CHAPTER 53A

HOSPICE SERVICES MANUAL

Authority

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

Source and Effective Date

R.2008 d.226, effective July 9, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 53A, Hospice Services Manual, expires on January 5, 2016. See: 47 N.J.R. 2044(a).

Chapter Historical Note

Chapter 53A, Hospice Services Manual, was adopted as R.1992 d.442, effective November 2, 1992. See: 24 N.J.R. 2778(a), 24 N.J.R. 4036(a).

Pursuant to Executive Order No. 66(1978), Chapter 53A, Hospice Services Manual, was readopted as R.1997 d.479, effective October 20, 1997. See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

Chapter 53A, Hospice Services Manual, was readopted as R.2003 d.100, effective February 4, 2003. See: 34 N.J.R. 2679(a), 35 N.J.R. 1277(a).

As a part of R.2003 d.320, effective August 4, 2003, Subchapter 3, Recipient Requirements, was renamed Subchapter 3, Beneficiary Requirements. See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

Chapter 53A, Hospice Services Manual, was readopted as R.2008 d.226, effective July 9, 2008. As a part of R.2008 d.226, Subchapter 5, Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS), was renamed Healthcare Common Procedure Coding System (HCPCS), effective August 4, 2008. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 53A, Hospice Services Manual, was scheduled to expire on July 9, 2015. See: 43 N.J.R. 1203(a).

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SUBCHAPTER 1. GENERAL PROVISIONS

Law Review and Journal Commentaries

A Hospice Primer. Dianne Rosen, 190 N.J.L.J. 12 (1998).

10:53A-1.1 Introduction

(a) Reimbursement for hospice services provided by Medicaid was authorized pursuant to § 1905(o) of the Social Security Act, codified as 42 U.S.C. § 1396d(o). N.J.S.A. 30:4D-6b(20) authorizes the New Jersey Division of Medical Assistance and Health Services to develop a program of hospice services. This chapter, N.J.A.C. 10:53A, Hospice Services, sets forth the rules for the provision of hospice services to the terminally ill who are eligible for Medicaid/NJ FamilyCare fee-for-service (FFS) program. Room and board services are also available for those Medicaid /NJ FamilyCare FFS beneficiaries residing in a nursing facility who are also 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).

(b) This chapter provides the rules for hospice services for Medicaid/NJ FamilyCare FFS beneficiaries who are not enrolled in, and receiving services through, a health maintenance organization (HMO). Hospice services provided to a beneficiary who is enrolled with an HMO are governed by the policies of the HMO and are not within the purview of these rules.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended U.S.C. references.
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.

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 and an unlimited number of subsequent 60-day periods.

"CAP" means a limitation on the payment amount or aggregate days of inpatient care as imposed by Medicaid/NJ FamilyCare FFS program 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/NJ FamilyCare FFS beneficiaries residing in a nursing facility, and services unrelated to the terminal illness that may be provided by Medicaid/NJ FamilyCare FFS as part of the hospice plan of care. The comprehensive hospice benefit does not include hospice services under ACCAP or any other waiver program.

"DHSS" means the New Jersey Department of Health and Senior Services.

"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/NJ FamilyCare FFS 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/NJ FamilyCare FFS services are forfeited when choosing hospice services; the individual or his or her representative's acknowledgment 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).

"Eligibility determining agency" means the agency responsible for determining a beneficiary's financial eligibility for hospice services. These agencies include the medical assistance customer centers, the county boards of social services and the Division of Youth and Family Services. These agencies determine financial eligibility after medical necessity has been certified. See N.J.A.C. 10:53A-3 for details.

"Hospice," for the purposes of the New Jersey Medicaid/NJ FamilyCare FFS program (hereafter referred to as the Program), means a public agency or private organization (or subdivision of such organization) which is licensed by the Department of Health and Senior Services as a provider of hospice services consistent with P.L. 1997, c.78; 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, as well as any other item or service, as specified in the beneficiary's plan of care, which is reimbursed by the Medicaid/NJ FamilyCare FFS program. Hospice providers in New Jersey may be hospital-based or home health agencies, or hospice agencies.

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

"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 employed by or under contract with the hospice, that provide and/or supervise hospice services. The interdisciplinary group, at a minimum, must be composed of a physician,

"Mental health services worker" means an individual, working under the direct supervision of a licensed mental health professional, who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or possesses one of the following credentials: certified psychiatric rehabilitation practitioner or community mental health associate.

"Off-site interventions" means planned mental health programming provided by the APH staff or PH staff during hours of APH or PH, respectively, at a location other than that of the program site in order to assist the beneficiary to apply or practice critical community-learned skills.

"Partial hospital" or "PH" means an individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

"Prevocational services" means prevocational services, as that term is defined at N.J.A.C. 10:52-2.10A.

"Prior authorization" means approval by the Division before a service is rendered.

"Programs of assertive community treatment (PACT)" means mental health rehabilitative services, which are delivered in a self-contained treatment program provided by a service delivery team and managed by a qualified program director, which merges treatment, rehabilitation and support services, which are individualized and tailored to the unique needs and choices of the beneficiary receiving the services.

"Qualified addictions staff" means individuals credentialed to provide supervision, clinical or direct care pursuant to the Alcohol and Drug Counselor Licensing and Certification Act, N.J.S.A. 45:2D-1 through 17.

"Rehabilitation counselor" means an individual licensed by the Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners (licensed rehabilitation counselor (LRC)), certified as a certified rehabilitation counselor (CRC) by the Certification in Rehabilitation Counseling Board or possessing the education, training and experience sufficient to qualify for either credential.

"Registered nurse" or "RN" means a person who has graduated from an accredited nursing program and who possesses a valid nursing license in the State of New Jersey.

"Skill development" means learning the requisite knowledge, attitudes and specific actions that lead to the performance of a critical competency needed for valued community role functioning. Skill development can be accomplished through either individual or group instruction; however, the staff-to-consumer ratio in group instruction must not exceed 1:10.

"Social worker" means an individual licensed by the New Jersey Board of Social Work Examiners as a certified social worker (CSW), licensed social worker (LSW) or licensed clinical social worker (LCSW).

"Vocational services" mean those interventions, strategies and activities which assist the beneficiary in acquiring skills to enter a specific occupation or assist the beneficiary in directly entering the workforce as an employee.

SUBCHAPTER 2. ENROLLING AS A PROVIDER

10:52A-2.1 Authority to provide services

(a) Each program site location, as described in N.J.A.C. 10:52-1.3, at which APH or PH services are provided and which has been approved to be a Medicaid provider by the Division's Office of Reimbursement Services shall provide services and be reimbursed for those services pursuant to N.J.A.C. 10:49 and 10:52 and this chapter.

(b) Each program site location, as described in N.J.A.C. 10:52-1.3, at which APH or PH services are provided, shall be approved to be a Medicaid provider by the Division's Office of Reimbursement Services and, additionally, shall either be licensed by the Commissioner of the Department of Human Services as a mental health program and have a purchase of services contract with the Division of Mental Health Services, or be licensed by the Commissioner of the Department of Health and Senior Services as a health care facility.

10:52A-2.2 Reporting change of address or ownership

A participating provider shall reapply to the DMAHS Office of Reimbursement Services prior to operating if there are any changes in ownership or site location. In the case of a site relocation, the provider shall reapply prior to operating at the new location. DMAHS shall not reimburse for services provided prior to the date of the approval of the application.

SUBCHAPTER 3. BENEFICIARY ELIGIBILITY REQUIREMENTS

10:52A-3.1 Eligibility for APH services

(a) In order to be eligible for APH services, an individual shall first be determined to be an eligible beneficiary in the Medicaid/NJ FamilyCare program in accordance with the Division's rules.

(b) In order to be eligible for APH services, a beneficiary shall be at least 18 years of age or older, unless prior authorized by DMAHS.

(c) In order to be eligible for APH services, a beneficiary shall:

1. At the time of referral or as a result of psychiatric evaluation provided or arranged for, have at least one of the following primary DSM-IV-TR diagnoses on Axis I:

i. Schizophrenia or Other Psychotic Disorders (298.9, 295.xx);

ii. Major Depressive Disorder (296.xx);

iii. Bipolar Disorders (296.xx, 296.89);

iv. Delusional Disorder (297);

v. Schizoaffective Disorder (295.7);

vi. Anxiety Disorders (300.xx); or

vii. A covered psychiatric disorder diagnosis consistent with codes, Axis I-V of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR as amended and supplemented, including some 301.XX Axis II codes if the personality disorder is considered in the severe range and the beneficiary is at high risk of psychiatric hospitalization;

2. Have disordered thinking or mood, bizarre behavior or psychomotor agitation or retardation to a degree that interferes with activities of daily living or abilities to fulfill family, student or work roles to such an extent that a structured intensive treatment program is needed and cannot adequately be addressed at a less restrictive level of care; the beneficiary also has a need for prescribed psychotropic medications or has a need for assistance with medication adherence; and

3. Have a Global Assessment of Functioning (GAF) Scale score of between 30 and 60, as found in the DSM-IV-TR page 32.

(d) In order to be eligible for APH services, a beneficiary shall be referred by the local designated screening center or psychiatric emergency service as a diversion from hospitalization or by an inpatient psychiatric facility if the treating psychiatrist or APN clearly justifies acute clinical need. Additionally, for a beneficiary to receive APH services, the beneficiary must receive, from the referring treatment team, a certification containing the clinical evidence necessary to support the referral, documenting the required specific conditions contained in (c)1, 2, and 3 above.

(e) In the case of a beneficiary who has previously been admitted to an APH program, in order to be eligible for APH services, the beneficiary shall be readmitted to an APH program only through a referral from the local designated screening center or psychiatric emergency service as a diversion from hospitalization or by an inpatient psychiatric facility if the treating psychiatrist or APN clearly justifies acute clinical need. Additionally, for a beneficiary to receive APH services, the beneficiary must receive, from the referring treatment team, a certification containing the clinical evidence necessary to support the referral, documenting the required specific conditions contained in (c)1, 2, and 3 above.

10:52A-3.2 Eligibility for PH services

(a) In order to be eligible for PH services, an individual shall first be determined to be an eligible beneficiary in the Medicaid/NJ Family Care program in accordance with the Division's eligibility rules at N.J.A.C. 10:49, 10:69, 10:71, 10:72, 10:78 and 10:79.

(b) In order to be eligible for PH services, an individual shall be at least 18 years of age or older, unless prior authorized by DMAHS.

(c) In order to be eligible for PH services, a beneficiary shall at the time of referral:

1. Have a primary diagnosis as set forth in N.J.A.C. 10:52A-3.1(c)1;

2. Have impaired functioning, which necessitates learning critical skills in order to achieve valued community roles and community integration in at least one of the following domains on a continuing, intermittent basis for at least one year or have recently decompensated to a significantly impaired status:

i. Maintenance of personal self-care;

ii. Development of interpersonal relationships;

iii. Ability to work;

iv. Ability to receive an education;

v. Ability to live in the community; or

vi. Ability to acquire or maintain safe, affordable housing when at risk of requiring a more restrictive living situation; and

3. Have a Global Assessment of Functioning (GAF) Scale scores of between 30 and 70, as set out in the DSM-IV-TR page 32.

(d) In order to be eligible for PH services, a beneficiary shall be referred by the APH or be significantly impaired such that a need for PH exists, and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions contained in (c)1, 2 and 3 above.

10:52A-3.3 Ineligibility for APH and PH services

(a) An applicant or beneficiary who presents with any of the following criteria shall be excluded from participation in APH and PH services:

1. Has a primary diagnosis of substance abuse or dependence;

2. Is an imminent danger to self or others;

3. Is in need of acute medical care;

4. Is in need of detoxification;

5. Has a primary diagnosis of "developmentally disabled" as defined in the term "developmental disability" at N.J.A.C. 10:44A-1.3; or

6. Is currently participating in a PACT program, unless authorized in accordance with N.J.A.C. 10:76.

SUBCHAPTER 4. PROGRAM REQUIREMENTS

10:52A-4.1 Program distinctions

APH programs deliver intense active treatment necessary to stabilize a beneficiary's acute symptomatology and more effectively address intractable symptoms. PH programs provide services which assist beneficiaries to integrate into valued community roles.

