

provisions of the Medicaid/NJ FamilyCare FFS 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 beneficiaries 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/NJ FamilyCare FFS program.

Amended by R.2003 d.203, effective August 4, 2003.  
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

In (a), in last sentence substituted "Medicaid/NJ FamilyCare FFS beneficiaries" for "Medicaid recipients"; in (b), in first and third sentence inserted "/NJ FamilyCare FFS" following "Medicaid"; substituted "beneficiary" for "recipient" and "beneficiaries" for "recipients" throughout.

### 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/NJ FamilyCare FFS program have the right to file for fair hearings.

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

Inserted "/NJ FamilyCare FFS" following "Medicaid".

### 10:53A-2.9 Advance directives

All hospices participating in the New Jersey Medicaid/NJ FamilyCare FFS program are subject to the provisions of State and Federal statutes regarding advance directives, including, but not limited to, appropriate notification to patients of their rights, development of policies and practices, and communication to and education of staff, community and interested parties. Detailed information may be located at N.J.A.C. 10:49-9.15, and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (42 U.S.C. §§ 1396a(a)(58) and 1396a(w)).

Repeal and New Rule, R.2001 d.294, effective August 20, 2001.  
See: 32 N.J.R. 2687(b), 33 N.J.R. 2808(a).

Rewrote the section.

Amended by R.2003 d.203, effective August 4, 2003.  
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

In first sentence, inserted "/NJ FamilyCare FFS" following "Medicaid".

## SUBCHAPTER 3. BENEFICIARY 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/NJ FamilyCare FFS eligible at the time of application.

(b) In order to receive hospice services, an applicant must be eligible for Medicaid/NJ FamilyCare FFS either in the community or in an institution. Additionally, an applicant 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, 10:72, and 10:78, incorporated herein by reference. Applicants eligible only for the Medically Needy component of the New Jersey Medicaid program are not eligible for hospice services under the Medicaid State Plan benefit.

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

2. Applicants not already eligible for Medicaid/NJ FamilyCare FFS but who express interest in hospice services should be referred to the county board of social services for a determination of eligibility. Applicants already residing in a nursing facility should be referred to the county board of social services in which the facility is located. Applicants in the community or waiting for placement in a nursing home should be referred to the county board of social services in their county of residence.

3. The providers of hospice services to Medicaid/NJ FamilyCare beneficiaries enrolled in a managed care organization or HMO shall comply with the procedures of that managed care organization or HMO, including, but not limited to, any prior authorization or other utilization control procedure required.

(c) In addition to financial eligibility, the individual applying for Medicaid/NJ FamilyCare FFS 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 elect his or her Medicare Part A benefits for hospice care. For dually eligible Medicare and Medicaid hospice beneficiaries, the hospice benefits election applies simultaneously under both the Medicare and Medicaid programs. Thus, Medicare is responsible for the payment of claims for services provided, as first payer of the hospice benefit. Medicaid is responsible for payment for services not covered under the Medicare hospice benefit when those services are Medicaid covered services, such as any co-payment, co-insurance deductibles, if applicable, and those Medicaid covered services listed in N.J.A.C. 10:53A-3.4(g).

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 beneficiary (unless provided under written arrangements made by the designated hospice); and

ii. Any Medicaid/NJ FamilyCare FFS 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 beneficiary'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 eligibility categories listed in N.J.A.C. 10:71 and 10:72, incorporated herein by reference, may be eligible for hospice if the applicant meets the criteria listed in (b) and (c) above.

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

Added (b)4; in (c)2, added the third and fourth sentences; rewrote (d); and deleted (d)1 through (d)6.

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

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

Rewrote the section.

### 10:53A-3.2 Application procedure for medical and financial eligibility for hospice services

(a) The application procedure 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 and the Election of Hospice Benefits Statement, FD-378. The hospice agency shall be responsible for confirming Medicaid/NJ FamilyCare FFS eligibility and monitoring on-going eligibility including transition into managed care organizations.

2. The hospice shall notify the agency (that is, the county board of social services (CBOSS), the Division of Youth and Family Services (DYFS), or the medical assistance customer center (MACC) (for SSI beneficiaries), as

applicable), that is 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.

i. The date of the signing of the Election of Hospice Benefits Statement, FD-378 determines the date of eligibility for hospice services if the applicant is eligible for Medicaid/NJ FamilyCare FFS.

