2. Prior authorization requests for special medical equipment shall be accompanied by documentation from the attending physician, the registered professional nurse who has primary responsibility for the recipient, and appropriate rehabilitative therapy personnel, which relates the medical necessity for the equipment and describes the extraordinary requirements of the recipient.

3. Pressure relief systems shall be reimbursed in a NF under the following conditions:

i. Air Fluidized and Low Air Loss therapy beds, as defined in N.J.A.C. 10:63–1.2, shall be considered special medical equipment and shall be prior authorized for reimbursement in a NF only when all of the following criteria, indicating medical necessity, are documented by the physician.

(1) The recipient has two stage III (full-thickness tissue loss) pressure sores or a stage IV (deep tissue destruction) pressure sore which involves two of the following sites: hips, buttocks, sacrum.

(2) The recipient with coexisting risk factors (such as vascular irregularities, nutritional depletion, diabetes or immune suppression) presents post-operatively with a posterior or lateral flap or graft site requiring short-term therapy until the operative site is viable.

(3) The recipient is bedridden or chair-bound as a result of severely limited mobility.

(4) The recipient is receiving maximal medical/nursing care, prior instituted conservative treatment has been unsuccessful and all other alternative equipment has been considered and ruled out.

(5) The bed is ordered, in writing, by the attending physician based on his or her comprehensive assessment (which includes a physical examination) and evaluation of the recipient.

(6) Prior authorization in conditions other than those defined above shall be considered on an individual basis by the MDO.

ii. Air fluidized and low air loss therapy beds shall not be covered for reimbursement in a NF under any of the following circumstances:

(1) As a preventative measure;

(2) After healing to stage II has occurred or wound stability (no significant change or evidence of healing) has been achieved;

(3) If the facility structure cannot support the weight of the bed or the facility electrical system is insufficient for the anticipated increase in energy consumption, air fluidized therapy shall be considered inappropriate. Reimbursement for an air fluidized bed shall be limited to the equipment itself. Payment shall not be made for architectural adjustments such as electrical or structural improvement.

iii. Prior authorization of air fluidized or low air loss therapy beds, if approved, shall be granted for 30 days only. Continued use beyond the initial approval period shall require prior authorization on a monthly basis. The following information shall be submitted to the MDO to obtain prior authorization:

(1) A completed FD–354 prior authorization form;

(2) The physicians' written prescription;

(3) A medical history relating to the wound which includes previous therapy and pressure relief systems utilized and found unsuccessful;

(4) Physician progress notes indicating medical necessity, plan of treatment and evaluation of response to treatment specific to the care of the wound;

(5) The wound care flow sheet documenting weekly the site, size, depth and stage of the wound, noting also the presence and description of drainage or odor;

(6) Laboratory values including a complete blood count and blood chemistries initially and on request thereafter;

(7) A nutritional assessment by a registered dietitian initially on request thereafter; and

(8) Photographs of the site upon permission of the recipient/family, after full due consideration is afforded to the recipient's right to privacy, dignity and confidentiality.

iv. After treatment with an air fluidized or low air loss therapy bed is initiated, the recipient shall:

(1) Be examined by the physician on a monthly basis;

(2) Remain on the therapy unit and be confined to bed, unless medically necessary. While confined to bed, due consideration shall be given to the recipient's need for social and sensory stimulation and recreational diversion by providing in-room visitation and social/recreational activities appropriate to the recipient's condition; and

(3) Be repositioned on a turning schedule of not less than every two hours.

v. Professional staff from the MDO may, at their discretion, perform an onsite visit to evaluate the recipient prior to or after therapy has been instituted. Continued approval shall be contingent upon the facility's compliance with the criteria and conditions defined in (d)3i, ii, iii and iv above and cooperation of the recipient to the therapeutic modality.

**Case Notes**

Nursing home resident was not entitled to Medicaid funds for wheelchair which nursing home was obligated to provide to Medicaid

resident. S.C. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 54.