10:52A-4.2 Conditions which shall be met for APH and PH services

(a) All of the following conditions shall be met for the provision of APH and PH services to each beneficiary:

1. Assigned staff shall complete an intake evaluation for each beneficiary within the identified timeframe established in N.J.A.C. 10:52A-4.7;

2. Assigned staff shall complete a comprehensive assessment for each beneficiary within the identified timeframe established in N.J.A.C. 10:52A-4.9;

3. The provider shall develop and maintain an Individualized Recovery Plan for each beneficiary, and shall update that Individualized Recovery Plan within the identified timeframe established in N.J.A.C. 10:52A-4.10;

4. Assigned staff shall record progress notes for each beneficiary within the identified timeframe established in N.J.A.C. 10:52A-4.11;

5. Assigned staff shall develop and maintain an applicable discharge plan for each beneficiary within the identified time frame established in N.J.A.C. 10:52A-4.12;

6. The provider shall monitor APH and PH services through a quality assurance, utilization review and outcome protocol;

7. Program hours of service:

i. APH and PH providers shall make services available to beneficiaries a minimum of five hours per day and a minimum of five days per week at the times most needed by the beneficiaries;

8. After conducting a treatment team evaluation, the treatment team shall certify that a beneficiary requires the services of APH or PH in strict accordance with the beneficiary eligibility requirements set forth in this chapter;

9. After the initial service plan required by N.J.A.C. 10:52A-4.7 has been developed, the treatment team shall examine the beneficiary to determine whether the beneficiary needs APH service. If so, the treatment team shall prepare a certification to that effect at least every 30 days to document that clinical evidence exists for continued stay. With respect to PH services, the treatment team shall examine the beneficiary and, if appropriate, prepare such a certification, every 60 days to document whether clinical evidence exists for continued stay; and

10. APH programs shall maintain affiliation agreements with local psychiatric community designated screening centers and inpatient hospital programs.

10:52A-4.3 Reimbursable and non-reimbursable APH and PH services

(a) Reimbursable APH services are:

1. Psychiatric services in APH:

i. APH providers shall provide a face-to-face, individual encounter with a psychiatrist or an advanced practice nurse a minimum of every other week for at least 15 minutes in APH. More frequent encounters may be required as deemed clinically necessary during all program hours based upon the beneficiaries' symptomatology and acuity;

2. Treatment services and interventions which assist a beneficiary to resolve an immediate crisis and attain stabilization in order to remain in the community through the support of a less intensive service, which include the following:

i. Individual and group therapy to help identify and manage symptoms and interpersonal problems that contribute to a greater risk of decompensation and relapse. This may include clinical approaches, such as Motivational Interviewing, Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT) and Cognitive Remediation/Rehabilitation interventions. Staff-to-client ratio in therapy groups shall not exceed 1:10;

ii. Cognitive behavioral skill-building groups focused on affect regulation, stress management and problem solving to promote independence;

iii. Relapse prevention groups to provide psychoeducation and to teach implementation skills; and

iv. Promotion of the beneficiary's commitment to change problematic behaviors and to follow up with aftercare plans;

3. Medication-related services, as needed, which include the following:

i. Medication counseling and education, as provided in N.J.A.C. 10:37-6.53 and 6.54;

ii. Information regarding, and documentation of, each beneficiary's current medication treatment or therapies;

iii. Procedures by which staff share clinical information regarding medication utilization;

iv. Educating beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and management procedures for responding to crisis situations; and/or

v. Medication education provided within the context of a collaborative and therapeutic relationship. Beneficiaries shall be provided with adequate information in an understandable format regarding a medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support beneficiaries in adhering to their medication regimens. A provider shall specifically review with the beneficiary how medication management issues will impact upon the beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible;

4. Integrated treatment for co-occurring mental health and substance use disorders, which is a distinct clinical approach combining mental health and addiction into a unified, comprehensive and blended philosophy which provides prevention, intervention and treatment techniques which simultaneously address the beneficiary's needs;

5. Assessment and regular monitoring of co-occurring physical health needs to include procurement of medically necessary treatment(s) and services;

6. Beneficiary outreach to facilitate continued participation in the APH program;

7. Integrating the support of family and significant others into a beneficiary's treatment plan;

8. Other planning activities, which may include the development of an advance directive, meeting the requirements of P.L. 2005, c. 233, with specific instructions on what steps need to be taken in the event of a relapse and the development of a personal wellness and recovery action plan;

9. Environmental and safety procedures, which conform with N.J.A.C. 10:37D-2.5 and 10:37F-2.7;

10. Referral procedures for crisis intervention in the event the beneficiary experiences exacerbation of medical or psychiatric symptoms; and

11. An illness management and recovery program, comprised of a broad set of strategies and activities, which help a beneficiary collaborate with practitioners to identify and pursue personally meaningful recovery goals founded upon a core set of interventions that include: psychoeducation, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring and relapse prevention techniques. This is accomplished by helping each beneficiary to develop coping strategies and skills which reduce the beneficiary's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations and reduce distress to the point where the beneficiary is able to enjoy an improved quality of life. The interventions are intended to be both didactic and practical in nature and can be provided in both group and individual settings. Such services shall be provided directly to beneficiaries and in support of family members or other significant individuals important to the beneficiaries. The services shall include, but are not limited to:

i. Coping skills, adaptive problem solving and social skills training, which teach a beneficiary strategies to self-manage symptoms and personal stress and strengthen life skills and abilities to attain his or her recovery goals;

ii. Psycho-education, which provides factual information, recovery practices, including evidence-based models concerning mental illness which instills hope and emphasizes the potential for recovery. Such services shall be geared toward the beneficiary developing a sense of mastery over his or her illness and life, and shall be effective in reducing relapse and rehospitalizations. The services may also provide support to the beneficiary's family and other members of the beneficiary's social network to help them manage the symptoms and illness of the beneficiary and reduce the level of family and social stress associated with the illness;

iii. Development of a comprehensive relapse prevention plan which offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery, including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing and monitoring of stressors which have triggered return of persistent symptoms in the past. In addition, adaptive problem-solving techniques shall be applied to avoid recurrences in the future;

iv. Dual disorder education which provides basic information to beneficiaries, family members or other significant individuals on the nature and impact of substance use and how it relates to the symptoms and experiences of mental illness and its treatment, as well as upon the attainment of the beneficiary's personal recovery goals;

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Each beneficiary shall be provided with adequate information in an understandable format regarding each medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support a beneficiary in adhering to a medication regimen. Practitioners shall specifically review with the beneficiary how medication management issues will impact the beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible; and

vi. Wellness activities consistent with the beneficiary's self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle, lack of physical exercise, overeating or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits.

(b) Reimbursable PH services are:

1. Psychiatric services in PH, which include assessment and ongoing treatment supervision.

i. A face-to-face, individual encounter with a psychiatrist or an advanced practice nurse shall be provided for each beneficiary at least once a month in PH. More frequent encounters may be required as deemed clinically necessary during all program hours based upon the beneficiary's symptomatology and acuity;

2. Counseling and case management services, which include evaluation, service planning and personal intervention;

3. Psychoeducational services for beneficiaries and families, which include mental health and medication education;

4. Prevocational services, as appropriate, directed toward maximizing vocational potential, including work readiness, prevocational experiences, prevocational training and counseling, prevocational assessment and planning. Prevocational services are an array of strategies and interventions that assist the beneficiary in acquiring general work behaviors, attitudes and skills in response to the interests and needs of beneficiaries who are considering, or intending to take on, roles which may be used in other life domains.

i. Prevocational intervention or strategies selected shall be based upon an assessment of the beneficiary's interest, needs, skills and supports and reflected in the beneficiary's Individualized Recovery Plan.

ii. Prevocational activities include, but are not limited to:

(1) Understanding and choosing work settings;

(2) Gathering and researching job information;

(3) Clarifying occupational values and interests;

(4) Defining work preferences;

(5) Identifying personal work criteria;

(6) Exploring barriers to working;

(7) Identifying and defining critical work skills;

(8) Researching personal work supports and resources;

(9) Identifying psychiatric illness management strategies related to working;

(10) Simulated work activities, such as work units to address work hardening, concentration, attendance and other skills; and

(11) Learning methods to respond to criticism, negotiating for needs, dealing with interpersonal issues, and adherence to medication requirements.

iii. Therapeutic subcontract work may be provided within the context of partial hospitalization as prevocational therapy, if already provided by the provider's program as of October 1, 2006.

(1) Therapeutic subcontract work activity shall consist of the production, assembly or packing tasks for compensation obtained by the organization under a contract with a vendor for which individuals with disabilities performing the tasks are paid under a wage and hour certificate, which meets all Federal requirements, typically less than minimum wage.

(2) The beneficiary's Individualized Recovery Plan shall stipulate that the therapeutic subcontract work is a form of intervention intended to address the beneficiary as identified in the beneficiary's assessment.

(3) The therapeutic subcontract work shall be facilitated by a qualified mental health services worker.

(4) The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health service worker.

(5) The staff to consumer ratio shall not exceed a ratio of 1:10 qualified mental health services worker to consumer;

5. Community integration services, such as independent living skills training and goal-oriented cultural activities;

6. Engagement strategy services designed to connect with a beneficiary over time in order to develop a commitment on the beneficiary's part to enter into therapeutic relationships supportive of the beneficiary's recovery. This service may include, but is not limited to, activities, such as initial contacts with potential program participants, as well as continued efforts to engage individuals to participate in program services;

7. Activities designed to assist a beneficiary to identify, achieve and retain personally meaningful life goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments. Examples of such goals include, but are not limited to, returning to work or school, returning to adult care-giving or parenting roles, resuming roles as a spouse or significant other, becoming a member of a religious community or becoming a neighbor;

8. An illness management and recovery program, comprised of a broad set of strategies and activities which help a beneficiary collaborate with practitioners to identify and pursue personally meaningful recovery goals founded upon a core set of interventions which include: psycho-education, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring, and relapse prevention techniques. This is accomplished by helping each beneficiary to develop coping strategies and skills which reduce the beneficiary's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations and reduce distress to the point where the beneficiary is able to enjoy an improved quality of life. They are intended to be both didactic and practical in nature and can be provided in both group and individual settings. Such services shall be provided directly to beneficiaries and in support of family members or other significant individuals important to the beneficiaries. The services shall include, but are not limited to:

i. Coping skills, adaptive problem solving and social skills training, which teach a beneficiary strategies to self-manage symptoms and personal stress and strengthen life skills and abilities to attain his or her recovery goals;

ii. Psycho-education which provides factual information, recovery practices, including evidence-based models concerning mental illness, which instills hope and emphasizes the potential for recovery. Such services shall be geared toward the beneficiary developing a sense of mastery over his or her illness and life, and shall be effective in reducing relapse and rehospitalizations. It may also provide support to the beneficiary's family and other members of the beneficiary's social network to help them manage the symptoms and illness of the beneficiary and reduce the level of family and social stress associated with the illness;

iii. Development of a comprehensive relapse prevention plan which offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery, including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing and monitoring of stressors which have triggered return of persistent symptoms in the past. In addition, adaptive problem-solving techniques shall be applied to avoid recurrences in the future;

iv. Dual disorder education, which provides basic information to beneficiaries, family members or other significant individuals on the nature and impact of substance use and how it relates to the symptoms and experiences of mental illness and its treatment, as well as upon the attainment of the beneficiary's personal recovery goals;

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Each beneficiary shall be provided with adequate information in an understandable format regarding each medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support a beneficiary in adhering to a medication regimen. Practitioners shall specifically review with the beneficiary how medication management issues will impact a beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible; and

vi. Wellness activities consistent with the beneficiary's self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle, lack of physical exercise, overeating or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits;

