with the recipient's individualized plan of care.

1. Required hospice services which shall be available to the hospice recipient include nursing care, medical social services, supervisory physician services, counseling services, durable medical equipment and supplies including drugs and biologicals, homemaker/home health aide services, physical therapy, occupational therapy and speech-language pathology services.

i. The following services are considered "core" hospice services: nursing care, medical social services, physician services and counseling services.

(1) A hospice provider shall ensure that substantially all core services are routinely provided directly by hospice employees.

(2) A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of hospice recipients during periods of peak patient loads or under extraordinary circumstances or to obtain physician specialty services.

(3) If contracted staff is used, the hospice shall maintain professional, financial and administrative responsibility for the services and shall assure the qualifications of the staff and that services meet all requirements under each level of care.

(c) Covered hospice services are reimbursed at predetermined, prospective, inclusive rates corresponding to one of four levels of care. Two of the levels of care are reimbursed for services provided in the home: Routine Home Care and Continuous Home Care; and two levels of care are reimbursed for services provided on an inpatient basis: Inpatient Respite Care and General Inpatient Care in either a hospital or nursing facility (see also, N.J.A.C. 10:53A–4.1). The provisions at (c)1 through 4 below apply to the levels of care provided by the hospice.

1. The routine home care rate is reimbursed if less skill than professional registered nursing, or licensed practical nursing, or less intensity than continuous home care is needed to enable the person to remain at home.

i. The routine home care rate includes the following services: routine nursing services, social work, counseling services, durable medical equipment, supplies, drugs, home health aide/homemakers, physical therapy, occupational therapy, and speech-language pathology services. The routine home care rate includes respite care delivered in the home that is not predominately nursing care.

ii. The routine home care rate is reimbursed when the recipient is not receiving continuous home care, regardless of the volume and intensity of routine home care services.

2. The continuous home care rate is reimbursed only during a period of medical crisis to maintain the recipient at home where most of care is skilled nursing care on a continuous basis to achieve palliation or management of the recipient's acute medical symptoms and only as necessary to maintain the recipient at home.

i. A minimum of eight hours of nursing care must be provided during a 24–hour day which begins and ends at midnight before the Continuous Home Care rate can be paid. The nursing care need not be sequential, that is, four hours may be provided in the morning and four hours in the evening of the same day.

ii. The nursing care must be provided either by a registered professional nurse, or a licensed practical nurse under the supervision of a registered professional nurse. More than half (four hours or more) of the period of care must be nursing care provided by licensed nurses.

iii. The Continuous Home Care rate includes homemaker/home health aide services which may be provided to supplement the nursing care, but not to substitute for the minimal amount of nursing care provided by the licensed nurses.

3. Inpatient respite care is short-term, occasional, inpatient care provided to the recipient in a hospital or nursing facility only when necessary to relieve the family members or other persons caring for the recipient at home.

i. The inpatient respite care rate is not reimbursed for more than five consecutive days.

ii. Inpatient respite care is provided by a hospice to a Medicaid hospice recipient in either a hospital or a nursing facility. The inpatient respite care rate or the payment of room and board services under hospice is not provided when a recipient is considered a nursing facility patient and not a hospice patient.

4. The general inpatient care rate is reimbursed when provided in a hospital or nursing facility during periods of acute medical crisis, for palliative care, for pain control, or management of acute and severe clinical problems which cannot be managed in another setting.

5. Concerning the limitation on the aggregate payments to hospice providers for inpatient respite care and general inpatient care, see N.J.A.C. 10:53A–4.3.

(d) Specific services provided by a hospice within each level of care related to the terminal illness and paid under the per diem rate schedule, are listed as follows:

1. Nursing care provided by or under the supervision of a registered professional nurse;

2. Physical therapy, occupational therapy, and speech-language pathology provided by a qualified therapist for the purpose of symptom control or to enable the recipient to maintain activities of daily living and basic functional skills;

3. Medical social services provided by a social worker who has at least a bachelor's degree in social work from a school accredited or approved by the Council of Social Work Education, and who is working under the direction of a physician and with the interdisciplinary team;

4. Homemaker/Home Health aide services shall be provided by a homemaker/home health aide who has been certified as having successfully completed a training program approved by the New Jersey State Board of Nursing, Department of Law and Safety. Home health aides shall provide those personal care services as described in the Home Care Services Manual, (N.J.A.C. 10:60), N.J.A.C. 10:60–2.2(c) under the supervision of a registered professional nurse;

i. Homemaker/Home Health aide services may be provided on a 24–hour, continuous basis but only during periods of a recipient's crisis, not a family crisis, and only as necessary to maintain the terminally ill recipient at home;

ii. A registered professional nurse shall visit the home of the hospice recipient at least every two weeks when homemaker/home health aide services are provided for the purpose of assessing the homemaker/home health aide services and provide education and supervision to the aide, as needed;

5. Durable medical equipment and supplies included in the plan of care, as well as self-help and personal comfort items which are reasonable and necessary for palliation and management of the recipient's terminal illness;

6. Drugs and biologicals included in the plan of care primarily for the relief of pain and symptom control for a recipient's terminal illness; and

7. Counseling, provided with respect to care of the terminally ill recipient, for family members or other persons caring for the recipient at home and provided by members of the interdisciplinary group, as well as by other qualified professionals as determined by the hospice provider.

i. Counseling, including dietary counseling, shall be provided both for the purpose of training the recipient's family or other caregiver to provide care, and for the purpose of helping the recipient and those caring for him or her to adjust to the nature of the recipient's illness.

ii. Bereavement counseling consists of counseling services provided to the recipient's family after the recipient's death under the supervision of a qualified professional. Bereavement counseling is a required inclusive component of hospice service and is not separately reimbursed by Medicaid.

(1) The plan of care shall clearly delineate the type of counseling services to be provided and the frequency of the delivery of the service which shall be offered up to one year following the death of the recipient.

iii. Dietary counseling, when necessary, provided by a qualified professional dietician or dietary consultant.

iv. Spiritual counseling including notice to the recipient as to the availability of appropriate clergy.

(e) Room and board services identical to those provided to non-hospice Medicaid recipients shall be provided for hospice recipients residing in a nursing facility. The recipient eligible for hospice services who is residing in a Medicaid approved nursing facility is considered a hospice recipient, not a patient of a nursing facility.

1. Room and board services include the performance of personal care services, assistance in activities of daily living, provision of patient social activities, the administration of medications, the maintenance of the cleanliness of a resident's room, and supervision and assistance in the use of durable equipment and prescribed therapies.

