

necessary for the size of the facility and needs of the beneficiaries.

7. In compliance with Federal and State rules and regulations, the facility shall provide, at least quarterly, to the beneficiary and/or his or her authorized representative, an accounting of all transactions with regard to the PNA account. The amount of balance in the beneficiary's account shall be available for the beneficiary and/or his or her authorized representative on request.

8. Management of funds shall be as follows:

i. For beneficiaries who are able to manage their funds, a family member must have authorization in writing from the beneficiary/authorized representative for a specific amount before funds are disbursed from the PNA.

ii. Beneficiaries who are unable to manage their funds should have representative payees appointed.

iii. Family members should withdraw funds only on presentation of receipts showing items purchased for the beneficiary, unless this appears to be a financial hardship for the family member.

iv. In cases where there is an outside representative payee, and the beneficiary appears to be denied access to his or her PNA funds, or personal items are not being purchased for him or her, the facility shall take steps to ensure that the beneficiary's right to his or her PNA benefits is restored. Such steps may include warning letters to the representative payee, use of the NF attorney, and/or referrals to the Office of the Ombudsman for Institutionalized Elderly and the Social Security Administration. In such cases, the facility may wish to request representative payeeship.

9. When drawing checks or cash to make disbursements from the beneficiary's PNA account, either an original invoice or a signed receipt from the beneficiary or an authorized representative shall be retained by the facility and referenced to the beneficiary's account. The receipt must stipulate the use of the funds or specify the items purchased.

10. When the facility draws checks on behalf of a beneficiary or reimburses the petty cash fund, disbursements of PNA shall be segregated from the operating expenses of the facility. At the end of each month, the general ledger control account shall be charged for the total PNA disbursed and each beneficiary's subsidiary ledger account shall reflect the monthly disbursements on that beneficiary's behalf.

11. Accumulated interest is the property of the beneficiary. Although a beneficiary's PNA may not be used for banking service charges, interest from the account may be used for this purpose.

12. Upon discharge or transfer to another NF or other place of residence, the facility shall provide the beneficiary with a final accounting statement and a check in the amount of the beneficiary's close-out balance within seven working days of the transfer; however, a beneficiary transferred to another NF shall be given the option of authorizing the sending facility in writing to transfer any balance to the beneficiary's account at the receiving facility. The transfer of a PNA account from one facility to another shall be documented in writing, with a copy given to the beneficiary and/or his or her authorized representative. A beneficiary discharged or transferred shall have the right to the return of his or her personal property, such as, television, radio or other items.

13. Unclaimed PNA funds left behind by a discharged beneficiary who cannot be located or where the authorized representative cannot be located, shall be forwarded within 30 days to the Bureau of Administrative Control, Mail Code #6, PO Box 712, Trenton, New Jersey 08625-0712.

14. Within 10 days after the death of a Medicaid beneficiary, whether death occurred in the NF, in a hospital, or during a period of therapeutic leave, the NF shall send a written notice regarding the existence of PNA funds both to the CWA and the individual identified by the beneficiary as the person to contact. A NF shall exercise all reasonable efforts to locate and notify any family, representative payee or interested person acting on behalf of the deceased Medicaid beneficiary.

i. The facility shall advise the contact person or responsible person that any claims made for PNA funds must be directed to the NF. When no CWA claim exists, the executor(rix) or administrator(rix), upon presentation of a letter of administration from the County Surrogate's Office, must be issued a check made payable to the estate of the deceased Medicaid beneficiary for the PNA funds. A check for the funds shall not be issued unless a Surrogate's letter is presented, except when a beneficiary dies intestate, leaving no surviving spouse, and the total value of the estate is less than \$ 5,000; in such case, an affidavit of administration in accordance with N.J.S.A. 3B:10-4 is acceptable.

ii. If there is an outstanding funeral bill which is deemed reasonable and there is no claim by the CWA or an executor/administrator, the NF may directly reimburse the funeral director from the PNA funds.

iii. If no claim for PNA funds is made to the NF within 30 days of death, a check made payable to the "Treasurer, State of New Jersey" shall be forwarded to the Bureau of Administrative Control, Mail Code #6, PO Box 712, Trenton, New Jersey 08625-0712. The following information shall be included:

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

(2) Beneficiary's name;

- (3) HSP (Medicaid) Case Number;
- (4) Date of death; and
- (5) Amount enclosed for that beneficiary.

iv. If a claim is received by the NF after the PNA funds have been forwarded to the Bureau of Administrative Control and within five years of the Medicaid beneficiary's death, the claim must be referred to the Bureau for processing. After five years, all claims received by the NF must be referred to the State Treasurer.

v. Any transactions involving distribution of a deceased Medicaid beneficiary's PNA funds must appear on the NF's record for audit purposes.