9. Skill development needed for beneficiary-chosen community environments, facilitating beneficiary-directed recovery and re-integration into community living, learning, working and social roles by developing critical competencies and skills. Skill development may be accomplished through either individual or group instruction; however, the direct staff-to-beneficiary ratio in group activities shall not exceed 1:10. Examples include, but are not limited to, developing:

i. Cognitive skills such as researching and recording information, decision making, identifying preferences and values, selecting clothing, interviewing, scheduling appointments, budgeting, personal nutrition planning, etc.;

ii. Physical skills such as showering, grooming, cooking, cleaning personal space, shopping, taking public transportation, parenting etc.; and

iii. Emotional skills such as negotiating, communicating, asking for help, avoiding risks to sobriety, greeting others, conversing, identifying psychiatric cues, planning for psychiatric emergencies, etc.;

10. Medication-related services, as needed, which include the following:

i. Medication counseling and education, as defined in N.J.A.C. 10:37-6.53 and 6.54;

ii. Knowledge and documentation of each beneficiary's current medication treatment and therapies;

iii. Providing a mechanism for staff to share clinical information regarding medication utilization; and

iv. Education of beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and established procedures for responding to crisis situations;

11. Goal-oriented verbal counseling, which may include individual, group and family modalities to address the emotional, cognitive and behavioral symptoms of mental health illness or to engage, motivate, stabilize and address related effects on role functioning including beneficiaries with a co-occurring mental health and substance use disorder. Goal-oriented verbal counseling may also include motivational interviewing, connecting skills and cognitive behavioral therapy;

12. Age-appropriate learning activities, which are directly tied to the learning of daily living or other community-integration competencies such as financial literacy, basic computer literacy and recognition of directions and safety warnings. Such basic computing, reading or writing skills are considered incidental and not student education;

13. Community integration services, which include independent living skills training, interpersonal skills such as greeting, talking about impersonal topics, conversing, learning about available community cultural opportunities, practicing social interaction, and spiritual and cultural activities;

14. Psychiatric services, which include assessment and ongoing treatment supervision;

15. Other planning activities including the development of an advance directive, which meets the requirements of P.L. 2005, c. 233, with specific instructions on the steps to be taken in the event of a relapse and the development of a personal wellness and recovery action plan (WRAP); and

16. Integrated treatment for co-occurring mental health and substance use disorders, which is a distinct clinical approach combining mental health and addiction into a unified, comprehensive and blended philosophy which provides prevention, intervention and treatment techniques which simultaneously address the beneficiary's needs.

(c) Services which shall not be reimbursed shall include:

1. Vocational services, such as technical occupational skills training, college preparation, individualized job development and marketing to employers;

2. Student education, including preparation of school-assigned class work or homework;

3. Off-site services and activities, unless conducted in accordance with the provisions of this chapter;

4. Transportation, which is not a component of active programming; and

5. Breaks or mealtimes.

(d) Reimbursement for APH and PH services shall be made pursuant to N.J.A.C. 10:52-4.3.

10:52A-4.4 Length and hours of service

(a) Length and hours of service for APH shall be as follows:

1. Initial length of service requests for APH shall not exceed a maximum of seven business days, while awaiting prior authorization (PA) approval.

2. Prior authorization for APH is required every 90 days for up to a maximum of six months per beneficiary.

3. Beneficiaries receiving APH services shall receive no less than two hours of services per day and no more than five hours of services per day. Beneficiaries receiving APH services shall receive a maximum of 25 hours of services per week.

(b) Length of service for PH. PH service is limited to 24 months per beneficiary. However, in calculating this 24-month period, time spent in both PH and APH shall be included.

1. Beneficiaries receiving PH services shall receive no less than two hours of services per day and no more than five hours of services per day. Beneficiaries receiving PH services shall receive a maximum of 25 hours of services per week.

(c) Readmission. At the conclusion of the six-month maximum length of stay, any future readmission to an APH program is permitted only if the readmission meets the eligibility requirements in N.J.A.C. 10:52A-3.1. The initial authorization for readmission shall not exceed a maximum of seven business days while awaiting prior authorization (PA) approval from DMAHS. Prior authorization for readmission to an APH shall be required every 90 days, up to a maximum of six months per beneficiary. In order to be eligible for readmission to PH services, a beneficiary shall be referred by the APH or a designated screening center or be significantly im-

paired such that a need for PH exists, and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions contained in N.J.A.C. 10:52A-3.2(c)1, 2 and 3. Readmission is limited to 24 months per beneficiary. However, in calculating this 24-month period, time spent in both PH and APH shall be included.

10:52A-4.5 Prior authorization for APH services

(a) APH services provided to beneficiaries age 22 years or older require prior authorization for such services. Initial length of service requests for APH shall not exceed a maximum of seven business days, while awaiting prior authorization approval when the beneficiary is referred to adult acute partial hospital service by the local designated screening center or an inpatient psychiatric facility. Following the initial seven business days of service, prior authorization through a DMAHS concurrent utilization process review will be required for the remainder of the time the service is provided. Prior authorization in APH is required every 90 days for up to a maximum of six months.

(b) When requesting prior authorization, Forms FD-07 and FD-07A, "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services" and "Request for Prior Authorization: Supplemental Information" shall be completed and forwarded to the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. (The forms may be obtained through the website www.njmmis.com or by contacting Unisys Provider Relations at 1-800-776-6334.) The "Brief Clinical History" and "Present Clinical Status" sections of the FD-07A "Request for Prior Authorization: Supplemental Information" form are particularly important and shall provide sufficient medical information to justify and support the proposed treatment request. A request for additional information may be made at the discretion of the Medicaid reviewer if the reviewer believes that insufficient medical information has been provided for the Division to make a determination. Failure to comply with such a request may result in a result in a reduction or denial of requested services.

(c) Each request for prior authorization shall reflect the criteria listed in N.J.A.C. 10:52A-3.1.

(d) The notification of the disposition (approved, modified, denied, or suspended) of a prior authorization request will be made by the Division.

10:52A-4.6 Staffing

(a) The APH and PH shall be staffed with personnel, who are licensed, when required, appropriately credentialed, culturally competent and trained to provide APH and PH services as set forth in this chapter. Staff may be engaged on a full time, part time or consulting basis, provided that services are adequate to meet the program needs of participating beneficiaries.

(b) The APH program shall maintain a qualified direct and clinical care staff-to-beneficiary ratio of 1:6 for active programming.

(c) The PH program shall maintain a qualified direct and clinical care staff-to-beneficiary ratio of 1:12 for active programming.

(d) For APH and PH each program shall have:

1. A program director who shall:

i. Have primary responsibility for program operation, development and management;

ii. Possess a professional credential such as:

(1) Licensed clinical social worker;

(2) Licensed professional counselor;

(3) Licensed rehabilitation counselor;

(4) Licensed clinical alcohol and drug counselor;

(5) Licensed psychologist;

(6) Advanced Practice Nurse; or

(7) Master of Science in Nursing with the requisite number of years of experience or possess a master's degree in a human service field and five years experience in mental health services, with two years supervisory experience; or

iii. Be available for crisis consultation and management and for coordination with outside practitioners;

2. A medical director who shall be licensed to practice in the State of New Jersey and be board certified in psychiatry. The medical director must be available to the APH program for sufficient time to oversee all clinical and medical responsibilities;

3. A psychiatrist or advanced practice nurse who shall provide oversight of clinical activity including psychiatric evaluations, medication prescription and individual therapy and shall be available for consultation or emergencies during operation of the program. The Medical Director may also provide this function; and

4. Staff, which shall also include the following, based upon the types of services and the intensity of services required by the beneficiaries:

i. Professional registered nurse(s);

ii. Clinician(s);

iii. Primary case coordinator(s) or counselor(s);

iv. Mental health service worker(s);

v. Qualified addictions staff, as required; and/or

vi. Primary staff providing pre-vocational services.

10:52A-4.7 Intake evaluation

(a) The intake staff in both APH and PH shall assess an applicant's eligibility for services and develop an initial service plan with the beneficiary. All intake procedures shall be guided by a beneficiary's preferences and goals with regard to treatment and community living.

1. The initial contact shall serve to orient and engage a new beneficiary in a culturally and linguistically appropriate manner and facilitate continuity of service.

2. Intake procedures shall be designed to facilitate the beneficiary's program participation at the earliest appropriate opportunity. A lack of completion of the formal intake process shall not preclude an otherwise eligible beneficiary from receiving services.

(b) In order to ensure that there is an adequate basis for a timely and accurate assessment, the provider agency shall develop and maintain written policies and procedures, which require that the following information be documented for all beneficiaries at intake interviews. These procedures shall include requirements for documenting the following:

1. Basic demographic information, including identification of an emergency contact;

2. Presenting problems and reason for referral, including the beneficiary's interests and preferences in achieving valued community living, learning, working or social roles;

3. A medical history, including a brief history of the illnesses, previous services received at an agency and elsewhere, a beneficiary's self-report of responses to previous treatment, a completed current mental status evaluation, medication information, current mental health and social service providers and any allergies;

4. A signed authorization for release of information, in accordance with all applicable legal requirements;

5. Basic family and social supports;

6. Legal information relevant to treatment;

7. Basic substance use information;

8. Basic employment and educational history; and

9. Risk factors (for example, under what circumstances the beneficiary may be a danger to self or others or present a risk of sexually predatory behaviors).

10:52A-4.8 Initial service plan

(a) Within 24 hours of admission, staff shall develop an initial service plan as part of the intake process. The plan shall address the beneficiary's urgent presenting problems in order to meet immediate needs for food, clothing, shelter, medication and safety.

(b) The initial service plan shall be reviewed and approved by a psychiatrist within two business days after completion based upon the professional judgment of the psychiatrist that the treatment specified is clinically appropriate.

(c) Based on the information obtained from the intake interview and assessment, staff shall record the beneficiary's strengths, weaknesses and needs as part of the initial service plan. The beneficiary's urgent presenting problems, including a medication review, shall be evaluated and addressed in the initial service plan.

(d) Staff shall document the initial service plan in the beneficiary's record and staff shall revise it as needed until staff develop an Individualized Recovery Plan.

10:52A-4.9 Comprehensive written assessment

(a) The provider shall develop written procedures that require that every beneficiary receive a comprehensive written assessment, which includes, at a minimum, the assessment of the beneficiary's acute symptomatology, skill and resource strengths and barriers to attainment of the beneficiary's self-expressed goals related to community integration and living, learning, working and social role recovery.

(b) Within 14 business days of the admission of a beneficiary to the APH program, and within 30 days of admission of a beneficiary to the PH program, a comprehensive written assessment shall be completed for the purpose of developing an Individualized Recovery Plan. The comprehensive assessment shall include, at a minimum, the following:

1. Acute symptomatology that requires treatment interventions in order to return the beneficiary to a pre-morbid level of functioning;

2. The beneficiary's interest in, and strengths and goals related to, participation in the program;

3. The beneficiary's functioning including, but not limited to, the ability to make friends and communicate;

4. The beneficiary's emotional and psychological characteristics including, but not limited to, mental status, trauma and abuse history, if applicable, understanding of his or her own illness and coping mechanisms;

5. A review of medical history including, but not limited to, applicable allergic and adverse medication reactions and screening for current physical, emotional, sexual abuse or neglect. If abuse or neglect is identified, staff shall refer the matter to the appropriate authorities, as required by law;

6. The beneficiary's expressed interests, preferences, strengths and goal(s) related to community roles and quality of life;

7. Identification of the beneficiary's strengths and barriers to goal attainment;

8. A social (family) history;

9. A nutritional screening to identify potential health complications and a need for nutritional education;

10. An assessment of cultural preferences;

11. An assessment of spiritual preferences;

12. A legal assessment, if applicable, assessing the beneficiary's legal history and any current relevant legal issues relating to the beneficiary;

13. An assessment of educational and vocational issues or needs, if applicable;

14. Community resources needed to help the beneficiary achieve the identified goals and objectives. Staff members shall document alternative services identified and not provided by the psychiatric acute partial hospital program and shall refer the beneficiary to the appropriate service(s);

15. An assessment of the beneficiary's emotional and psychological functioning including, but not limited to, mental status and understanding of his or her own illness, and coping mechanisms;

16. An assessment of activities of daily living including, but not limited to, transportation, budgeting, self-medication and hygiene; and

17. Living arrangements, including housing, entitlements and subsidies.

(c) Assigned staff shall sign, date and maintain all assessment and evaluation documentation in the beneficiary's file.