2. The Pre-admission Screening (PAS) rules do not apply to a hospice patient admitted directly to a nursing facility or changed from nursing facility care to hospice care. This individual would be considered a hospice patient, not an NF patient. If the hospice patient revokes the hospice benefit and returns to that NF's care or the care of another NF, the PAS rules apply which are in the Long Term Care Services Manual, N.J.A.C. 10:63 (see N.J.S.A. 30:4D–17.10).

(f) Physician services for administration, interdisciplinary group activities, and general supervisory activities of the medical director, his or her designated representative, or other physician employees of the hospice provider, or those working under arrangements with the hospice, are consid-

ered "core services" and are included in the hospice per diem rate. These services shall not be billed separately to the fiscal agent.

1. The cost of physician services for direct personal care shall be covered as a separate service only for physician employees of the hospice who do not volunteer for these services. In such instances, the physician may receive separate reimbursement above the hospice per diem rate when physician services are billed by this employee. The hospice shall not bill on behalf of the physician for these direct personal care services. For the procedures for the reimbursement of these services, see N.J.A.C. 10:53A–4.2.

(g) Regarding other covered services, some Medicaid services which are not duplicative of hospice services may be covered by Medicaid for the hospice recipient. These services include optometric and optical services, prosthetic and orthotic services, medical day care services, and personal care assistant services. These services must be approved by the interdisciplinary team, be consistent with the plan of care and be determined to be medically necessary.

1. The personal care assistant (PCA) services shall be provided to hospice recipients by Medicaid approved PCA providers. (See Home Care Services chapter, N.J.A.C. 10:60–1.7, 1.8 and 1.9.) Personal care assistant services shall be included in the plan of care, and must not be duplicate services covered and reimbursed under the hospice per diem.

2. Personal care assistant services for hospice recipients shall be used only to replace the live-in primary adult caregiver as defined in N.J.A.C. 10:60–1.2, and provided under the limitations of N.J.A.C. 10:60–1.9.

Amended by R.1994 d.508, effective October 17, 1994.
See: 26 N.J.R. 1283(a), 26 N.J.R. 4185(a).

10:53A–3.5 Services unrelated to the terminal illness

(a) The hospice recipient, by signing the Election of Hospice Benefits Statement, FD–378 (6/92) agrees to waive most regular Medicaid services. However, Medicaid covered services unrelated to the terminal illness, included in the plan of care, may be provided by approved Medicaid providers upon approval of the interdisciplinary team of the hospice.

1. The reasons for providing unrelated services and the verification that the unrelated services are not, in any way, related to the terminal illness shall be documented in the plan of care by a member of the interdisciplinary team.

i. Documentation shall clearly specify those services that are related to and those services that are unrelated to the terminal illness.

ii. Services unrelated to the terminal illness are subject to the same coverage provisions, limitations, prior authorization requirements, and conditions applied to services available to other general non-hospice Medicaid recipients.

iii. All payments for services (except for physician's services) that are unrelated to the terminal illness may be denied if not approved by the interdisciplinary team, documented in the plan of care and on file in the patient's medical record.

(b) The fourth unlimited benefit period beyond 210 days of hospice care must also be approved by the interdisciplinary team of the hospice as an integral part of the plan of care.

1. If a fourth unlimited period of hospice services is anticipated, the hospice shall document in the recipient's medical record, the approval of this period by the interdisciplinary team at the beginning of the third benefit period. Approval by the interdisciplinary team prior to the delivery of hospice services is required for payment for services.

2. A new Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92) is required for the approval by the interdisciplinary team for the fourth unlimited benefit period.

(c) The documentation of the approval of unrelated services and the fourth benefit period shall be filed in the recipient's medical record with the copy of the claim form and be made available upon request for post-payment review purposes.

10:53A–3.6 Plan of care

(a) Requirements for the initial plan of care for recipients of hospice services are listed below:

1. At least one of the persons involved in developing the initial plan of care shall be a registered professional nurse or physician.

2. In establishing the initial plan of care, the member of the basic interdisciplinary group (a physician, a registered professional nurse, a medical social worker, or a counselor) who assesses the recipient's needs shall contact at least one other group member before writing the initial plan of care.

3. The initial plan of care shall be established on the same day as the assessment if the day of assessment is to be considered a covered day for hospice services.

4. At a minimum, the other two members of the basic interdisciplinary group shall review the initial plan of care and provide their input to the plan of care within two calendar days of the day of assessment.

5. The initial plan of care shall be approved by the Medical Director of the hospice by his or her signature on the plan of care in the medical record, thereby assuming professional medical responsibility for the hospice care.

(b) Requirements for the continuing plan of care for recipients of hospice services are listed below:

1. All services provided to each hospice recipient must be approved by the interdisciplinary team of the hospice as an integral part of the plan of care. The medical necessity for emergent/urgent services shall be justified by the attending physician and documented in the plan of care in the medical record.

2. The plan of care shall be signed by the attending physician, the Medical Director or his or her physician designee and the interdisciplinary group prior to the complete implementation of the plan of care, thereby assuming the professional medical responsibility for the hospice care.

3. The plan of care shall be reviewed and updated in a timely manner as specified by the plan of care, but at least once a month, by the attending physician, the Medical Director or physician designee, and the interdisciplinary team. These reviews shall be documented in the hospice recipient's medical record.

4. The plan shall include the assessment of the recipient's needs and identification of the services, including the management of discomfort and symptom relief. The scope and frequency of hospice services and other services needed to meet the needs of the hospice recipient and the family shall be stated in detail in the plan of care and appropriately documented in the medical record.

10:53A–3.7 Provision for recipient fair hearings

Pursuant to N.J.A.C. 10:49–10 (Notices, Appeals and Fair Hearings), Medicaid recipients have the right to file for fair hearings.

SUBCHAPTER 4. BASIS OF PAYMENT

10:53A–4.1 Post-eligibility treatment of income

(a) For a hospice recipient residing at home, who is eligible only for hospice services, the policy for handling the post-eligibility treatment of income is the same as that of the Division's home and community-based waivers, for example, CCPED. For these recipients, there is no available income to be applied to the cost of care because the maintenance standard in the home and community-based waiver programs has been determined to be equal to the income eligibility standard for Title XIX approved facilities (see N.J.A.C. 10:71–5).

(b) For a recipient who is residing in a nursing facility and receiving hospice under Medicaid, payment to the hospice for room and board services shall be reduced by the recipient's available income. Available income is that amount which remains after deducting certain amounts from the recipient's gross income, as determined in accordance with the N.J.A.C. 10:71.