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 the 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 board of social services (CBOSS)), shall inform the Disability Review Section of the beneficiary'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 beneficiary 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 could have met the eligibility criteria for Aid to Children with Dependent Children (AFDC) that were in place on July 16, 1996, as set forth in N.J.A.C. 10:81 and 10:82, 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 procedure for financial eligibility is as follows:

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

2. For the beneficiary who had been eligible for regular Medicaid/NJ FamilyCare FFS benefits (such as the Medicaid expansion under NJ FamilyCare as set forth in N.J.A.C. 10:69, Medicaid Only or New Jersey Care . . . Special Medicaid Programs), the CBOSS is responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of Medicaid/NJ FamilyCare FFS eligibility for hospice by returning the Hospice Eligibility Form (FD-383).

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).

5. If the applicant for Medicaid hospice services is SSI eligible, the MACC 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). (See N.J.A.C. 10:49, Administration, (Appendix Form #14), for the list of medical assistance customer center.)

6. The medical eligibility materials (copies of the Physician Certification/Recertification for Hospice Benefits, FD-385 form and the Election of Hospice Benefits Statement, FD-378,) shall be forwarded by the hospice to the MACC, CBOSS 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 CBOSS. For individuals determined eligible, see (b)2 above for processing responsibilities.

(c) Rules for retroactive Medicaid/NJ FamilyCare FFS eligibility in N.J.A.C. 10:49, Administration, apply to those

beneficiaries eligible for Medicaid/NJ FamilyCare FFS prior to their Medicaid/NJ FamilyCare FFS 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 Benefit Statement, FD-378 is signed. Retroactive eligibility for hospice services may be established for up to three months prior to Medicaid eligibility provided the Election of Benefit Statement, FD-378 had been signed. Such cases shall be referred to the following addresses for determination of retroactive eligibility:

i. For SSI beneficiaries:

Retroactive Eligibility Unit  
Division of Medical Assistance and Health  
Services  
PO Box 712, Mail Code #10  
Trenton, New Jersey 08625-0712;

ii. For Medicaid Only and New Jersey Care . . . Special Program beneficiaries, the county welfare agency of the beneficiary's residence; and

iii. For children in foster care; the Division of Youth and Family Services district office.

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 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.

(d) The hospice shall notify the agency determining eligibility (MACC, CBOSS or DYFS) through a copy of the Hospice Eligibility Form, FD-383 of a change in the beneficiary's status which could affect the eligibility for Medicaid/NJ FamilyCare and/or for hospice services, a change in the hospice provider status, or a change in a beneficiary's address. The CBOSS, DYFS, or MACC will be responsible for notifying the Social Security Administration of the beneficiary's change in status, if applicable.

(e) A limited access Health Benefits Identification (HBID) Card shall be issued to a fee-for-service Medicaid beneficiary 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.

(f) For Medicaid/NJ FamilyCare beneficiaries who are also enrolled in a commercial managed care organization or HMO, the hospice provider shall coordinate services and obtain approval from the private HMO as the primary payer.

(g) For Medicaid/NJ FamilyCare beneficiaries enrolled in managed care plans, hospice services are provided by their

HMO. The HMO procedures of the beneficiary's particular HMO shall apply to hospice services.

Amended by R.1994 d.508, effective October 17, 1994.

See: 26 N.J.R. 1283(a), 26 N.J.R. 4185(a).

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

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

In (a)3ii(2) and (b)2, added reference to eligibility for AFDC prior to July 16, 1996; and added (f).

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

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

Rewrote the section.

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

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

In the introductory paragraph of (a)2 and in (b)5, substituted "medical assistance customer center" for "Medical Assistance Customer Center"; in the introductory paragraph of (a)2, deleted "(5/01)" following "FD-383" and deleted the last sentence and the address; in (b)4 and (b)5, deleted "(5/01)" following "(FD-383)"; in the introductory paragraph of (c)1, substituted "addresses" for "address"; added (c)1i through (c)1iii; and in (e), substituted "Health Benefits Identification (HBID) Card" for "Medicaid Eligibility Identification Card (MEI) with the statement 'Except for hospice and physician services, CHECK WITH HOSPICE PROVIDER for other services'".

### 10:53A-3.3 Benefit periods

(a) There are two 90-day benefit periods and an unlimited number of subsequent 60-day periods. The benefit periods shall be recorded on a Hospice Benefits Statement, FD-379 (Form #2 in the Appendix, incorporated herein by reference) and filed in the beneficiary's medical record.

(b) Contents of the Election of Hospice Benefits Statement, FD-378 (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/NJ FamilyCare FFS services other than hospice services are waived by the signing of the Election of Hospice Benefits Statement, FD-378 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) If the applicant or his or her representative files an Election of Hospice Benefits Statement, FD-378, the hospice applicant is eligible for two 90-day benefit periods of hospice services totaling 180 days and an unlimited number of subsequent 60-day periods with the approval of the hospice provider.