(d) Assigned staff from the interdisciplinary treatment team shall make reasonable efforts to involve the family and significant others in the assessment process to the extent possible.

10:52A-4.10 Individualized Recovery Plan

(a) The interdisciplinary treatment team shall develop an Individualized Recovery Plan for each beneficiary participating in an APH and PH program. The Individualized Recovery Plan shall address urgent problems or barriers which staff have prioritized from the comprehensive assessment and, to the greatest extent possible, effectuate agreement and mutual understanding between the beneficiary and the program staff.

(b) In each APH program, staff shall formulate the Individualized Recovery Plan and implement it at the completion of the comprehensive assessment, but no later than 14 business days after the beneficiary's admission to the program. In each PH program, staff shall formulate the Individualized Recovery Plan and implement it at the completion of the comprehensive assessment, but no later than six weeks after the beneficiary's admission to the program.

(c) In each APH program, assigned staff from the interdisciplinary treatment team shall document in the Individualized Recovery Plan the beneficiary's progress toward treatment objectives and his or her response to interventions, and shall revise and update the Individualized Recovery Plan every 30 days. In each PH program, assigned staff from the interdisciplinary treatment team shall document in the Individualized Recovery Plan the beneficiary's progress toward treatment objectives and his or her response to interventions, and shall revise and update the Individualized Recovery Plan every 90 days for the first year and every 180 days thereafter.

(d) The Individualized Recovery Plan shall:

1. Be written in language which can be easily understood by the beneficiary;

2. Contain the signatures of the beneficiary, primary case coordinator or counselor and direct care staff supervisor. The beneficiary's signature on the Individualized Recovery Plan shall indicate that the beneficiary was involved in the formulation of the plan or that the beneficiary reviewed and approved of the plan. In the event that the beneficiary is not involved in the development of the plan or the beneficiary does not agree with any part of the plan, his or her lack of participation or disagreement shall be documented in the comments section of the Individualized Recovery Plan;

3. Contain the direction of the course of treatment;

4. Contain the psychiatrist's or advanced practice nurse's signature, which shall reflect agreement with the direction of the course of treatment;

5. Contain the beneficiary's self-stated overall goals and objectives related to chosen, valued role(s) and specific plans to achieve these roles, with target dates for achievement, including further in-depth and ongoing assessment in the identified areas;

6. List specific interventions, strategies and activities to implement the Individualized Recovery Plan, including clear reference to necessary off-site services to assist in the transfer of learning;

7. Identify the staff responsible for implementing each intervention; and

8. Contain a comment section under which the beneficiary states in his or her own words any concerns, agreements or disagreements with either the development or final Individualized Recovery Plan.

(e) The adult APH and PH program shall include the beneficiary and family (with consent) participation in service planning. To assure family participation in developing the Individualized Recovery Plan and revisions, the program staff shall seek input from family members at each service planning milestone, provided that the beneficiary has given written consent to release information related to the treatment of his or her mental illness.

(f) The beneficiary shall attend treatment team meetings to discuss progress and potential plan revisions. Staff shall document the beneficiary's involvement in the record.

(g) The treatment team shall document any progress after each Individualized Recovery Plan meeting.

(h) Following completion of the Individualized Recovery Plan, the treatment team shall develop an active treatment schedule which addresses the issues identified in the comprehensive assessment.

10:52A-4.11 Documentation requirements for APH and PH

(a) The APR and PH programs shall maintain a comprehensive signature log, signed by each beneficiary, which reflects the beneficiary's daily participation in the program.

(b) Each APH program shall provide daily documentation for each beneficiary in the program. Each PH program shall provide weekly documentation for each beneficiary in the program. Documentation shall include, but not be limited to:

1. A summary of the beneficiary's participation in therapies or activities and clinical progress;

2. A description of any significant events which may have an effect on the beneficiary's achievement of his or her stated goals and objectives; and

3. Treatment plan revisions, which shall be based on the beneficiary's response to treatment plan interventions.

(c) Each progress note entry into the beneficiary's record shall be legible, signed, dated and shall include staff title and credentials.

(d) A record of participation by the beneficiary shall be maintained by an assigned group facilitator.

(e) Each provider shall make all records available for review by the Department.

10:52A-4.12 Discharge planning for APH and PH

(a) A discharge plan shall be initiated by the interdisciplinary treatment team, with beneficiary participation, at the time of admission and shall be updated with the Individualized Recovery Plan.

(b) The discharge plan shall consist of relevant, measurable goals and objectives to assist the beneficiary in accomplishing his or her discharge plan.

(c) The discharge plan shall be implemented when the beneficiary's functioning or symptomatology has improved as evidenced by scores on the Global Assessment of Functioning Scale.

(d) The discharge plan shall be implemented when the beneficiary meets the criteria for, has need for, or could benefit from, more or less intensive level of service or has achieved significant accomplishment of established goals and objectives.

(e) A discharge summary shall be written within 10 days of the beneficiary's discharge, termination or transfer from the program and shall be maintained thereafter in the beneficiary's record. The summary shall include, but need not be limited to, the following:

1. The beneficiary's presenting problem;

2. The beneficiary's admission date and date of termination from the program;

3. The course of treatment and the beneficiary's responses;

4. The reason for termination; and

5. The beneficiary's current medications.

(f) The discharge planner shall send a copy of the discharge plan to all identified receiving providers.

10:52A-4.13 Quality assurance and outcome review

(a) Each APH and PH program shall maintain an established Quality Assurance Plan for the program to improve performance and treatment outcomes.

(b) Quality assurance indicators shall be based on beneficiary-identified issues and high risk factors.

(c) The Quality Assurance Plan shall be reviewed and updated annually.

(d) A copy of the Quality Assurance Plan shall be sent to the appropriate Medical Assistance Customer Center annually.

10:52A-4.14 Off-site services

(a) Off-site interventions may be provided, as long as the beneficiary is accompanied or supervised by staff.

1. The off-site interventions shall be:

i. Individualized for each beneficiary and non-stigmatizing;

ii. Integrated as a subordinate component of the beneficiary's Individualized Recovery Plan, which clearly describes each specific off-site intervention and how the intervention relates to the overall achievement of the beneficiary's specific goals and objectives in the Individualized Recovery Plan, particularly in assisting beneficiaries to apply skills learned to community settings.

iii. Properly documented in the beneficiary's record to include when the off-site activity commenced and terminated; and

iv. Limited to a defined and measurable period of time.

v. Services which are solely recreational or diversional in nature shall not be considered an APH or PH activity.

(b) Off-site services provided shall average less than 10 percent of each APH and PH program beneficiary's average active programming time in APH and PH during the previous month. If off-site activities are greater than 10 percent additional justification is required in the beneficiary's record and shall be subject to program audit by the Division. In no case may the time be more than 20 percent.

1. The beneficiary must sign in at the site of the APH or PH program prior to participating in any off-site activity and sign out of the program after completion of the off-site activity.

2. Transportation to and from an off-site activity shall not be counted as billable time for a beneficiary unless:

i. A qualified clinical staff member is in the vehicle functioning as a counselor;

ii. There are no more than four clients in the vehicle or, if there are more than four clients in the vehicle, a second staff person accompanies the clinical staff member and functions as the driver; and

iii. The clinical staff conducts activities for the beneficiary during the period of transportation which meet all of the requirements for reimbursable activities of the program.

10:52A-4.15 Quality assurance reviews

(a) DMAHS shall conduct quality assurance reviews of all hospital-based mental health programs annually or more frequently, as required by DMAHS if deficiencies in the program are identified by DMAHS staff.

(b) DMAHS shall notify a program of any noncompliance findings revealed during the quality assurance review within 20 days of the review having been completed.

(c) A program shall respond in writing to any notification of findings within 30 days of notice.

(d) The program response shall include a corrective action plan to address and prevent all incidences of non-compliance.

(e) The corrective action plan shall include, but may not be limited to:

1. A timeline detailing remediation of noncompliance issues;

2. A detailed description of those steps determined necessary by the provider to ensure compliance with the corrective plan; and

3. Individuals and titles responsible for ensuring compliance with that plan.

(f) DMAHS shall review the corrective action plan submitted by the program. If the corrective action plan does not adequately address the deficiencies identified in a quality assurance review, DMAHS shall return the plan to the program for revision. Any program deficiencies identified by DMAHS shall be rectified by the program within 30 days of receipt.

(g) DMAHS has the authority to restrict and/or terminate program admissions of NJ FamilyCare/Medicaid or Work First New Jersey (WFNJ)/General Assistance (GA) beneficiaries because of provider noncompliance with Medicaid standards, such as, but not limited to, actions taken by DMHS, quality assurance reviews conducted by DMAHS and immediate health and safety concerns.

(h) Programs may be subject to follow-up visits by DMAHS staff based on the outcome of quality assurance reviews conducted by DMAHS.

10:52A-4.16 Termination of program

Each hospital that discontinues an APH or PH program shall do so in an orderly fashion. Each hospital shall comply with all applicable closure and pre-closure requirements contained in State and Federal statutes, laws, rules and regulations. Additionally, the hospital shall notify the DMAHS Office of Provider Relations in writing at least 60 days in advance of the actual closing. The hospital shall develop a plan which specifies and provides referral for mental health services that are needed to provide for the present and future mental health needs of each beneficiary.

SUBCHAPTER 5. BENEFICIARY RIGHTS AND RESPONSIBILITIES

10:52A-5.1 Beneficiary rights

(a) At the time of admission to an APH or PH program, program staff shall present and explain to each beneficiary all rights of the beneficiary under all applicable State and Federal statutes, laws, rules and regulations, as well as under all relevant hospital policies.

(b) A signed, witnessed statement shall be recorded in the beneficiary's record to the effect that the beneficiary's rights have been explained to the beneficiary.

(c) The psychiatric APH and PH program shall post, and advocate for, the beneficiary's exercise of rights.

(d) Any actions by staff to promote or assist the beneficiary in exercising his or her rights shall be clearly documented in the beneficiary's record.

CHAPTER 53

(RESERVED)

Chapter Historical Note

Chapter 53, Manual for Special Hospital Services, was filed and became effective April 27, 1990, as R.1990 d. 256. See: 22 N.J.R. 765(a), 22 N.J.R. 1598(c). Chapter 53 expired on April 27, 1995, pursuant to Executive Order 66 (1978).

CHAPTER 53A

HOSPICE SERVICES MANUAL

Authority

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

Source and Effective Date

R.2008 d.226, effective July 9, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 53A, Hospice Services Manual, expires on July 9, 2015. See: 43 N.J.R. 1203(a).

Chapter Historical Note

Chapter 53A, Hospice Services Manual, was adopted as R.1992 d.442, effective November 2, 1992. See: 24 N.J.R. 2778(a), 24 N.J.R. 4036(a).

Pursuant to Executive Order No. 66(1978), Chapter 53A, Hospice Services Manual, was readopted as R.1997 d.479, effective October 20, 1997. See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

Chapter 53A, Hospice Services Manual, was readopted as R.2003 d.100, effective February 4, 2003. See: 34 N.J.R. 2679(a), 35 N.J.R. 1277(a).

As a part of R.2003 d.320, effective August 4, 2003, Subchapter 3, Recipient Requirements, was renamed Subchapter 3, Beneficiary Requirements. See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).