1. Instructions for the use of the "Statement of Available Income for Medicaid Payment (PA–3L)" form, incorporated herein by reference as Form # 10 in the Appendix, are as follows:

i. The hospice is responsible for ensuring that the amount of the recipient's available income is reported and that the amount corresponds to that attributed to the recipient's account on the Statement of Available Income for Medicaid Payment (PA–3L). The available income must be deducted by the hospice from the amount billed the fiscal agent. The hospice shall be liable to the Division for any available income not reported to the fiscal agent by the hospice.

ii. The Statement of Available Income for Medicaid Payment (PA–3L) is completed by the CWA on each non-SSI Medicaid recipient that receives hospice services in the community, the NF or the hospital.

(1) The PA–3L form reflects the recipient's available income that remains after deducting certain amounts for the maintenance of a community spouse, the maintenance of other dependent relatives, health insurance premiums, and the personal needs allowance (PNA). A PA–3L form must be attached to a copy of the 1500 N.J., Health Insurance Claim Form and be kept in the recipient's billing record when requesting payment from Medicaid for the cost of hospice care, as specified in (b)1ii(2) through (5) below.

(2) The hospice is responsible for maintaining a personal needs allowance (PNA) account and making these monies available for use by the recipient.

(3) It is the responsibility of the hospice to deduct the applicable amount of the available income (which corresponds to that attributed to the recipient on the PA–3L form) from the total per diem charges for the payment of room and board services on the 1500 N.J. claim form.

(4) The PA–3L form shall be obtained by the hospice from the NF for each recipient of hospice services who has been on the Long Term Care Facility billing system. The hospice shall negotiate the change in the collection of this income with the nursing facility, if applicable, or collect it from the recipient and/or family.

(5) For the hospice applicant who has not previously been on the Long Term Care Facility billing system as an NF patient, the CWA shall generate the PA–3L form for the use of the hospice.

(6) For individuals with no income, or income below $60.00 per month, who continue to qualify for Supplemental Security Income (SSI) payments and Medicaid, no PA–3L form is required upon admission to hospice care status.

(A) For these hospice recipients, confirmation of the SSI status should be obtained from the MDO and documented in the hospice billing record.

(B) When submitting the 1500 N.J. claim form, the hospice shall note in the recipient's billing record and state in the "REMARKS" area of the claim form, the wording "SSI Eligible".

(c) Regarding adjustments to the PA–3L, the CWA is required to report all changes of income on an amended PA–3L form to the hospice.

1. When special exceptions apply (for example, in the month of admission, for verified living expenses, and for the first two months of Medicare premium deductions), the PA–3L form will reflect those changes for the applicable month(s).

2. The recipient and/or the family are required to report all changes of available income to the CWA. Additionally, the hospice should report any changes in financial circumstances to the CWA. For those changes which impact on available income, a new PA–3L form must be generated by the CWA, indicating the month for which the change is effective.

3. When an amended PA–3L form affects the periods of service that have already been billed by the hospice, a "RETROACTIVE ADJUSTMENT" shall be submitted to the fiscal agent. The reason for the adjustment shall be recorded in the "REMARKS" area of the 1500 N.J. claim form and also in the recipient's billing record at the hospice.

4. On post-payment quality assurance review, the hospice is liable to the Division for any of the recipient's available income not deducted appropriately from the claim forms.

(d) The instructions for when to apply the available income are as follows: For any full or part of a calendar month in hospice care status, all available income shown on the PA–3L form shall be applied to the cost of the care and subtracted from the per diem charge on the 1500 N.J. claim form, except as indicated in (d)1 through 4 below.

1. The instructions in this paragraph apply on admission from a nursing facility. For the recipient who is admitted to hospice care status from an NF during a given calendar month, the available income may have already been utilized by the NF to offset the cost of care in the same month of admission to hospice care status. Thus, no income is applicable to the hospice for the first calendar month. This applies only if it is a partial calendar month of hospice room and board services. No new PA–3L form is generated by the CWA but a copy of the PA–3L form must be obtained from the NF and kept in the patient's record. The hospice must certify to this fact in the recipient's billing record and in the "REMARKS" area of the claim form with the following statement:

"INCOME APPLIED TO THE NF COST OF CARE FOR (ADD THE MONTH AND YEAR TO WHICH THE COST IS APPLIED)"

2. The instructions in this paragraph apply on admission from the community. For a hospice recipient admitted from the community, an exemption for verified living expenses is permitted in computing available income. An amended PA–3L form shall be generated from the CWA indicating the adjusted amount to be deducted from the hospice per diem charge for that month. Under no circumstances must the requested exemption exceed the verified living expenses. (This deduction is not applicable for hospice recipients who are returning to hospice care from the hospital.)

3. In reviewing the PA–3L form to determine what income should be applied to a billing month, the effective date in each of the numbered columns (PA–3L # 1, # 2, and # 3) shall be carefully checked. This is particularly significant for hospice recipients admitted from the community or the hospital, as income may change within the first three months due to changes in income deductions, specifically Medicare premium payments.

4. The instructions for completing the PA–3L form when the recipient has been discharged or has died, are as follows:

i. For the discharge month or that partial part of the month in the hospice care, the available income amount shown on the PA–3L form shall be applied to the cost of care. If the income exceeds the charge for that month, the balance of income not applied to the cost of care shall be returned to the recipient. Exceptions to this general policy are indicated in (d)4ii through v below.

ii. For the hospice recipient who is discharged to the community, the amount of available income may be reduced by an amount to cover anticipated living expenses. However, this must be reflected on the PA–3L form by the CWA. When the PA–3L form does not reflect the reduction, contact the CWA to effect the change.

iii. For the hospice recipient who dies on the first, second, or third day of the month, and income is not available because the check could not be endorsed and was returned, the 1500 N.J. claim form must be so annotated in the "REMARKS" area stating "Recipient expired on (date)—income not available for use." No further documentation is required.

iv. For the hospice recipient who dies after the third day of the month and the income is not available because the check was returned, the 1500 N.J. claim form should be so annotated and documentation (that is, SSA transmittal receipt) retained in the hospice billing files. The 1500 N.J. claim form must be annotated in the "REMARKS" area—"Check returned—SSA transmittal receipt available—income not available for use."

v. For the hospice recipient who is admitted to nursing facility care (in the same or in a different NF) after being discharged from the hospice, the hospice shall provide information to the NF concerning the amount of available income which was applied to the bill in the discharge month so that the NF may accurately reflect the balance amount for the NF admission month billing. The nursing facility must also complete an MCNH–33 form to notify the CWA and MDO of the discharge of the hospice patient from hospice care and the income applied to the hospice service, so that a new PA–3L form can be issued for the month of admission to the NF.