(g) Questions regarding personal needs allowance administration, for example, procedures, policy, or use of funds, should be directed to the Department:

Division of Long Term Care Services  
PO Box 367  
Trenton, New Jersey 08625-0367

Recodified from N.J.A.C. 10:63-1.16 and amended by R.2005 d.389, effective January 17, 2006.  
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).  
Rewrote the section.

#### Case Notes

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

#### 8:85-1.17 Residents rights

(a) The NF shall ensure that each resident and his or her representative are informed of their rights upon admission and provided with a written statement of all resident rights, in accordance with 42 CFR 483.10 through 483.15, the Nursing Home Resident Rights Act, N.J.S.A. 30:13-1 et seq. and N.J.A.C. 8:39-4.1.

(b) The NF shall ensure that every resident who is entitled to Medicaid benefits shall receive a written statement of the services covered in the Medicaid per diem rate, those services required to be offered by the NF on an as-needed basis, and any charges not covered under the Medicaid program while in the facility.

(c) The NF shall notify each resident of his or her right under State law to make decisions concerning his or her medical care and his or her right to formulate an advance directive in compliance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., and the advance directive provisions of the Omnibus Reconciliation Act of 1990, effective December 1, 1991 and

Department of Health and Senior Services licensing requirements at N.J.A.C. 8:39-9.5.

Recodified from N.J.A.C. 10:63-1.17 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (c), added "or her" following "his", substituted "N.J.S.A. 26:2H-53 et seq.," for "P.L. 1991, c.201", and added "and Senior Services".

#### 8:85-1.18 Medicaid/Medicare

(a) The New Jersey Medicaid Program will reimburse for NF services provided to combination Medicare/Medicaid beneficiaries only after Medicare covered benefits have been fully utilized or when medically necessary services are not covered by the Medicare Program. (Exceptions—see (f)1i below.)

1. A facility shall begin to bill Medicare for eligible residents immediately upon receipt of Medicare certification.

2. Failure by a facility to bill Medicare for Medicare/Medicaid eligible residents who meet the criteria for Medicare reimbursement for long-term care services, and who occupy Medicare certified beds may result in the termination of a facility's Medicaid provider agreement.

(b) Only skilled nursing facilities (SNFs), as defined in N.J.A.C. 8:85-1.2, certified by the Centers for Medicare & Medicaid Services (CMS) and the New Jersey Department of Health and Senior Services are eligible to be reimbursed by Medicare for services rendered consistent with all Medicare requirements.

(c) Medicare covers eligible beneficiaries needing post-hospital skilled nursing care when they are placed in Medicare certified facilities.

(d) Medicare-eligible residents shall be placed in Medicare certified beds. If no Medicare certified beds are vacant at the time a Medicare-eligible person is admitted, a nursing facility patient who is occupying a Medicare certified bed but who is not eligible for Medicare reimbursement, may be relocated to allow the newly admitted patient to occupy a Medicare certified bed. In accordance with 42 C.F.R. 483.10(o), such relocation shall only occur when the individual agrees to the relocation. The nursing facility shall provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer. If consent is not granted, Medicaid shall reimburse the nursing facility for a timely submitted claim reimbursable under Medicaid rules.

(e) When Medicare benefits are denied, terminated or exhausted, because of coverage limitations, Medicaid may be billed on behalf of eligible beneficiaries, provided that:

1. The services are allowable and provided within the standards and procedures established by the New Jersey Medicaid program as described in this manual. Medicaid shall reimburse a nursing facility if Medicare does not pay the claim and the claim is Medicaid reimbursable.