Chapter 53A, Hospice Services Manual, was readopted as R.2008 d.226, effective July 9, 2008. As a part of R.2008 d.226, Subchapter 5, Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS), was renamed Healthcare Common Procedure Coding System (HCPCS), effective August 4, 2008. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

Law Review and Journal Commentaries

A Hospice Primer. Dianne Rosen, 190 N.J.L.J. 12 (1998).

10:53A-1.1 Introduction

(a) Reimbursement for hospice services provided by Medicaid was authorized pursuant to § 1905(o) of the Social Security Act, codified as 42 U.S.C. § 1396d(o). N.J.S.A. 30:4D-6b(20) authorizes the New Jersey Division of Medical Assistance and Health Services to develop a program of hospice services. This chapter, N.J.A.C. 10:53A, Hospice Services, sets forth the rules for the provision of hospice services to the terminally ill who are eligible for Medicaid/NJ FamilyCare fee-for-service (FFS) program. Room and board services are also available for those Medicaid /NJ FamilyCare FFS beneficiaries residing in a nursing facility who are also 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).

(b) This chapter provides the rules for hospice services for Medicaid/NJ FamilyCare FFS beneficiaries who are not en-

rolled in, and receiving services through, a health maintenance organization (HMO). Hospice services provided to a beneficiary who is enrolled with an HMO are governed by the policies of the HMO and are not within the purview of these rules.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended U.S.C. references.
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.

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 and an unlimited number of subsequent 60-day periods.

"CAP" means a limitation on the payment amount or aggregate days of inpatient care as imposed by Medicaid/NJ FamilyCare FFS program 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/NJ FamilyCare FFS beneficiaries residing in a nursing facility, and services unrelated to the terminal illness that may be provided by Medicaid/NJ FamilyCare FFS as part of the hospice plan of care. The comprehensive hospice benefit does not include hospice services under ACCAP or any other waiver program.

"DHSS" means the New Jersey Department of Health and Senior Services.

"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/NJ FamilyCare FFS 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/NJ FamilyCare FFS services are forfeited when choosing hospice services; the individual or his or her representative's acknowledgment 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).

"Eligibility determining agency" means the agency responsible for determining a beneficiary's financial eligibility for hospice services. These agencies include the medical assistance customer centers, the county boards of social services and the Division of Youth and Family Services. These agencies determine financial eligibility after medical necessity has been certified. See N.J.A.C. 10:53A-3 for details.

"Hospice," for the purposes of the New Jersey Medicaid/NJ FamilyCare FFS program (hereafter referred to as the Program), means a public agency or private organization (or subdivision of such organization) which is licensed by the Department of Health and Senior Services as a provider of hospice services consistent with P.L. 1997, c.78; 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, as well as any other item or service, as specified in the beneficiary's plan of care, which is reimbursed by the Medicaid/NJ FamilyCare FFS program. Hospice providers in New Jersey may be hospital-based or home health agencies, or hospice agencies.

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

"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 employed by or under contract with 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 and who is employed by or under contract with the hospice.

"Medicare-certified hospice program" means a public/private organization which provides hospice care, as described in 42 U.S.C. § 1395x(dd), in individual homes, on an outpatient basis and on a short-term inpatient basis.

"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 beneficiaries in a nursing facility (identical to those provided to non-hospice beneficiaries 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.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended "Hospice"; and added "Medicare-certified hospice program".
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Amended "Benefit period", "CAP", "Comprehensive hospice benefits", "Election of Hospice Benefits Statement", "Hospice", "Hospice indicator", "Interdisciplinary group", "Medical Director", and "Room and board services".
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
Added definitions "DHSS" and "Eligibility determining agency".

10:53A-1.3 Contracting with physicians

Effective August 5, 1997, hospice providers are no longer required to routinely provide all physician services directly. Medical directors and physician members of the interdisciplinary group (IDG) are no longer required to be employed by the hospice. These physicians can now be under contract with the hospice.

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

SUBCHAPTER 2. PROVIDER REQUIREMENTS

10:53A-2.1 Hospice enrollment requirements and billing processes

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

1. Be licensed by the Department of Health and Senior Services as a provider of hospice services in accordance with N.J.A.C. 8:42C. A copy of the license must be submitted to the Division of Medical Assistance and Health Services;

2. Be enrolled as a Medicare (Title XVIII) hospice provider. A copy of the Medicare provider enrollment agreement must be submitted to the Division of Medical Assistance and Health Services;

i. As stated in the Social Security Act, Section 1861(d)(d)(2)(A)(ii) (42 U.S.C. § 1395x(dd)) on Medicare certification, the term "hospice program" means a public or private organization which provides for such care in individuals' homes, on an outpatient basis, and on a short-term inpatient basis. Thus, a Medicare certified hospice shall not limit or market hospice services exclusively to a long term care facility population; and

3. Complete and submit the Medicaid "Provider Application" (FD-20); "Ownership and Controlling Interest Statement" (CMS-1513); and the "Medicaid Provider Agreement" (FD-62).

i. Documents specific to provider enrollment, referenced in (a)3 above, are located as Forms #8, #9, and #10 in the Appendix of the Administration chapter (N.J.A.C. 10:49—Appendix), and may be obtained from and submitted to:

Unisys Corporation
Provider Enrollment
PO Box 4804
Trenton, New Jersey 08650-4804

ii. Hospice provider agreements are approved by the:

Unisys Corporation
Provider Enrollment
PO Box 4804
Trenton, New Jersey 08650-4804

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/NJ FamilyCare FFS hospice beneficiary'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/NJ FamilyCare FFS beneficiary residing in a nursing facility (NF), the nursing facility must be a Medicaid/NJ

FamilyCare FFS-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 beneficiaries in an NF (identical to those provided to non-hospice beneficiaries 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 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 beneficiary he or she must be an approved Medicaid/NJ FamilyCare FFS physician provider (see Physician Services chapter, N.J.A.C. 10:54).

(f) The fiscal agent shall furnish a provider manual to the hospice enrolled as a Medicaid/NJ FamilyCare FFS provider.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Inserted new (a)1; recodified existing (a)1 and (a)2 as (a)2 and (a)3; and inserted new (a)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 (a)3, substituted "CMS" for "HCFA".

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

(a) In order for a hospice beneficiary 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 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 to the medical assistance customer center (MACC), county board of social services (CBOSS) or Division of Youth and Family Services (DYFS), as applicable, in order to change providers. (See Form #6, the Hospice Eligibility Form, FD-383, in the Appendix in this chapter, incorporated herein by reference and N.J.A.C. 10:53A-3.2 for the policy for medical and financial eligibility for Medicaid/NJ FamilyCare FFS.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
In (a)3, deleted "(6/92)" following the first occurrence of "FD-383" and "(5/01)" following the second occurrence of "FD-383", and substituted "medical assistance customer center" for "Medical Assistance Customer Center" and "county board of social services" for "County Board of Social Services".

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/NJ FamilyCare FFS beneficiary at the time the beneficiary elects to receive hospice services as the primary physician in the determination and the delivery of the beneficiary's medical care.

2. The written Physician Certification/Recertification for Hospice Benefits Form, FD-385 (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 beneficiary revokes the 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 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 each subsequent 60-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 each subsequent 60-day benefit period, as described below:

i. An additional Physician Certification/Recertification for Hospice Benefits Form, FD-385 must be obtained prior to each subsequent 60-day 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 on file for review by the Division in the beneficiary's medical record.

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

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 employed by or under contract with 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 beneficiary's attending physician;

3. Periodic review and updating of the plan of care for each beneficiary 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 beneficiary.

(d) A hospice beneficiary, 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 beneficiary.

(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.

Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
In (b), substituted "employed by or under contract with" for "employees of" preceding "the hospice"; substituted "beneficiary" for "recipient" throughout.

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

(a) If a beneficiary 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 CBOSS and the DHSS field office, a completed Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient LTC-2 (Form #9 in the Appendix, incorporated herein by reference) to prompt a change in the beneficiary's status. For SSI beneficiaries, the hospice shall be responsible for notifying the

MACC of the beneficiary's death or discharge from the NF by completing FD-383 (Appendix Form #6). The MACC will be responsible for notifying the Social Security Administration of the beneficiary's change in status.

(b) If the beneficiary 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 beneficiary 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 beneficiary is removed from the Long Term Care Facility billing system effective on the date the Election of Hospice Benefits Statement, FD-378 (Appendix Form #1) is signed. On that date and thereafter, the Medicaid/NJ FamilyCare fiscal agent will directly reimburse the hospice for services rendered to the hospice beneficiary 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 beneficiary 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 (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.

Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote (a); in (b)1, inserted "/NJ FamilyCare" following "Medicaid" in the second sentence; substituted "beneficiary" for "recipient" throughout.
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
In (a), substituted "LTC-2" for "(MCNH-33)" and deleted "(5/01)" following "FD-383"; and in (b), substituted "beneficiary" for "patient".

10:53A-2.6 Recordkeeping

(a) The medical record of the hospice beneficiary 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).

Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
In (a), in main paragraph substituted "beneficiary" for "recipient".

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/NJ FamilyCare FFS beneficiaries selected for a quality assurance review.

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

i. Number of beneficiaries;

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

iii. Number of days of service per beneficiary 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

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Each beneficiary shall be provided with adequate information in an understandable format regarding each medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support a beneficiary in adhering to a medication regimen. Practitioners shall specifically review with the beneficiary how medication management issues will impact the beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible; and

vi. Wellness activities consistent with the beneficiary's self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle, lack of physical exercise, overeating or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits.

(b) Reimbursable PH services are:

1. Psychiatric services in PH, which include assessment and ongoing treatment supervision.

i. A face-to-face, individual encounter with a psychiatrist or an advanced practice nurse shall be provided for each beneficiary at least once a month in PH. More frequent encounters may be required as deemed clinically necessary during all program hours based upon the beneficiary's symptomatology and acuity;

2. Counseling and case management services, which include evaluation, service planning and personal intervention;

3. Psychoeducational services for beneficiaries and families, which include mental health and medication education;

4. Prevocational services, as appropriate, directed toward maximizing vocational potential, including work readiness, prevocational experiences, prevocational training and counseling, prevocational assessment and planning. Prevocational services are an array of strategies and interventions that assist the beneficiary in acquiring general work behaviors, attitudes and skills in response to the interests and needs of beneficiaries who are considering, or intending to take on, roles which may be used in other life domains.

i. Prevocational intervention or strategies selected shall be based upon an assessment of the beneficiary's interest, needs, skills and supports and reflected in the beneficiary's Individualized Recovery Plan.

ii. Prevocational activities include, but are not limited to:

(1) Understanding and choosing work settings;

(2) Gathering and researching job information;

(3) Clarifying occupational values and interests;

(4) Defining work preferences;

(5) Identifying personal work criteria;

(6) Exploring barriers to working;

(7) Identifying and defining critical work skills;

(8) Researching personal work supports and resources;

(9) Identifying psychiatric illness management strategies related to working;

(10) Simulated work activities, such as work units to address work hardening, concentration, attendance and other skills; and

(11) Learning methods to respond to criticism, negotiating for needs, dealing with interpersonal issues, and adherence to medication requirements.

iii. Therapeutic subcontract work may be provided within the context of partial hospitalization as prevocational therapy, if already provided by the provider's program as of October 1, 2006.

(1) Therapeutic subcontract work activity shall consist of the production, assembly or packing tasks for compensation obtained by the organization under a contract with a vendor for which individuals with disabilities performing the tasks are paid under a wage and hour certificate, which meets all Federal requirements, typically less than minimum wage.

(2) The beneficiary's Individualized Recovery Plan shall stipulate that the therapeutic subcontract work is a form of intervention intended to address the beneficiary as identified in the beneficiary's assessment.

(3) The therapeutic subcontract work shall be facilitated by a qualified mental health services worker.

(4) The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health service worker.