10:53A–4.2 Basis of payment—hospice providers

(a) The Division reimburses an approved hospice provider for those hospice services related to the terminal illness and included in the recipient's plan of care according to the methodology and indices in section 1814(i)(1)(C) (ii) and 1814(i)(2)(B) of the Social Security Act.

1. One of four predetermined, cost-related prospective payment rates subject to the "cap" amounts (see N.J.A.C. 10:53A–1.1 for definition of "cap") is reimbursed for each day the recipient is receiving hospice services (see N.J.A.C. 10:53A–4.3 for calculations). The rates vary depending on the level of care which is based on the type and intensity of services furnished on that day and are consistent with the plan of care. The levels of care are, as follows:

i. Routine home care;

ii. Continuous home care;

iii. Inpatient respite care; and

iv. General inpatient care.

(b) The rules regarding the reimbursement for each level of care which relate to the per diem rate are described below:

1. The hospice is reimbursed at the routine home care rate for routine nursing services, social work, counseling services, durable medical equipment, medical supplies and equipment, drugs, biologicals, home health aide/homemakers, physical therapy, occupational therapy, and speech-language pathology services. Routine home care is also reimbursed for home care provided continuously that is not predominately nursing care and includes respite care delivered in the home.

i. The routine home care rate is reimbursed when the recipient is not receiving continuous home care, regardless of the volume and intensity of routine home care services.

2. The hospice is reimbursed at the continuous home care rate for services provided in periods of acute medical crisis, where the predominance of care is skilled nursing care on a continuous basis, to achieve palliation or management of the recipient's acute medical symptoms and only as necessary to maintain the recipient at home.

i. At least eight hours of nursing care in a 24–hour period has to be provided before the continuous home care rate may be paid. Continuous home care is reimbursed at the continuous home care daily rate divided by 24 to determine the hourly rate. For every hour of continuous care furnished, the hourly rate is reimbursed up to 24 hours furnished in a day, as applicable.

ii. Up to 24 hours of nursing care in a 24–hour period in the home may be provided primarily by the registered professional nurse, or a licensed practical nurse together with and under the supervision of a registered professional nurse, with the support of the homemaker/home health aide staff.

3. The hospice is reimbursed at the inpatient respite care rate for care provided on an intermittent, non-routine, and/or occasional need basis for each day a hospice eligible recipient is in an approved inpatient facility (nursing facility or general hospital) receiving respite care. The recipient is not in need of general inpatient care.

i. Payment for Inpatient Respite Care is made for a maximum of five consecutive days at a time, including the date of admission but not counting the date of discharge. Payment of the sixth day and any subsequent day is reimbursed at the Routine Home Care rate.

(1) The hospice may be paid the appropriate home care rate (either the routine or continuous home care rate) for the discharge day unless the recipient dies as an inpatient. When the recipient dies as an inpatient, the Inpatient Respite Rate is reimbursed for the day of death.

ii. Payments to a hospice for inpatient respite care are also limited according to the aggregate number of days of inpatient respite care furnished to Medicaid patients per year for that particular hospice. (See N.J.A.C. 10:53A–4.4 for further description relating to the calculation of this limitation.)

iii. The inpatient respite care rate is not reimbursed to the nursing facility for care provided to nursing facility patients that are not Medicaid hospice patients of a Medicaid approved hospice.

4. The general inpatient care rate is reimbursed for services provided in a hospital or nursing facility in periods of acute medical crisis, for hospitalized recipients for palliative care for pain control or management of acute and severe clinical problems which cannot be managed in other settings. For example, reimbursement at the general inpatient care rate is made during situations when the recipient's condition is such that it is no longer possible to

maintain the recipient at home, as determined and specified in the plan of care.

i. None of the other fixed payment rates, such as routine home care, are applicable for the day on which the patient receives hospice general inpatient care, except as stated below for the day of discharge.

(1) For the day of discharge from an inpatient unit, the appropriate home care rate (either the routine or continuous home care rate) is reimbursed unless the recipient dies as an inpatient. In this situation, when the recipient dies, the general inpatient care rate is reimbursed for the day of death.

ii. Payments to a hospice for general inpatient care are limited according to the aggregate number of days of inpatient care furnished to Medicaid patients per year for that particular hospice. (See N.J.A.C. 10:53A–4.4 for information on calculating this limitation.)

(c) In addition to the per diem rates listed in (a) above, the following rates may be reimbursed according to the special circumstances listed below:

1. The room and board rate is reimbursed on a per diem basis for hospice services provided to Medicaid hospice recipients at the specific Medicaid approved NF where the hospice recipient is residing. This rate may be reimbursed to the hospice in addition to the rate for routine home care or continuous home care. (Note: The hospice patient residing in a NF is not a Medicaid recipient of nursing facility care but a hospice recipient.)

i. The room and board rate is calculated at 95 percent of the highest approved Medicaid NF per diem rate (institutionally specific) effective at the time services are provided, and excluding retroactive rate adjustments, retroactive add-ons and special program rates. The rate is adjusted every six months to reflect changes in the nursing facility's case mix. The NF contracts with the hospice to accept the recipient based on actual room and board components provided to the recipient by the NF. The provider number and name of the nursing facility where the recipient resides and with whom the hospice contracts must be placed in the "REMARKS" area of the 1500 N.J. claim form.

(1) The calculated rate used by the hospice as the per diem room and board rate may be obtained from:

Bureau of Institutional and Provider Reimbursement

Division of Medical Assistance and Health Services

CN–712

Trenton, New Jersey 08625–0712

ii. The Division shall continue to pay the hospice the room and board rate for the purpose of retaining the bed for therapeutic leave or during a period of hospitalization, if indicated. The hospice is responsible through its contract with the NF to reimburse the NF to retain the bed.

(1) Nursing facility bed reservation days rate (for therapeutic leave from the NF to home): The hospice is reimbursed the room and board rate for reserving an NF bed for hospice recipients residing in an NF who return to a home setting temporarily for therapeutic leave. The bed reservation days rate (not to exceed 24 days per calendar year) is paid to the hospice provider in addition to the rate of routine home care or continuous home care.

(2) Nursing facility bed reservation days rate is reimbursed during a period of hospitalization (commonly known as "bed hold days"): The hospice is reimbursed the room and board rate for reserving a nursing facility bed for hospice recipients residing in a nursing facility who require inpatient hospitalization. Bed reservation days (not to exceed 10 consecutive days per period of hospitalization) are paid to the hospice in addition to the rate for general inpatient care.

(3) The responsibility for the bed reservation policy, listed in (c)1ii(1) and (2) above, and the submission of claims for these days rests with the hospice.