No Medicaid payment was allowable for more costly wheelchair for nursing home resident where suitable wheelchairs were available and more costly chair was not authorized for reimbursement. S.C. v. DMAHS, 96 N.J.A.R.2d (DMA) 20.

**10:63–2.16 Consultant services; general**

If the NF has significant, unresolved or recurring problems, the NF shall be required to provide appropriate consultation in any service area until the problems are corrected.

**10:63–2.17 Transportation services**

(a) The NF shall assist a Medicaid recipient in obtaining transportation when the recipient requires a Medicaid-covered service or care not regularly provided by the NF.

(b) If a transportation service is provided by the NF to an inpatient of the NF, no additional reimbursement shall be allowed. Reimbursement shall be included in the per diem rate.

(c) Ambulance service shall not require authorization from the MDO, but shall be reimbursable to the transportation provider only when the use of any other method of transportation is medically contraindicated. (See N.J.A.C. 10:50–1.3(c)2 for specific conditions for ambulance service reimbursement.)

(d) Invalid coach services shall not require prior authorization from the MDO.

1. Invalid coach services shall be provided by a transportation provider approved in accordance with N.J.A.C. 10:50, Transportation Services.

2. An invalid coach may be utilized when a Medicaid recipient requires transportation from place to place for the purpose of obtaining a Medicaid-covered service and when the use of an alternative mode of transportation, such as a taxi, bus, livery, or private vehicle would create a serious risk to life or health.

(e) Transportation by taxi, train, bus and other public conveyances shall not be directly reimbursable by the New Jersey Medicaid program. Inquiry should be made to the County Welfare Agency for authorization and payment for such transportation.

(f) Policy and procedures regarding the provision of transportation services are outlined in the New Jersey Medical Transportation Services Manual (N.J.A.C. 10:50–1.3 through 1.6).

**10:63–2.18 Bed and board**

(a) Beds are provided in rooms licensed by the New Jersey Department of Health. A NF providing care to children shall have available protective cribs for infants and small children, as well as appropriate furniture, sized and scaled for children.

(b) Board shall be provided to meet basic nutritional needs and shall include the provision of therapeutic diets as prescribed by the attending physician.

**10:63–2.19 Housekeeping and maintenance services**

(a) Housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment and laundering of personal clothing (excluding dry cleaning) shall be required.

**10:63–2.20 Non-covered services**

(a) Non-covered services in NFs shall include, but not be limited to, the following:

1. Admission or continued care primarily for diet therapy of exogenous obesity, bed rest, rest cure, or care of non-medical nature;

2. Private duty nursing;

3. Private attendant services;

4. Services and supplies not related to the care of the resident, such as guest meals and accommodations, television, telephone, and personal items;

5. Practitioner or therapy services furnished on a fee-for-service basis by an owner, partner, administrator, stockholder, or others having direct or indirect financial interest in the NF; or

6. Partial care services in independent clinics.

**10:63–2.21 Special care nursing facility (SCNF)**

(a) A special care nursing facility (SCNF) is a nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the Division of Medical Assistance and Health Services to provide care to New Jersey Medicaid recipients who require specialized nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. 10:63–2. A SCNF or SCNF unit shall have a minimum of 24 beds.

1. The minimum bed requirement shall be waived for SCNFs that were approved by the Division prior to the adoption of this regulation. In addition, the requirement will be waived in those instances where a SCNF's Certificate of Need stipulates a specific number of beds approved by the New Jersey Department of Health.

2. A SCNF shall provide intensive medical, nursing and psychosocial management to the seriously ill individual who has potential for measurable and consistent maturation or rehabilitation, or has a technologically and/or therapeutically complex condition which requires the delivery of intensive and coordinated health care services on a 24 hour basis. Length of stay in a SCNF shall be determined by the individual's progress and the overall response to the therapeutic regimen.

(b) A SCNF shall provide the services of an interdisciplinary team, under the direction of a physician specialist, who has training and expertise in the treatment specific to the medical condition and specialized needs of the target population of the SCNF.