(5) The staff to consumer ratio shall not exceed a ratio of 1:12 qualified mental health services worker to consumer;

5. Community integration services, such as independent living skills training and goal-oriented cultural activities;

6. Engagement strategy services designed to connect with a beneficiary over time in order to develop a commitment on the beneficiary's part to enter into therapeutic relationships supportive of the beneficiary's recovery. This service may include, but is not limited to, activities, such as initial contacts with potential program participants, as well as continued efforts to engage individuals to participate in program services;

7. Activities designed to assist a beneficiary to identify, achieve and retain personally meaningful life goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments. Examples of such goals include, but are not limited to, returning to work or school, returning to adult care-giving or parenting roles, resuming roles as a spouse or significant other, becoming a member of a religious community or becoming a neighbor;

8. An illness management and recovery program, comprised of a broad set of strategies and activities which help a beneficiary collaborate with practitioners to identify and pursue personally meaningful recovery goals founded upon a core set of interventions which include: psycho-education, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring, and relapse prevention techniques. This is accomplished by helping each beneficiary to develop coping strategies and skills which reduce the beneficiary's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations and reduce distress to the point where the beneficiary is able to enjoy an improved quality of life. They are intended to be both didactic and practical in nature and can be provided in both group and individual settings. Such services shall be provided directly to beneficiaries and in support of family members or other significant individuals important to the beneficiaries. The services shall include, but are not limited to:

i. Coping skills, adaptive problem solving and social skills training, which teach a beneficiary strategies to self-manage symptoms and personal stress and strengthen life skills and abilities to attain his or her recovery goals;

ii. Psycho-education which provides factual information, recovery practices, including evidence-based models concerning mental illness, which instills hope and emphasizes the potential for recovery. Such services shall be geared toward the beneficiary developing a sense of mastery over his or her illness and life, and shall be effective in reducing relapse and rehospitalizations. It may also provide support to the beneficiary's family and other members of the beneficiary's social network to help them manage the symptoms and illness of the beneficiary and reduce the level of family and social stress associated with the illness;

iii. Development of a comprehensive relapse prevention plan which offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery, including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing and monitoring of stressors which have triggered return of persistent symptoms in the past. In addition, adaptive problem-solving techniques shall be applied to avoid recurrences in the future;

iv. Dual disorder education, which provides basic information to beneficiaries, family members or other significant individuals on the nature and impact of substance use and how it relates to the symptoms and experiences of mental illness and its treatment, as well as upon the attainment of the beneficiary's personal recovery goals;

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Each beneficiary shall be provided with adequate information in an understandable format regarding each medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support a beneficiary in adhering to a medication regimen. Practitioners shall specifically review with the beneficiary how medication management issues will impact a beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible; and

vi. Wellness activities consistent with the beneficiary's self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle, lack of physical exercise, overeating or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits;

9. Skill development needed for beneficiary-chosen community environments, facilitating beneficiary-directed recovery and re-integration into community living, learning, working and social roles by developing critical competencies and skills. Skill development may be accomplished through either individual or group instruction; however, the direct staff-to-beneficiary ratio in group activities shall not exceed 1:12. Examples include, but are not limited to, developing:

i. Cognitive skills such as researching and recording information, decision making, identifying preferences and values, selecting clothing, interviewing, scheduling appointments, budgeting, personal nutrition planning, etc.;

ii. Physical skills such as showering, grooming, cooking, cleaning personal space, shopping, taking public transportation, parenting etc.; and

iii. Emotional skills such as negotiating, communicating, asking for help, avoiding risks to sobriety, greeting others, conversing, identifying psychiatric cues, planning for psychiatric emergencies, etc.;

10. Medication-related services, as needed, which include the following:

i. Medication counseling and education, as defined in N.J.A.C. 10:37-6.53 and 6.54;

ii. Knowledge and documentation of each beneficiary's current medication treatment and therapies;

iii. Providing a mechanism for staff to share clinical information regarding medication utilization; and

iv. Education of beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and established procedures for responding to crisis situations;

11. Goal-oriented verbal counseling, which may include individual, group and family modalities to address the emotional, cognitive and behavioral symptoms of mental health illness or to engage, motivate, stabilize and address related effects on role functioning including beneficiaries with a co-occurring mental health and substance use disorder. Goal-oriented verbal counseling may also include motivational interviewing, connecting skills and cognitive behavioral therapy;

12. Age-appropriate learning activities, which are directly tied to the learning of daily living or other community-integration competencies such as financial literacy, basic computer literacy and recognition of directions and safety warnings. Such basic computing, reading or writing skills are considered incidental and not student education;

13. Community integration services, which include independent living skills training, interpersonal skills such as greeting, talking about impersonal topics, conversing, learning about available community cultural opportunities, practicing social interaction, and spiritual and cultural activities;

14. Psychiatric services, which include assessment and ongoing treatment supervision;

15. Other planning activities including the development of an advance directive, which meets the requirements of P.L. 2005, c. 233, with specific instructions on the steps to be taken in the event of a relapse and the development of a personal wellness and recovery action plan (WRAP); and

16. Integrated treatment for co-occurring mental health and substance use disorders, which is a distinct clinical approach combining mental health and addiction into a unified, comprehensive and blended philosophy which provides prevention, intervention and treatment techniques which simultaneously address the beneficiary's needs.

(c) Services which shall not be reimbursed shall include:

1. Vocational services, such as technical occupational skills training, college preparation, individualized job development and marketing to employers;

2. Student education, including preparation of school-assigned class work or homework;

3. Off-site services and activities, unless conducted in accordance with the provisions of this chapter;

4. Transportation, which is not a component of active programming; and

5. Breaks or mealtimes.

(d) Reimbursement for APH and PH services shall be made pursuant to N.J.A.C. 10:52-4.3.

Amended by R.2012 d.050, effective March 5, 2012.
See: 43 N.J.R. 2112(a), 44 N.J.R. 594(a).
In (b)4iii(5) and (b)9, substituted "1:12" for "1:10".

10:52A-4.4 Length and hours of service

(a) Length and hours of service for APH shall be as follows:

1. Initial length of service requests for APH shall not exceed a maximum of seven business days, while awaiting prior authorization (PA) approval.

2. Prior authorization for APH is required every 90 days for up to a maximum of six months per beneficiary.

3. Beneficiaries receiving APH services shall receive no less than two hours of services per day and no more than five hours of services per day. Beneficiaries receiving APH services shall receive a maximum of 25 hours of services per week.

(b) Length of service for PH. PH service is limited to 24 months per beneficiary. However, in calculating this 24-month period, time spent in both PH and APH shall be included.

1. Beneficiaries receiving PH services shall receive no less than two hours of services per day and no more than five hours of services per day. Beneficiaries receiving PH services shall receive a maximum of 25 hours of services per week.

(c) Readmission. At the conclusion of the six-month maximum length of stay, any future readmission to an APH program is permitted only if the readmission meets the eligibility requirements in N.J.A.C. 10:52A-3.1. The initial authorization for readmission shall not exceed a maximum of seven business days while awaiting prior authorization (PA) approval from DMAHS. Prior authorization for readmission to an APH shall be required every 90 days, up to a maximum of

six months per beneficiary. In order to be eligible for readmission to PH services, a beneficiary shall be referred by the APH or a designated screening center or be significantly impaired such that a need for PH exists, and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions contained in N.J.A.C. 10:52A-3.2(c)1, 2 and 3. Readmission is limited to 24 months per beneficiary. However, in calculating this 24-month period, time spent in both PH and APH shall be included.

10:52A-4.5 Prior authorization for APH services

(a) APH services provided to beneficiaries age 22 years or older require prior authorization for such services. Initial length of service requests for APH shall not exceed a maximum of seven business days, while awaiting prior authorization approval when the beneficiary is referred to adult acute partial hospital service by the local designated screening center or an inpatient psychiatric facility. Following the initial seven business days of service, prior authorization through a DMAHS concurrent utilization process review will be required for the remainder of the time the service is provided. Prior authorization in APH is required every 90 days for up to a maximum of six months.

(b) When requesting prior authorization, Forms FD-07 and FD-07A, "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services" and "Request for Prior Authorization: Supplemental Information" shall be completed and forwarded to the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. (The forms may be obtained through the website www.njmmis.com or by contacting Unisys Provider Relations at 1-800-776-6334.) The "Brief Clinical History" and "Present Clinical Status" sections of the FD-07A "Request for Prior Authorization: Supplemental Information" form are particularly important and shall provide sufficient medical information to justify and support the proposed treatment request. A request for additional information may be made at the discretion of the Medicaid reviewer if the reviewer believes that insufficient medical information has been provided for the Division to make a determination. Failure to comply with such a request may result in a result in a reduction or denial of requested services.

(c) Each request for prior authorization shall reflect the criteria listed in N.J.A.C. 10:52A-3.1.

(d) The notification of the disposition (approved, modified, denied, or suspended) of a prior authorization request will be made by the Division.

10:52A-4.6 Staffing

(a) The APH and PH shall be staffed with personnel, who are licensed, when required, appropriately credentialed, culturally competent and trained to provide APH and PH services as set forth in this chapter. Staff may be engaged on a full time, part time or consulting basis, provided that services are adequate to meet the program needs of participating beneficiaries.

(b) The APH program shall maintain a qualified direct and clinical care staff-to-beneficiary ratio of 1:6 for active programming.

(c) The PH program shall maintain a qualified direct and clinical care staff-to-beneficiary ratio of 1:15 for active programming.

(d) For APH and PH each program shall have:

1. A program director who shall:

i. Have primary responsibility for program operation, development and management;

ii. Possess a professional credential such as:

(1) Licensed clinical social worker;

(2) Licensed professional counselor;

(3) Licensed rehabilitation counselor;

(4) Licensed clinical alcohol and drug counselor;

(5) Licensed psychologist;

(6) Advanced Practice Nurse; or

(7) Master of Science in Nursing with the requisite number of years of experience or possess a master's degree in a human service field and five years experience in mental health services, with two years supervisory experience; or

iii. Be available for crisis consultation and management and for coordination with outside practitioners;

2. A medical director who shall be licensed to practice in the State of New Jersey and be board certified in psychiatry. The medical director must be available to the APH program for sufficient time to oversee all clinical and medical responsibilities;

3. A psychiatrist or advanced practice nurse who shall provide oversight of clinical activity including psychiatric evaluations, medication prescription and individual therapy and shall be available for consultation or emergencies during operation of the program. The Medical Director may also provide this function; and

4. Staff, which shall also include the following, based upon the types of services and the intensity of services required by the beneficiaries:

i. Professional registered nurse(s);

ii. Clinician(s);

iii. Primary case coordinator(s) or counselor(s);

iv. Mental health service worker(s);

v. Qualified addictions staff, as required; and/or

vi. Primary staff providing pre-vocational services.

Amended by R.2012 d.050, effective March 5, 2012.
See: 43 N.J.R. 2112(a), 44 N.J.R. 594(a).
In (c), substituted "1:15" for "1:12".

10:52A-4.7 Intake evaluation

(a) The intake staff in both APH and PH shall assess an applicant's eligibility for services and develop an initial service plan with the beneficiary. All intake procedures shall be guided by a beneficiary's preferences and goals with regard to treatment and community living.

1. The initial contact shall serve to orient and engage a new beneficiary in a culturally and linguistically appropriate manner and facilitate continuity of service.

2. Intake procedures shall be designed to facilitate the beneficiary's program participation at the earliest appropriate opportunity. A lack of completion of the formal intake process shall not preclude an otherwise eligible beneficiary from receiving services.

(b) In order to ensure that there is an adequate basis for a timely and accurate assessment, the provider agency shall develop and maintain written policies and procedures, which require that the following information be documented for all beneficiaries at intake interviews. These procedures shall include requirements for documenting the following:

1. Basic demographic information, including identification of an emergency contact;

2. Presenting problems and reason for referral, including the beneficiary's interests and preferences in achieving valued community living, learning, working or social roles;

3. A medical history, including a brief history of the illnesses, previous services received at an agency and elsewhere, a beneficiary's self-report of responses to previous treatment, a completed current mental status evaluation, medication information, current mental health and social service providers and any allergies;

4. A signed authorization for release of information, in accordance with all applicable legal requirements;

5. Basic family and social supports;

6. Legal information relevant to treatment;

7. Basic substance use information;

8. Basic employment and educational history; and

9. Risk factors (for example, under what circumstances the beneficiary may be a danger to self or others or present a risk of sexually predatory behaviors).