(d) Payment of the four "level of care" rates will be made to hospice providers at the predetermined minimum prospective Medicaid payment rates revised annually by the Federal Health Care Financing Administration (HCFA) (see N.J.A.C. 10:53A–5 for the references for the methodology). The payment rates will be adjusted by the Division for regional differences in wages, using indices and methodology determined by HCFA.

1. The regional designation of a provider for wage adjustment purposes will be determined by the location of the main business office of the hospice provider.

2. Since the four level of care rates are prospective rates, there shall be no retroactive adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. The rate paid for any particular day may vary depending on the level of care furnished to the recipient. The cap and limitation on payment for inpatient care are described in N.J.A.C. 10:53A–4.4.

(e) No deductible shall be imposed for services furnished by hospices to Medicaid recipients during the period of election, regardless of the setting in which the services are provided.

1. Hospices shall not charge Medicaid recipients directly for Medicare coinsurance amounts.

(f) For recipients at home who are dually eligible for both Medicare and Medicaid, and who are receiving Medicare hospice benefits, the hospice may bill Medicaid Fiscal Agent for the five percent co-payment for outpatient drugs and biologicals on the 1500 N.J. claim form.

1. The co-payment reimbursement shall be a maximum of five percent per prescription cost of each outpatient drug and/or biologicals but shall not exceed $5.00 for each prescription.

2. Copies of the Explanation of Medicare Benefits (EOMB), or other health, or insurance carriers' denial, or Explanation of Benefits (EOB) statements, or other third party liability statements, shall be attached to the copy of the 1500 N.J. claim form filed in the recipient's billing record, as well as an invoice for the outpatient drugs and/or biologicals to which the five percent co-payment is applied for post payment review. The pharmacy attachment or EOMB (EOB, etc.) shall not be attached to the 1500 N.J. claim form submitted to the Fiscal Agent.

(g) For recipients who are dually eligible for Medicare and Medicaid and who are receiving Medicare hospice benefits, the hospice may bill the Medicaid Fiscal Agent for the co-payment for each Inpatient Respite Care day equal to five percent of the payment made for each respite care day by Medicare.

1. Copies of the EOMB, or other health or life insurance carriers' denial, or EOB statements, or other third party liability statements shall be attached to a copy of the 1500 N.J. claim form filed in the recipient's medical record, as well as an invoice for Inpatient Respite Care to which the five percent co-payment is applied. The invoice for Inpatient Respite Care or the EOMB (EOB, etc.) shall not be attached when submitting the 1500 N.J. claim form to the Fiscal Agent.

(h) In addition, for dually eligible Medicare and Medicaid hospice recipients, 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 month's comprehensive hospice benefit and/or room and board charges on each claim form.

(j) The amount of the Medicare co-insurance payment to be reimbursed to the hospice by Medicaid shall be submitted on a separate 1500 N.J. claim form from the other per diem charges.

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 hospice recipients 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 an employee of the hospice agency shall be submitted on the 1500 N.J. by the physician to the Medicaid fiscal agent.

1. Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement.

2. The physician may bill for services which are not provided on a volunteer basis. However, the physician shall treat Medicaid recipients on the same basis as other recipients 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 recipients.

(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 the Physician Services Manual (N.J.A.C. 10:54) separate from the method of calculation of the hospice per diem rates listed in N.J.A.C. 10:53A–4.1.

1. The hospice shall state the name of the physician who has been designated the attending physician (whenever the attending physician is not a hospice employee) in the plan of care and on the Election of Hospice Benefits Statement, FD–378 (6/92); and specify whether the attending physician services are either related or unrelated to the recipient's terminal illness.

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 recipients 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 recipients during that same period.

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

ii. If the total number of days of inpatient care furnished to Medicaid hospice recipients 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 recipients during that same period.

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

(c) The hospice shall report to the Medicaid Hospice Program, the aggregate number of inpatient days (both for inpatient general and inpatient respite care) and the aggregate total number of days of hospice care provided to all Medicaid recipients during the "cap" period. For a hospice enrolling as an approved Medicaid hospice provider during a time other than the first day of the "cap year" for the first time, the "cap" will be applicable for a period of more than 12 months and not more than 23 months.

1. The report shall be sent and received no later than the January 1 following the end of the "cap" period (October 31 of the previous year) to the following address:

Division of Medical Assistance and Health Services
Hospice Program
CN–712
Trenton, New Jersey 08625–0712

SUBCHAPTER 5. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:53A–5.1 Introduction

(a) The New Jersey Medicaid program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS procedure codes as listed in this subchapter are relevant to certain Medicaid 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 the Hospice Services Manual. 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. In addition, 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.

(c) States have the flexibility to establish hospice rates at amounts no lower than Medicare hospice rates based on the same methodology used in setting Medicare rates, and adjusted to disregard offsets attributable to Medicare coinsurance amounts. The New Jersey Medicaid program is setting hospice rates for the four "levels of care" at the prospective predetermined levels which are determined by HCFA.

(d) The rates marked with an asterisk are adjusted for regional differences in wages, using indices based on regions listed in Addendums A and B in the State Medicaid Manual, Transmittal No. 27 (April 1987) (section 4305–4309), in the State Medicaid Manual, Transmittal No. 50 (October 1990) and in Federal statute as referenced in (b) above. These State Medicaid Manuals give specific directions for calculating individual hospice agency rates for the four levels of hospice care (routine, continuous, inpatient respite and general inpatient care) and for the co-payment for inpatient respite care. State Medicaid Manuals may be obtained through the United States Department of Health and Human Services, Health Care Financing Administration.

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 as referenced in N.J.A.C. 10:53A–5.1(b)

*Y6333 ROUTINE HOME CARE RATE

Per diem rate, calculated as referenced in N.J.A.C. 10:53A–5.1(d)

*Y6334 CONTINUOUS HOME CARE RATE

The continuous home care rate is reimbursed at an hourly rate for at least eight hours of nursing care in a 24 hour period calculated as referenced in N.J.A.C. 10:53A–5.1(d).

*Y6335 INPATIENT RESPITE CARE RATE

Inpatient respite care is reimbursed on a per diem basis for not more than five consecutive days (including the day of admission and not the day of discharge) for short-term, occasional inpatient care subject to the limitation of the "cap" according to Federal statute as referenced in N.J.A.C. 10:53A–5.1(b), adjusted annually as specified in Sections 4306.3 of the State Medicaid Manual and described in N.J.A.C. 10:53A–4.4.

