

In (a), added "For services rendered prior to January 1, 1999," at the beginning; and added (b).

Recodified from N.J.A.C. 10:60-1.9 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (b), amended N.J.A.C. references. Former N.J.A.C. 10:60-1.4, Covered home health services, recodified to N.J.A.C. 10:60-2.1.

#### 10:60-1.5 Limitations of home care services

(a) When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the Division retains the right to limit or deny the provision of home care services on a prospective basis.

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Amended by R.1997 d.277, effective July 7, 1997.

See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(a).

In (f), amended internal cite and added last sentence; and in (g), substituted "obtain prior authorization . . . with N.J.A.C. 10:49-6.1" for "notify the Medicaid District Office (MDO), either in writing or by telephone" and amended "failure to comply" clause to conform.

Recodified from N.J.A.C. 10:60-1.12 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

Rewrote the section. Former N.J.A.C. 10:60-1.5, Certification of need for services, recodified to N.J.A.C. 10:60-2.2.

#### 10:60-1.6 Advance directives

(a) All home health, private duty nursing, hospice and personal care agencies participating in the New Jersey Medicaid or NJ KidCare programs shall comply with the provisions of the Federal Patient Self Determination Act (P.L. 105-33) 1902(w) of the Social Security Act, 42 U.S.C. § 1396a, and shall notify Medicaid and NJ KidCare beneficiaries about their rights under P.L. 1991, c.201 to make decisions concerning their medical care and their right to formulate an advance directive.

##### 1. Such agencies shall:

i. Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the home health or personal care 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 Department of Health and Senior Services (DHSS) statement of New Jersey law, "Your Right to Make Health Care Decisions in New Jersey," to beneficiaries upon initial visit for home health or personal care services, regarding their rights to make decisions concerning their medical care available from the DHSS. Such rights include 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 beneficiaries, upon initial receipt of home health or personal care, concerning the agency's written policies on the implementation of such rights;

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

v. Not condition the provision of care, or otherwise discriminate against a beneficiary, based on whether or not the beneficiary 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 (a)1 above shall not prohibit the application of a State law which allows a home health or personal care agency 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 shall be included in the health care agency's written policies.

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Recodified from 10:60-1.13 by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

Recodified from N.J.A.C. 10:60-1.14 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (a), inserted references to NJ KidCare and changed P.L. reference in the introductory paragraph; and substituted references to beneficiaries for references to recipients throughout. Former N.J.A.C. 10:60-1.6, Plan of care, recodified to N.J.A.C. 10:60-2.3.

#### 10:60-1.7 Relationship of the home care provider with the Medicaid District Office (MDO) and the DHSS Long-Term Care Field Office (LTCFO)

(a) Preadmission screening (PAS) shall be required for all Medicaid-eligible or NJ KidCare-Plan A-eligible individuals and other individuals applying for nursing facility (NF) services or the Home and Community-Based Services Waiver programs. DHSS professional staff will conduct PAS assessments of individuals in hospitals and community settings to evaluate need for nursing facility services and to determine the appropriate setting for the delivery of services. Individuals in hospitals or community settings who are referred for nursing facility care and who have been determined by the LTCFO not to require nursing facility placement, or who select alternatives to nursing facility care, will be referred for home care services.

(b) A health services delivery plan (HSDP) will be completed by the DHSS staff at the conclusion of the PAS assessment and shall be a component of the referral package to the home care provider. The HSDP shall be forwarded to the authorized care setting and shall be attached to the beneficiary's medical record upon admission to a nursing facility or when the beneficiary receives services from home care agencies. The HSDP may be updated as required to reflect changes in the beneficiary's condition. The HSDP provides data base history which reflects current or potential health problems and required services. The discharge planning unit or social service department of the hospital shall provide home care agencies with HSDPs for individuals who have been assessed in a hospital setting. DHSS will provide HSDPs for individuals who have been assessed in a community setting during the PAS process. For individuals deemed appropriate for a Home and Community-Based Services Waiver administered by the Department of Human Services, a copy of the appropriate HSDP will be forwarded to the MDO director.