10:52A-4.8 Initial service plan

(a) Within 24 hours of admission, staff shall develop an initial service plan as part of the intake process. The plan shall address the beneficiary's urgent presenting problems in order to meet immediate needs for food, clothing, shelter, medication and safety.

(b) The initial service plan shall be reviewed and approved by a psychiatrist within two business days after completion based upon the professional judgment of the psychiatrist that the treatment specified is clinically appropriate.

(c) Based on the information obtained from the intake interview and assessment, staff shall record the beneficiary's strengths, weaknesses and needs as part of the initial service plan. The beneficiary's urgent presenting problems, including a medication review, shall be evaluated and addressed in the initial service plan.

(d) Staff shall document the initial service plan in the beneficiary's record and staff shall revise it as needed until staff develop an Individualized Recovery Plan.

10:52A-4.9 Comprehensive written assessment

(a) The provider shall develop written procedures that require that every beneficiary receive a comprehensive written assessment, which includes, at a minimum, the assessment of the beneficiary's acute symptomatology, skill and resource strengths and barriers to attainment of the beneficiary's self-expressed goals related to community integration and living, learning, working and social role recovery.

(b) Within 14 business days of the admission of a beneficiary to the APH program, and within 30 days of admission of a beneficiary to the PH program, a comprehensive written assessment shall be completed for the purpose of developing an Individualized Recovery Plan. The comprehensive assessment shall include, at a minimum, the following:

1. Acute symptomatology that requires treatment interventions in order to return the beneficiary to a pre-morbid level of functioning;

2. The beneficiary's interest in, and strengths and goals related to, participation in the program;

3. The beneficiary's functioning including, but not limited to, the ability to make friends and communicate;

4. The beneficiary's emotional and psychological characteristics including, but not limited to, mental status, trauma and abuse history, if applicable, understanding of his or her own illness and coping mechanisms;

5. A review of medical history including, but not limited to, applicable allergic and adverse medication reactions and screening for current physical, emotional, sexual abuse or neglect. If abuse or neglect is identified, staff shall refer the matter to the appropriate authorities, as required by law;

6. The beneficiary's expressed interests, preferences, strengths and goal(s) related to community roles and quality of life;

7. Identification of the beneficiary's strengths and barriers to goal attainment;

8. A social (family) history;

9. A nutritional screening to identify potential health complications and a need for nutritional education;

10. An assessment of cultural preferences;

11. An assessment of spiritual preferences;

12. A legal assessment, if applicable, assessing the beneficiary's legal history and any current relevant legal issues relating to the beneficiary;

13. An assessment of educational and vocational issues or needs, if applicable;

14. Community resources needed to help the beneficiary achieve the identified goals and objectives. Staff members shall document alternative services identified and not provided by the psychiatric acute partial hospital program and shall refer the beneficiary to the appropriate service(s);

15. An assessment of the beneficiary's emotional and psychological functioning including, but not limited to, mental status and understanding of his or her own illness, and coping mechanisms;

16. An assessment of activities of daily living including, but not limited to, transportation, budgeting, self-medication and hygiene; and

17. Living arrangements, including housing, entitlements and subsidies.

(c) Assigned staff shall sign, date and maintain all assessment and evaluation documentation in the beneficiary's file.

(d) Assigned staff from the interdisciplinary treatment team shall make reasonable efforts to involve the family and significant others in the assessment process to the extent possible.

10:52A-4.10 Individualized Recovery Plan

(a) The interdisciplinary treatment team shall develop an Individualized Recovery Plan for each beneficiary participating in an APH and PH program. The Individualized Recovery Plan shall address urgent problems or barriers which staff have prioritized from the comprehensive assessment and, to the greatest extent possible, effectuate agreement and mutual understanding between the beneficiary and the program staff.

(b) In each APH program, staff shall formulate the Individualized Recovery Plan and implement it at the completion of the comprehensive assessment, but no later than 14 business days after the beneficiary's admission to the program. In each PH program, staff shall formulate the Individualized Recovery Plan and implement it at the completion of the comprehensive assessment, but no later than six weeks after the beneficiary's admission to the program.

(c) In each APH program, assigned staff from the interdisciplinary treatment team shall document in the Individualized Recovery Plan the beneficiary's progress toward treatment objectives and his or her response to interventions, and shall revise and update the Individualized Recovery Plan every 30 days. In each PH program, assigned staff from the interdisciplinary treatment team shall document in the Individualized Recovery Plan the beneficiary's progress toward treatment objectives and his or her response to interventions, and shall revise and update the Individualized Recovery Plan every 90 days for the first year and every 180 days thereafter.

(d) The Individualized Recovery Plan shall:

1. Be written in language which can be easily understood by the beneficiary;

2. Contain the signatures of the beneficiary, primary case coordinator or counselor and direct care staff supervisor. The beneficiary's signature on the Individualized Recovery Plan shall indicate that the beneficiary was involved in the formulation of the plan or that the beneficiary reviewed and approved of the plan. In the event that the beneficiary is not involved in the development of the plan or the beneficiary does not agree with any part of the plan, his or her lack of participation or disagreement shall be documented in the comments section of the Individualized Recovery Plan;

3. Contain the direction of the course of treatment;

4. Contain the psychiatrist's or advanced practice nurse's signature, which shall reflect agreement with the direction of the course of treatment;

5. Contain the beneficiary's self-stated overall goals and objectives related to chosen, valued role(s) and specific plans to achieve these roles, with target dates for achievement, including further in-depth and ongoing assessment in the identified areas;

6. List specific interventions, strategies and activities to implement the Individualized Recovery Plan, including clear reference to necessary off-site services to assist in the transfer of learning;

7. Identify the staff responsible for implementing each intervention; and

8. Contain a comment section under which the beneficiary states in his or her own words any concerns, agreements or disagreements with either the development or final Individualized Recovery Plan.

(e) The adult APH and PH program shall include the beneficiary and family (with consent) participation in service planning. To assure family participation in developing the Individualized Recovery Plan and revisions, the program staff shall seek input from family members at each service planning milestone, provided that the beneficiary has given written consent to release information related to the treatment of his or her mental illness.

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/NJ FamilyCare FFS services which are not duplicative of hospice services may be covered by Medicaid/NJ FamilyCare FFS for the hospice beneficiary. 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 a hospice beneficiary by Medicaid/NJ FamilyCare FFS approved PCA providers. (See N.J.A.C. 10:60-1.7, 1.8 and 1.9, concerning Home Care Services). 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 beneficiaries 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).
Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.

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

(a) The hospice beneficiary, by signing the Election of Hospice Benefits Statement, FD-378 (6/92) agrees to waive most regular Medicaid/NJ FamilyCare FFS services. However, Medicaid/NJ FamilyCare FFS covered services unrelated to the terminal illness, included in the plan of care, may be provided by approved Medicaid/NJ FamilyCare FFS 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/NJ FamilyCare FFS beneficiaries.

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 unlimited number of subsequent 60-day periods beyond 180 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 an unlimited number of 60-day periods of hospice services is anticipated, the hospice shall document in the beneficiary's medical record, the approval of this period by the interdisciplinary team at the beginning of the first 60-day 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 each benefit period.

(c) The documentation of the approval of unrelated services and each subsequent 60-day period shall be filed in the beneficiary's medical record with the copy of the claim form and be made available upon request for post-payment review purposes.

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-3.6 Plan of care

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

1. All services provided to each hospice beneficiary 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 beneficiary's medical record.

4. The plan shall include the assessment of the beneficiary'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 beneficiary and the family shall be stated in detail in the plan of care and appropriately documented in the medical record.

Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" throughout.

10:53A-3.7 Provision for beneficiary fair hearings

Pursuant to N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings, Medicaid/NJ FamilyCare FFS beneficiaries 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).
Substituted "/NJ FamilyCare FFS beneficiaries" for "recipients" following "Medicaid".

SUBCHAPTER 4. BASIS OF PAYMENT

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

(a) For a hospice beneficiary 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 ACCAP. For these beneficiaries, 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 standards for Title XIX approved facilities (see N.J.A.C. 10:71-5).

(b) For a beneficiary who is residing in a nursing facility and receiving hospice under Medicaid/NJ FamilyCare FFS, payment to the hospice for room and board services shall be reduced by the beneficiary's available income. Available income is that amount, which remains after deducting certain amounts from the beneficiary'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 PR-1 Form #10 in the Appendix, incorporated herein by reference, are as follows:

i. The hospice is responsible for ensuring that the amount of the beneficiary's available income is reported and that the amount corresponds to that attributed to the beneficiary's account on the Statement of Available Income for Medicaid Payment PR-1. The hospice shall be liable to the Division for any available income not reported to the fiscal agent by the hospice. A PR-1 table, that is maintained by the fiscal agent, will be referenced during claims processing to determine the PR-1 amount to be deducted from the hospice claims during claims processing.

ii. The Statement of Available Income for Medicaid Payment PR-1 is completed by the CBOSS on each non-SSI Medicaid/NJ FamilyCare FFS beneficiary that receives hospice services, who is a hospice beneficiary residing in the NF.

(1) The PR-1 form reflects the beneficiary'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 PR-1 form must be attached to a copy of the CMS 1500 claim, and be kept in the beneficiary's billing record when requesting payment from Medicaid/NJ FamilyCare FFS 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 beneficiary.

(3) The PR-1 form shall be obtained by the hospice from the NF for each beneficiary 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 beneficiary and/or family.

(4) For the hospice applicant who has not previously been on the Long Term Care Facility billing system as an NF patient, the CBOSS shall generate the PR-1 form for the use of the hospice.

(5) 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 PR-1 form is required upon admission to hospice care status.

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

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

(c) Regarding adjustments to the PR-1, the CBOSS is required to report all changes of income on an amended PR-1 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 PR-1 form will reflect those changes for the applicable month(s).

2. The beneficiary and/or the family are required to report all changes of available income to the CBOSS. Additionally, the hospice should report any changes in financial circumstances to the CBOSS. For those changes which impact on available income, a new PR-1 form must be generated by the CBOSS, indicating the month for which the change is effective.

3. When an amended PR-1 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 CMS 1500 claim and also in the beneficiary billing record at the hospice.

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

(d) The hospice shall receive the PR-1 completed by the CBOSS according to the following instructions for when the available income is applied: For any full or part of a calendar month in hospice care status, all available income shown on the PR-1 form shall be applied to the cost of the care except as indicated in (d)1 through 4 below.

1. The instructions in this paragraph apply on admission from a nursing facility. For the beneficiary 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 PR-1 form is generated by the CBOSS but a copy of the PR-1 form must be obtained from the NF and kept in the patient's record. The hospice must certify to this fact in the beneficiary'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)"

The fiscal agent shall deduct the PR-1 amount from the first claim submitted for a beneficiary by either an NF or hospice provider for any calendar month. For example, when the first claim received by the fiscal agent is submitted by a hospice for services provided in an NF, the PR-1 amount will be applied to the fullest extent possible. PR-1 amounts not exhausted by hospice claims for NF room and board services for a beneficiary for any given month will be applied to NF claims for the same beneficiary for the same calendar month and vice versa.

2. The instructions in this paragraph apply on admission from the community. For a hospice beneficiary admitted from the community, an exemption for verified living expenses is permitted in computing available income. An amended PR-1 form shall be generated from the CBOSS 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 beneficiaries who are returning to hospice care from the hospital.)