*Y6336 GENERAL INPATIENT CARE RATE

Payments are limited according to the aggregate inpatient days furnished to all recipients subject to the limitation of the "cap" according to Federal statute as referenced in N.J.A.C. 10:53A–5.1(b), adjusted annually as specified in Sections 4306.3 of the State Medicaid Manual and described in N.J.A.C. 10:53A–4.4.

Z2015 ROOM AND BOARD RATE

Room and board rate is reimbursed on a per diem basis for hospice services provided to a Medicaid recipient at the specific Medicaid approved NF rate (see NF rate setting methodology in Long Term Care Services Manual (N.J.A.C. 10:63)) where the recipient is residing. The rate is calculated at 95 percent of the highest approved per diem rate (institutionally specific) effective at the time services are provided and excluding retroactive rate adjustments, retroactive add-ons and special program rates adjusted every six months.

Y6337 THERAPEUTIC LEAVE DAYS RATE

Reimbursed at the same rate as the room and board rate in Z2015 for reserving an NF bed for a recipient who returns home, not to exceed 24 days per calendar year, in addition to the routine home care or continuous home care rate, as applicable.

Y6338 BED HOLD DAYS RATE

Reimbursed at the same rate as the room and board rate in Z2015 for reserving an NF bed for a recipient who requires inpatient hospitalization, not to exceed 10 consecutive days per period of hospitalization, in addition to the general inpatient care rate.

*Y6339 HOSPICE RESPITE CO–PAYMENT

Reimbursed on a per diem basis for dually Medicare/Medicaid recipients at five percent of the hospice Medicare inpatient respite care rate.

Y6343 DRUG AND BIOLOGICALS CO–PAYMENT

Reimbursed at a maximum of five percent per prescription cost for each outpatient drug or biological not to exceed $5.00 for each prescription for those recipients residing in an NF who are dually eligible Medicare/Medicaid recipients.

APPENDIX I

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 BENEFITS (FD–381)
FORM #5—TERMINATION OF HOSPICE BENEFITS (FD–382)
FORM #6—HOSPICE ELIGIBILITY FORM (FD–383)
FORM #7—CHANGE OF HOSPICE (FD–384)
FORM #8—PHYSICIAN CERTIFICATION/RECERTIFICATION FOR HOSPICE BENEFIT FORM (FD–385)
FORM #9—NOTIFICATION FROM LONG TERM CARE FACILITY OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT (MCNH–33)
FORM #10—STATEMENT OF AVAILABLE INCOME FOR MEDICAID PAYMENT (PA–3L)
FORM #11—LONG TERM CARE TURNAROUND DOCUMENT (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, _____,
(Applicant's Name and HSP (Medicaid) Case Number)
elect to receive the Medicaid hospice benefits from _____
(Hospice Agency and Medicaid Provider Billing Number)

this day of _____ 19___. 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, 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.

I realize that my family and I have the opportunity for limited respite or relief care in an inpatient nursing facility or hospital.

In accepting these services, I relinquish my rights to regular Medicaid 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 benefits if I am still eligible for Medicaid.

I understand that the hospice benefits consists of four benefit periods—two 90–day periods, one 30–day period, and a fourth unlimited period. I may be responsible for hospice charges if I become ineligible for Medicaid.

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 210 consecutive days. After the 210 days of hospice benefits, my benefits will automatically expire unless I choose to request to enter the fourth unlimited benefit period 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 recipient, I must elect to use the Medicare and Medicaid hospice benefits simultaneously.

Check one:

☐ I am a Medicare recipient and have elected to use the Medicare hospice benefits. My Medicare eligibility for hospice benefits begins _____ (Date).

☐ My Medicare hospice benefits have been exhausted as of _____ (Date).

☐ I am not a Medicare recipient.

☐ I am currently a nursing facility resident, residing at:

_____

Facility Name/Address

_____

_____

Signature of the Applicant

FD–378 (6/92)

FORM # 2
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES
HOSPICE BENEFITS STATEMENT

Recipient's Signature or Mark	Recipient's Name (Print or Type)
HSP (Medicaid) Case Number	
Witness' Signature	Relationship to Hospice Recipient
Date Signed	Effective Date of Election

SECOND CERTIFICATION PERIOD
(To be signed only if benefits previously revoked or temporarily terminated)

Recipient's Signature or Mark	Recipient's Name (Print or Type)
Witness' Signature	Relationship to Hospice Recipient
Date Signed	Effective Date of Second Period

THIRD CERTIFICATION PERIOD
(To be signed only if benefits are previously revoked or temporarily terminated)

Recipient's Signature or Mark	Recipient's Name (Print or Type)
Witness' Signature	Relationship to Hospice Recipient
Date Signed	Effective Date of Third Period

FOURTH CERTIFICATION PERIOD
(To be signed if hospice benefits are to continue)

Recipient's Signature or Mark	Recipient's Name (Print or Type)
Witness' Signature	Relationship to Hospice Recipient
Date Signed	Effective Date of Fourth Period

FD–379 (6/92)

FORM # 3
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES
REPRESENTATIVE STATEMENT FOR THE
ELECTION OF HOSPICE BENEFITS

I, _____, due to the physical/mental
(Legal Representative)
incapacity of _____,
(Applicant's Name and HSP (Medicaid) Case Number)
am authorized in accordance with State laws to execute, change or revoke the election of Medicaid hospice benefits on behalf of _____, who has been certified as terminally ill. As the representative for _____, I will sign all necessary forms required for the administration of hospice benefits.

_____
Signature of the Legal Representative

_____
Date

_____
Witness

_____
Date

FD–380 (6/92)

FORM # 4
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES
REVOCATION OF HOSPICE BENEFITS

I, _____
(Recipient's Name and HSP (Medicaid) Case Number)
revoke the hospice benefits allowed to me by Medicaid and rendered by _____,
(Hospice Agency and Medicaid Provider Billing Number)
effective this _____ day of _____, 19___.

_____ _____
Hospice Recipient's Signature or Mark Date

FD–381 (6/92)

FORM # 5
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES
TERMINATION OF HOSPICE BENEFITS

Hospice benefits for _____
(Recipient's Name and HSP (Medicaid) Case Number)
_____ are hereby terminated effective _____, 19___, for the following reason.

- ☐ Patient is deceased. Date of death is _____, 19___.
- ☐ Patient has not requested extension of Medicaid hospice benefits.
- ☐ Patient has become financially ineligible for Medicaid.
- ☐ Patient has become medically ineligible for hospice benefits as there is no physician certification or recertification of the terminal illness or need for hospice services.
- ☐ OTHER: (Please explain.)_____

_____
_____
_____

- ☐ Condition improved. Inactive status.