(c) For the many individuals in the community setting referred for home care services outside the PAS process described in (a) above, an HSDP shall not be provided.

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Recodified from 10:60-1.14 by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

Recodified from N.J.A.C. 10:60-1.15 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (a), inserted "NJ KidCare—Plan A—eligible" in the first sentence, substituted "DHSS" for "MDO" in the second sentence, and substituted "LTCFO" for "MDO" in the third sentence; in (b), substituted reference to the DHSS for references to the MDO in the first and sixth sentences, added the last sentence, and substituted references to beneficiaries for references to recipients throughout. Former N.J.A.C. 10:60-1.7, Clinical records, recodified to N.J.A.C. 10:60-2.4.

#### **10:60-1.8 Standards of performance for concurrent and post payment quality assurance review**

(a) An initial visit to evaluate the need for home health services or personal care assistant services shall be made by the provider. Following the initial visit, the provider shall advise the Division or its designated agent, using the HCFA 485 form, that services have begun for the beneficiary. Providers shall use this form even when the Medicaid or NJ KidCare fee-for-service beneficiary is not a Medicare beneficiary. The HCFA 485 form shall be submitted to the MDO that serves the county in which the beneficiary resides and shall be postmarked within five business days of initial assessment, reassessment, or termination. MDO's shall not accept faxed HCFA 485 forms. If the Division discovers that a home health agency did not submit the documentation within the prescribed time frame, the Division shall recover any payments for services rendered from the sixth business day of initial assessment until a completed HCFA 485 form is received by the Division. In cases when the beneficiary is eligible for both Medicare and Medicaid fee-for-service or NJ KidCare fee-for-service programs, the HCFA 485 form shall be completed and submitted to the MDO within five business days of when the Medicaid/NJ KidCare fee-for-service program becomes the primary payer.

1. The HCFA 485 shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services, however, shall be kept on file in the agency, with the prescription. Providers shall enter the Medicaid Eligibility Identification (MEI) Number or NJ KidCare Identification Number in block 1 when completing the HCFA 485, 486 or 487 form. For the non-Medicare certified agency, the provider shall submit to the MDO an MDO approved notification form which shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services shall be kept on file in the agency.

2. The HCFA 485 shall be submitted to the MDO upon initiation of services and every 62 days thereafter on a continuing basis. If at any time there occurs a significant change in the beneficiary's plan of care and there is an increase of 50 percent or more of a particular skilled home care service, the agency shall submit a HCFA 485 or 486 or 487 as the circumstances warrant to the MDO. Providers shall notify the MDO, using the HCFA 485, when services have been terminated.

3. Upon receipt of the HCFA 485 form, using a case screening methodology, Division staff shall conduct concurrent reviews on a selected number of cases, by making on-site visits to Medicaid/NJ KidCare fee-for-service beneficiaries at their places of residence. Division staff will use the standards listed in (c) through (j) below to conduct the review.

4. If the Division determines that the services provided were in compliance with the standards listed in (c) through (j) below, payment shall continue to be made to the provider. If the Division determines that the services provided were not in compliance, or should be reduced, the Division shall notify the provider and beneficiary in writing if there is a disparity of need determined which would result in a change in service(s). If a provider and/or beneficiary disagrees with the Division's determination, a fair hearing may be requested in accordance with procedures set forth in N.J.A.C. 10:60-10 and 10:49-9.14 and 10.

5. On a random selection basis, MDO staff shall conduct post-payment quality assurance reviews. At the specific request of the MDO, the provider shall submit a plan of care and other documentation for those Medicaid and NJ KidCare fee-for-service beneficiaries selected for a quality assurance review.

6. Upon completing the post-payment quality assurance review, the MDO shall forward a performance report to the provider, based on compliance with the standards described in this section.

(b) The professional staff from the MDO will use the standards listed in (c) through (j) below to conduct a post-payment quality assurance review of home care services as provided to the Medicaid or NJ KidCare fee-for-service beneficiary.