1. A hospice beneficiary 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 beneficiary 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 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 is required to be filed following a break or revocation of hospice service.

i. The beneficiary or his or her representative shall file a signed statement with the hospice provider that indicates the beneficiary revokes the election for Medicaid/NJ FamilyCare FFS 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 beneficiary forfeits hospice services for any remaining days in the benefit period. A beneficiary 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 CBOSS, DYFS or the MACC) of the revocation of hospice, verbally if possible, and also by filling out and submitting the Hospice Eligibility Form, FD-383 (5/01) to the eligibility source (CBOSS, MACC or DYFS, as applicable) so that the beneficiary's hospice eligibility may be terminated. The hospice shall also fill out the Termination of Hospice Benefits, FD-382 (Form #5 in the Appendix, incorporated herein by reference) and retain this form in the beneficiary's medical record.

(e) Entitlement to all other Medicaid/NJ FamilyCare FFS services may be restored if the beneficiary continues to be Medicaid/NJ FamilyCare FFS eligible, under the following circumstances:

1. When the 180 days of hospice entitlement has expired, and the beneficiary does not choose the unlimited benefit periods; or

2. When the beneficiary revokes hospice services.

(f) When a hospice beneficiary 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 shall be completed and submitted to the eligibility determining agency after the beneficiary has signed the Revocation of Hospice

Benefits, FD-381 form indicating he or she has revoked the Medicaid/NJ FamilyCare FFS hospice benefit.

i. For SSI beneficiaries, the hospice shall submit the FD-383 to the medical assistance customer center;

ii. For Medicaid Only and New Jersey Care . . . Special Program beneficiaries, the hospice shall submit the FD-383 to the county welfare agency of the beneficiary's residence; and

iii. For children in foster care, the hospice shall submit the FD-383 to the Division of Youth and Family Services district office.

2. The nursing facility shall conform to the nursing facility rules and regulations in N.J.A.C. 10:63, Long Term Care Services, for admission and placement and shall treat this beneficiary in the same manner as other persons being admitted or placed in the NF.

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

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

Deleted (f)2i

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

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

Rewrote the section.

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

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

In the introductory paragraph of (f), deleted a comma following "proceed"; in the introductory paragraph of (f)1, deleted "(5/01)" following "FD-383" and substituted "eligibility determining agency" for "MACC"; and added (f)1i through (f)1iii.

**10:53A-3.4 Covered hospice services**

(a) The amount, character, and scope of New Jersey Medicaid/NJ FamilyCare FFS hospice services shall be the same for all hospice beneficiaries 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 beneficiary consistent with the beneficiary's individualized plan of care.

1. Required hospice services which shall be available to the hospice beneficiary 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 beneficiaries 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.

2. Effective on August 4, 2003, any other item or service which is specified in the patient's plan of care and for which payment may otherwise be made under Medicaid shall be a covered service under the Medicaid/NJ FamilyCare hospice benefit. For example, a hospice determines that a patient's condition has worsened and has become medically unstable and that an inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

(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 beneficiary 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 beneficiary at home where most of care is skilled nursing care on a continuous basis to achieve palliation or management of the beneficiary's acute medical symptoms and only as necessary to maintain the beneficiary 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 beneficiary in a hospital or nursing facility only when necessary to relieve the family members or other persons caring for the beneficiary 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 beneficiary 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 beneficiary 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 beneficiary to maintain activities of daily living and basic functional skills;

3. Medicaid social services provided by a social worker who has met the Medicare certification requirements for education (See 42 U.S.C. § 1395x) and 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.

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

ii. A registered professional nurse shall visit the home of the hospice beneficiary 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 beneficiary's terminal illness;

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

7. Counseling, provided with respect to care of the terminally ill beneficiary, for family members or other persons caring for the beneficiary 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 beneficiary's family or other caregiver to provide care, and for the purpose of helping the beneficiary and those caring for him or her to adjust to the nature of the beneficiary's illness.

ii. Bereavement counseling consists of counseling services provided to the beneficiary's family after the beneficiary'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/NJ FamilyCare.

(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 beneficiary.

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

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

(e) Room and board services identical to those provided to non-hospice Medicaid/NJ FamilyCare FFS beneficiaries shall be provided for hospice beneficiaries residing in a nursing facility. The beneficiary eligible for hospice services who is residing in a Medicaid/NJ FamilyCare FFS participating nursing facility is considered a hospice beneficiary 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 benefits and returns to that NF's care or the care of another NF, the PAS rules apply which are in N.J.A.C. 10:63, Long Term Care Services.

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