_____
(Hospice Agency and Medicaid Provider Billing Number)

_____ _____
Hospice Medical Director Date

FD–382 (6/92)

FORM # 6
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES
HOSPICE ELIGIBILITY FORM

THIS SECTION TO BE COMPLETED BY THE HOSPICE AGENCY

☐ Initial application ☐ Change in status
☐ Change of address

1. Recipient's Name _____
2. HSP (Medicaid) Case # _____
3. Recipient's Address _____
4. Birthdate:
   Sex: Male ☐ Female ☐
   SSN:_____
   Race:_____
5. Is the recipient currently receiving Room and Board Service in a nursing facility:
   Yes ☐ No ☐ If yes, give name and address of facility:
6. Medicare entitlement: PART A Yes ☐ No ☐
   PART B Yes ☐ No ☐
   HIC # _____
7. Medicaid eligibility: Yes ☐ No ☐ Unknown ☐
   If no, give the name of the person, the relationship to recipient, and the telephone number of the person who will initiate the medicaid application.
8. Other insurance (Include company name, policy number, and policy holder):
9. ☐ Election of hospice benefit on _____
   Physician Certification on _____
10. ☐ Termination of benefit on _____
    Reason: Death ☐ Revocation ☐ Other (Explain) ____
11. ☐ Change of hospice provider on _____
    From: _____, Medicaid Provider Billing No. ___
    To: _____, Medicaid Provider Billing No. ___

Name, Address and Medicaid Provider Billing Number of provider submitting form:

Contact person and telephone number: _____ Date: _

THIS SECTION TO BE COMPLETED BY THE MDO, CWA, OR DYFS DISTRICT OFFICE AS CONFIRMATION OF ELIGIBILITY

12. Medicaid eligibility effective date: _____ termination date: _____
13. HSP (Medicaid) Case # (if not entered above): _____
14. Attach copy of computer screen showing effective date and termination date of "Special Program Code 15".

    Note: Hospice eligibility dates correspond to election or revocation dates.

Contact person and telephone number: _____ Date _

Agency _____

FD–383 (6/92)

INSTRUCTIONS FOR SUBMITTING THE HOSPICE ELIGIBILITY FORM (FD–383 (6/92))

The Hospice Eligibility Form (FD–383 (6/92)) is to be initiated by the hospice provider. The purpose of this form is to ensure that the recipient is medically and financially eligible for Medicaid hospice services and is identified in the eligibility system at the CWA, MDO, or DYFS District Offices as a hospice recipient (Special Program Segment 15). Accurate completion of this form will ensure payment to the hospice provider for services provided to medicaid hospice recipients.

Form FD–383 should also be completed by the hospice provider when the person elects or revokes the hospice benefit, the Medicaid recipient dies, if there is a change of hospice providers, or a change in Medicaid recipient's address.

The first section of form FD–383 must be completed by the hospice provider and sent to the agencies as follows:

- To the Medicaid District Office (MDO) for SSI eligibles.
- To the County Welfare Agency (CWA) of the person's residence for Medicaid Only and New Jersey Care ... Special Medicaid Programs applicants.
- To the Division of Youth and Family Services (DYFS) District Office for children in DYFS foster care.

The hospice provider must send the original copy of form FD–383 to one of the above agencies with a copy to:

Division of Medical Assistance and Health Services
Hospice Program CN–712
Trenton, New Jersey 08625–0712

The MDO, CWA, or DYFS District Office will process the data and return a copy of form FD–383 to the hospice provider with a copy of the computer screen showing the effective date and termination date of "Special Program Code 15". Please refer to the Hospice Services Manual instructions for more detail on the eligibility process.

FORM # 7

STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHANGE OF HOSPICE

I, _____, wish to change
(Recipient's Name and HSP (Medicaid) Case Number)
the designation of the particular hospice from which I receive hospice care. I no longer wish to receive hospice service from _____,
(Hospice Agency and Medicaid Provider Billing Number)
but instead wish to receive hospice services from _____
(Hospice
_____ effective this _____
Agency and Medicaid Provider Billing Number)
day of _____, 19___.

I understand that this change of hospice providers is not a revocation of the remainder of this election period.

_____	_____
Recipient's Signature or Mark	Witness Signature
_____	_____
Date	Date

FD–384 (6/92)

FORM # 8

STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PHYSICIAN'S CERTIFICATION/RECERTIFICATION FOR HOSPICE BENEFITS FORM

I, _____, as the attending physician of

_____, who is under
(Recipient's Name and HSP (Medicaid) Case Number)
my care at this time, hereby certify (or recertify) that this patient is terminally ill, this his/her life expectancy is six months or less provided the illness follows its usual course, and that hospice services are reasonable and necessary for the treatment of this terminal illness or related condition.

Signature of the Attending Physician

Print the Attending Physician's Name

Date

FD–385 (6/92)

FORM # 9

NOTIFICATION FROM LONG TERM CARE FACILITY OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT (MCNH–33)

SAMPLE

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NOTIFICATION FROM LONG-TERM CARE FACILITY OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT

I. PATIENT INFORMATION:

1. Name: _____ (LAST / FIRST) 2. Social Security Account No.: ___-___-____
3. HSP(Medicaid) Case No.: _____ Confirmed By: _____ (CWA) ☐ Medicaid Only ☐ SSI
4. Authorized by: _____ Medicaid District Office

II. PROVIDER INFORMATION:

1. Provider Number: ____
2. LTCF Name: _____ 5. MEDICAID DISTRICT OFFICE
3. Address: _____ MDO Street Address: _____
4. City, State, Zip: _____ City, State, Zip: _____

III. ADMISSION INFORMATION:

1. Admission Date: ___ / ___ / ___ 2. Is this a new admission? ___Yes ___ No (If yes, send copy of MCNH-33 to CWA.)
3. Admitted to room number: _____ Bed number: _____
4. Admitted from: ___ Community Boarding Home ___ Medicare to Medicaid ___ Psychiatric Hospital
   ___ Private to Medicaid (anticipated Medicaid effective date: ___ / ___ / ___ (Attach PA-4 to MDO copy)
   ___ Hospital ___ Other LTCF ___ Other (identify) _____
5. Name and Address of hospital LTCF _____ Admission Date: ___ / ___ / ___
6. If admitted from hospital/LTCF give the name/address of previous residence:
   _____ (Hospital Name and Address or Home Address)

IV. TERMINATION INFORMATION:

1. Discharge Date: ___ / ___ / ___ 2. Has discharge been ordered by physician? ___Yes ___ No
3. Bed will be reserved in room number: _____ Bed number: _____
4. Discharged to hospital _____ (NAME OF HOSPITAL) (do not send MCNH-33 to CWA)
5. Discharged to: ___ Community (from LTCF/Hospital) ___ Other LTCF ___ Other (identify)
6. Death: ___ in LTCF ___ in hospital

V. CERTIFICATION: The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program. The facility also certifies that upon discharge to a hospital, the patient's room/bed will be reserved for the full period of time covered by the New Jersey Medicaid Bed Reserve policy.