3. In reviewing the PR-1 form to determine what income should be applied to a billing month, the effective date in each of the numbered columns (PR-1 #1, #2, and #3) shall be carefully checked. This is particularly significant for hospice beneficiaries 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 PR-1 form when the beneficiary 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 PR-1 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 beneficiary. Exceptions to this general policy are indicated in (d)4ii through v below.

ii. For the hospice beneficiary 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 PR-1 form by the CBOSS. When the PR-1 form does not reflect the reduction, contact the CBOSS to effect the change.

iii. For the hospice beneficiary 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 CMS 1500 claim shall be so annotated in the "REMARKS" area stating "Beneficiary expired on (date)—income not available for use." A notation on the billing record shall be made that the hospice provider returned the check to the hospice beneficiary's estate.

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

v. For the hospice beneficiary who is admitted to nursing facility care (in the same or in a different NF) after being discharged from the hospice, the hospice shall notify the NF of the amount of the patient's available income that was applied to the hospice's room and board bill in the discharge month, so that the NF may accurately reflect the balance amount of the NF admission month billing. The following is directed to the hospice for informational purposes only: The nursing facility will also complete an LTC-2 form and attach a copy of the CMS 1500 claim (copy only to CBOSS) to notify the CBOSS, MACC, and the Department of Health and Senior Services, Long-Term Care Field Office of the admission of the hospice patient from hospice care to NF care. The amount of the patient's available income that was applied to the hospice room and board care should be calculated on the CMS 1500 claim form so that a new PR-1 form can be issued for the month of admission to 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).
In (d)4iii, added requirement for notation on the billing record of returned checks.
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
Substituted "CMS" for "HCFA" throughout; in the introductory paragraph of (b), inserted a comma following "amount"; in (b)1i, deleted the former second sentence and inserted the last sentence; in the introductory paragraph of (b)1ii, inserted a comma following "services"; deleted former (b)1ii(3); recodified former (b)1ii(4) through (b)1ii(6) as (b)1ii(3) through (b)1ii(5); in (c)1, substituted "PR-1" for "PA-3L"; in the introductory paragraph of (d), deleted "and subtracted from the per diem charge on the HCFA 1500 claim," following "cost of the care"; in (d)1, added the second paragraph; in (d)4iii, substituted "beneficiary's" for "recipient's"; and in (d)4v, substituted "notify the NF of" for "provide the NF with a copy of the HCFA 1500 claim indicating", "Long-Term" for "Long Term" and "PR-1" for "PA-3L".

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 beneficiary's plan of care according to the methodology and indices in section 1814(i)(1)(C)(ii), 1814(i)(2)(B), and 1814(i)(2)(D) of the Social Security Act.

1. One of the four predetermined, cost-related prospective payment rates subject to the "cap" amounts (see N.J.A.C. 10:53A-1.2 for definition of "cap") is reimbursed for each day the beneficiary is receiving hospice services (see N.J.A.C. 10:53A-4.4 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 related to the per diem 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/homemaker services, physical therapy, occupational therapy, and speech-language pathology services. The "routine home care rate" is also reimbursed to the hospice 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 beneficiary is not receiving "continuous home care rate" 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 beneficiary's acute medical symptoms and only as necessary to maintain the beneficiary 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 con-

tinuous 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 beneficiary is in an approved inpatient facility (nursing facility or general hospital) receiving respite care. The beneficiary 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 beneficiary dies as an inpatient. When the beneficiary 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/NJ FamilyCare FFS 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 hospice "inpatient respite care rate" is not reimbursed to the nursing facility for care provided to nursing facility patients that are not Medicaid/NJ FamilyCare FFS hospice patients of a Medicaid/NJ FamilyCare participating hospice. Thus, even though the hospice patients are residing in a nursing facility, the provider shall consider the beneficiary, for reimbursement purposes, a hospice patient, not a nursing facility patient.

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 beneficiaries 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 beneficiary's condition is such that it is no longer possible to maintain the beneficiary 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 beneficiary dies as an inpatient. In this situation, when the beneficiary 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/NJ FamilyCare FFS 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/NJ FamilyCare FFS hospice beneficiaries at the specific Medicaid participating NF where the hospice beneficiary 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 Medicaid/NJ FamilyCare FFS hospice beneficiary residing in a NF is not a beneficiary of the nursing facility (NF) but a hospice beneficiary.)

i. The room and board rate is calculated at 95 percent of the 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 for private and county nursing facilities. The "approved Medicaid NF per diem rate effective at the time services are provided," means the rate that was effective for the date of service, and shall not include any subsequent retroactive rate adjustments made between the date of service and the date of claim submission. After the NF's room and board rate is calculated, the patient's total available income shall be deducted to determine the rate billed to the Medicaid program. The NF contracts with the hospice to accept the beneficiary based on actual room and board components provided to the beneficiary by the NF. The provider number and name of the nursing facility where the beneficiary resides and with whom the hospice contracts must be placed in the "REMARKS" area of the CMS 1500 claim.

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

Department of Health and Senior Services
Division of Senior Benefits and Utilization
Office of Nursing Facility Rate Setting and Reimbursement
PO Box 715
Trenton, New Jersey 08625

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 beneficiaries 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 beneficiaries 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 Centers for Medicare and Medicaid Services (CMS) (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 CMS.

1. A hospice program shall submit claims for payment for hospice routine home care and continuous home care furnished in an individual's home based on the geographic location at which the service is furnished, that is, the county in which the beneficiary's home is located, rather than the location of the service provider's business office.

2. A hospice program shall submit claims for payment for hospice routine home care and continuous home care provided to a beneficiary whose permanent residence is a nursing facility based on the geographic location at which the service is furnished; that is, the county in which the nursing facility is located, rather than the location of the service provider's business office.

3. A hospice program shall submit claims for payment for hospice inpatient respite care and general inpatient care, which is furnished in an approved inpatient facility based on the geographic location at which the service is furnished, that is, the county in which the approved inpatient facility is located, rather than the location of the service provider's business office.

4. The regional designation of a provider for wage adjustment purposes will be determined by the location at which the hospice service is provided to the beneficiary.

5. 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 beneficiary. 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/NJ FamilyCare FFS beneficiaries during the period of election, regardless of the setting in which the services are provided.

1. Hospices shall not charge Medicaid/NJ FamilyCare beneficiaries directly for Medicare coinsurance amounts.

(f) For beneficiaries at home who are dually eligible for both Medicare and Medicaid, and who are receiving Medicare hospice benefits, the hospice may bill the Medicaid fiscal agent for the five percent co-payment for outpatient drugs and biologicals on the CMS 1500 claim.

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 CMS 1500 claim filed in the beneficiary'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 CMS 1500 claim submitted to the Medicaid fiscal agent.

(g) For beneficiaries 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 Medicare 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 CMS 1500 claim filed in the beneficiary'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 CMS 1500 claim to the fiscal agent.

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

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

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

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
In (a)1, amended N.J.A.C. references; in (b)3iii, added the second sentence; and in (c)1i inserted the second sentence.
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
Substituted "CMS" for "HCFA" throughout; in (c)1i, inserted the second sentence; added new (d)2 and (d)3; recodified former (d)2 and (d)3 as (d)4 and (d)5; in (d)4, substituted "at which the hospice service is provided to the beneficiary" for "of the main business office of the hospice provider".

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

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

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

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

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

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

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

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

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

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

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

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
In the introductory paragraph of (b), substituted "CMS" for "HCFA"; and in (d)1, deleted "(2/02)" following "FD-378".

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

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

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

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

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

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

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

iii. If the total number of days of inpatient care exceeds the maximum allowable number, the amount of the limitation will be determined by:

(1) 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);

(2) Multiplying the excess inpatient care days by the routine home care rate;

(3) Adding the amounts determined in the calculations of (b)1iii(1) and (2) above; and

(4) Comparing the amount in (b)1iii(3) above with interim payments made to the hospice for inpatient care during the "cap period."

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

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

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Deleted (c).
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.
Administrative correction.
See: 42 N.J.R. 1200(a).

10:53A-4.5 Submitting claims for payment

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

(b) Documents needed specifically for the administration of the Hospice Care Program are Forms #1 through #10 located in the Appendix at the end of this chapter and may be obtained by writing to the following address:

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

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

SUBCHAPTER 5. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:53A-5.1 Introduction

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

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

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

(d) The rates marked with an asterisk are adjusted for regional differences in wages, in accordance with 42 CFR 418.306, using indices based on regions listed initially in the

Federal statute as referenced in (b) above. Specific directions for calculating individual hospice rates for the four levels of hospice care (routine, continuous, inpatient respite and general inpatient care); for the co-payment for inpatient respite care; and for the annual update of the rates and the wage indices, can be found in the Federal Register, published annually, in accordance with 42 CFR 418.306, or by contacting the United States Department of Health and Human Services, Centers for Medicare and Medicaid Administration.

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
In (d), rewrote the second sentence and deleted the third sentence.
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote the section.
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
In (a), substituted "Centers for Medicare & Medicaid Services' Healthcare" for "Health Care Financing Administration's (HCFA)" and inserted "fee-for-service".

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

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

*T2042	ROUTINE HOME CARE RATE Per diem rate, calculated as referenced in N.J.A.C. 10:53A-5.1(d) and 4.2(b)1 and (d)1.
*T2043	CONTINUOUS HOME CARE RATE Per diem rate, calculated as referenced in N.J.A.C. 10:53A-5.1(d) and 4.2(b)2 and (d)1.
*T2044	INPATIENT RESPITE CARE RATE Per diem rate, calculated and adjusted annually in N.J.A.C. 10:53A-4.2(d) and 4.4.
*T2045	GENERAL INPATIENT CARE RATE Per diem rate, calculated and adjusted annually and limited according to N.J.A.C. 10:53A-4.2(b)3 and (d).
T2046	ROOM AND BOARD RATE Per diem rate, calculated and adjusted annually as referenced in N.J.A.C. 10:53A-4.2(c) and (d).
Y6337	THERAPEUTIC LEAVE DAYS Per diem rate, calculated, and annually adjusted, as referenced in N.J.A.C. 10:53A-4.2(c)1ii and (d).
Y6338	BED RESERVATION DAYS RATE Per diem rate, calculated and adjusted annually as referenced in N.J.A.C. 10:53A-4.2(c)1ii and (d).
Y6339	HOSPICE RESPITE CO-PAYMENT Per diem rate, as referenced in N.J.A.C. 10:53A-4.2(g).
Y6343	DRUG AND BIOLOGICALS CO-PAYMENT Reimbursed as referenced in N.J.A.C. 10:53A-4.2(f).

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended N.J.A.C. references.
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
In "ROUTINE HOME CARE RATE" and "CONTINUOUS HOME CARE RATE", revised N.J.A.C. references.
Amended by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).
Rewrote the table.

APPENDIX A

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

FORM #1

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

ELECTION OF HOSPICE BENEFITS STATEMENT

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

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

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

I may request volunteer services from the hospice.

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

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

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

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

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

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

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

Check one:

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

[ ] I am not a Medicare beneficiary.

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

_____

Facility Name/Address

_____

_____

_____

Signature of the Applicant

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

APPENDIX B

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. The Fiscal Agent Billing Supplement can be downloaded free of charge from: www.njmmis.com. When revisions are made to the Fiscal Agent Billing Supplement, a revised version will be posted on www.njmmis.com and copies will be filed with the Office of Administrative Law. If you do not have access to the internet and require a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation
PO Box 4801
Trenton, New Jersey
08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey
08625-0049

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Recodified from Appendix II and 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, inserted the second sentence, and substituted "a revised version will be posted on www.njmmis.com" for "replacement pages will be distributed to providers" in the third sentence and "If you do not have access to the internet and require" for "For" in the last sentence.

APPENDIX I

(RESERVED)

Amended by R.1997 d.479, effective November 17, 1997.
See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).
Amended by R.2003 d.320, effective August 4, 2003.
See: 34 N.J.R. 2899(a), 35 N.J.R. 3568(a).
Rewrote Forms #1 and #2.
Repealed by R.2008 d.226, effective August 4, 2008.
See: 40 N.J.R. 1582(a), 40 N.J.R. 4578(a).

APPENDIX II

(RESERVED)

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