This form completed by: _____ (Name) _____ (Title) _____ (Date) _____ (Signature)

VI. CWA USE ONLY:

Medicaid Effective Date: ___ / ___ / ___
_ Medicaid Only - PA-3L attached
_ SSI only - no PA-3L required
_ Not eligible
_ Transcript requested - Date: ___ / ___ / ___
Remarks:

COUNTY WELFARE OFFICE

Street Address: _____
City and Zip: _____

Signature of Case Worker: _____ Date: _____

FORM # 10

STATE OF AVAILABLE INCOME FOR MEDICAID PAYMENT (PA–3L)

SAMPLE

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

STATEMENT OF AVAILABLE INCOME FOR MEDICAID PAYMENT

Redetermination Date: _____ (MM/YY) SSA No.: _____ ELIG. EFF. DATE _____ PRINT DATE _____

HSP (Medicaid) CASE NUMBER _____ LAST _____ FIRST _____ COUNTY _____

Long-Term Care Facility: _____

Address: _____

SSI STATUS ___ (LAC/PS) LTCF Provider No._____ Previous Provider No.: _____

	LTCF Information		PA3L #1 Information	PA3L #2 Information	PA3L #3 Information		Remarks
Effective Date							Admit, Change, Redetermination
Social Security Income							Claim #
Buy-In Amount							HIC #
[illegible]							
Railroad/Veteran							Claim #
Pension/Other Benefit							Specify
Other Income							Specify
[illegible]	$						Spouse's S.S.A. #
[illegible]	$		$	$	$		M=Married Couple same LTCF G=Foreign Pension/VA A & A C=Combined Situation
Workshop/Other							
Maint./Home							Specify
Maint./Spouse Dependent							Specify
Health Premium	$						Policy #
[illegible]							
Available Income			$	$	$		R=Representative Payee
Month of Adm./Disch. Exempt							Specify
Resources	SPECIFY (i.e., address)						Circle One Yes No

Name and Address of Representative Payee

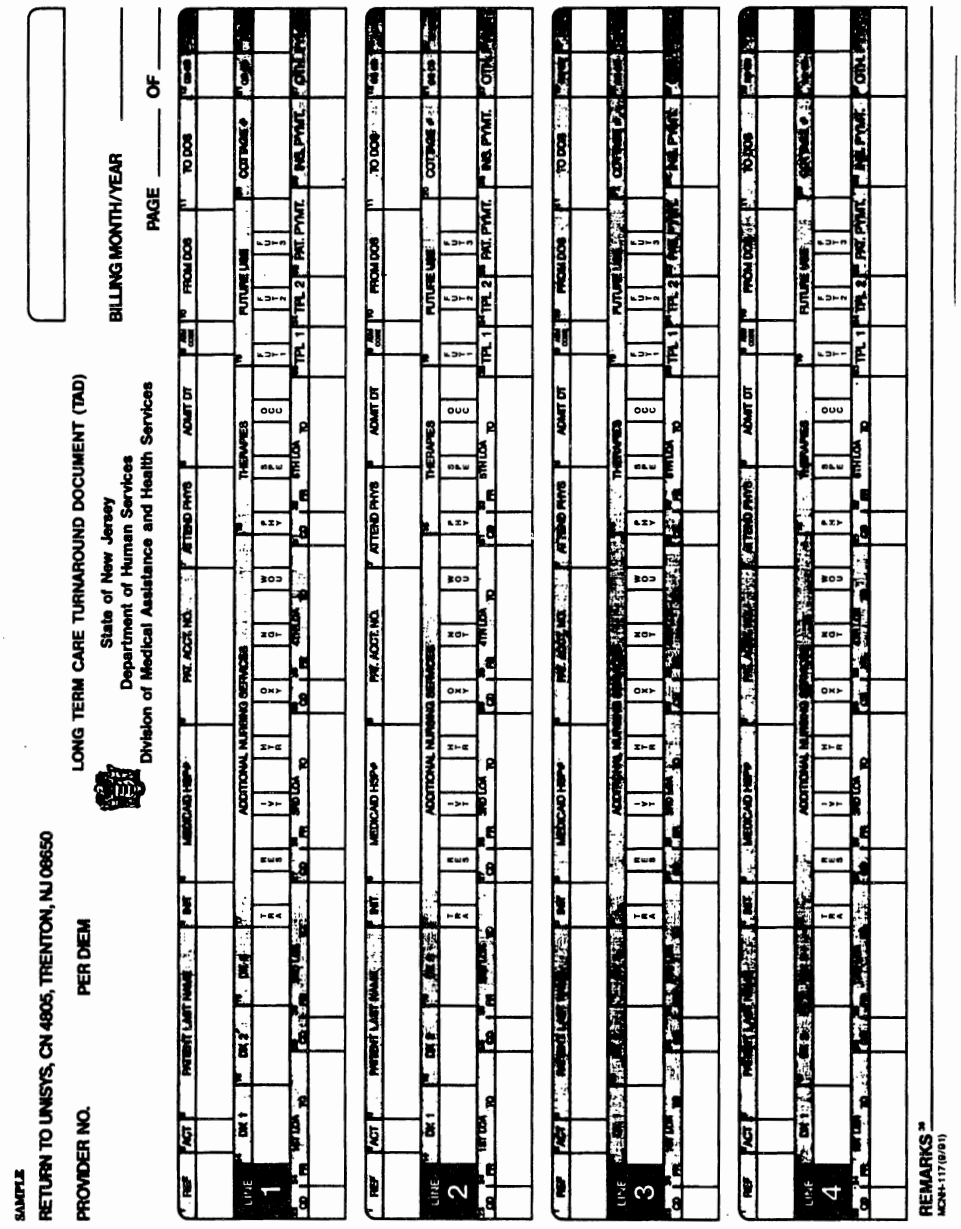
Signature: IM Worker: _____ Date: _____

Supervisor: _____ Date: _____

PA-3L (rev. 6/88) BUREAU OF CLAIMS & ACCOUNT

FORM # 11

LONG TERM CARE TURNAROUND DOCUMENT (TAD)



APPENDIX II

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Paramax/Unisys Corporation
CN–4801
Trenton, New Jersey 08650–4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN–049
Trenton, New Jersey 08625–0049