1. Within a focused, specialized therapeutic program, targeted, when appropriate, at timely discharge to alternative health care settings, such as conventional NF or community-based services, the SCNF shall provide:

i. Aggressive management and treatment to stabilize, improve and monitor current conditions;

ii. Appropriate, intensive rehabilitative therapies and counseling services; and

iii. Coordinated care planning and delivery of required services.

(c) A SCNF shall provide services to Medicaid recipients who have been determined, through the PAS process, to require extended rehabilitation and/or complex care.

1. Extended rehabilitation shall be considered for a medically stable individual with a condition whose prognosis indicates the potential for rehabilitative progress which requires a prescribed period of therapeutic treatment and goal-directed services provided by a qualified interdisciplinary team to restore the individual to the highest practical level of physical, cognitive and behavioral functioning. The individual may remain for a period of up to 12 months, with a review after six months. Length of stay will be extended for periods of six months, if continued benefit from the service can be demonstrated.

2. Complex care shall be considered for a medically stable individual judged to have plateaued who demonstrates the need for prolonged, technologically and/or therapeutically complex care. Although the rehabilitative component may be less intense, the individual continues to require focused assessment, coordinated care planning and direct services on a continuing basis provided by a interdisciplinary team with training and expertise in the treatment of the medical conditions and specialized needs of the resident population of the SCNF. The individual may remain for a period of up to 2 years with review every 12 months. Length of stay will be extended for periods of six months if continued benefit from the service can be demonstrated.

3. Medicaid recipients who are suitably placed in the community, receiving care in appropriate alternative placements or referred for social reasons only shall not be authorized for admission to a SCNF.

(d) Discharge procedures shall include utilizing Medicaid discharge protocols established by N.J.A.C. 10:63, and the following:

1. The recipient shall be discharged upon achievement of maximum benefit from the specialized programming and maximum level of functioning and when the individual's condition can be appropriately managed in either the community or other forms of institutional care.

2. Outpatient treatment and supported community services may be needed to assist in community integration.

3. In the case of a recipient residing in a SCNF unit of a conventional NF, who is determined by Division staff to no longer require special programming, yet continues to require conventional NF services, such a recipient shall be accepted for placement into a conventional NF bed in the facility. If a conventional NF bed within the facility is not available within a reasonable time, the SCNF shall assist the individual in finding placement in another facility. The SCNF shall be afforded 30 to 60 days from then date of the determination to effect transfer of the recipient to a bed within the facilities conventional bed allocation or arrange transfer to another conventional NF.

(e) The SCNF shall provide all required services, as defined in this subchapter.

1. A SCNF shall provide those medical services as defined in N.J.A.C. 10:63–2.3, with the following modifications and/or additions:

i. A free-standing SCNF shall have a designated medical director who is board eligible/certified in a medical specialty as targeted by the medical diagnoses, medical conditions and/or resident population of the SCNF. The medical director shall also function as a primary care attending physician. If a speciality medical group provides medical services to the SCNF, a member of that group shall be designated as the medical director.

(1) In lieu of the requirements contained in i above, a free-standing SCNF may have a designated medical director who is a licensed physician and was serving as medical director prior to the effective date of these rules.

ii. For each resident there shall be a designated primary care physician specialist who is board eligible/certified in a medical specialty determined by the medical diagnoses, medical conditions and or resident population of the SCNF;

iii. Responsibilities of the primary care physician include but are not limited to:

(1) History, physical exam and diagnosis on admission and a comprehensive physical exam conducted on a yearly basis;

(2) Medical assessment shall reflect a correlation of the staging of existing diagnosis and premorbid conditions to the prognosis for rehabilitation.

(3) Each resident shall be examined and evaluated as required by the individual's condition as designated by the medical care plan.

2. A SCNF shall provide those nursing services as defined in N.J.A.C. 10:63–2.2 with the following modifications and/or additions:

i. A free-standing SCNF shall have a director of nurses or a nursing administrator who is a registered professional nurse in the State of New Jersey and possesses a Master's Degree or a Baccalaureate Degree in Nursing and has a minimum of two years experience as a nursing administrator or who has at least two years of supervisory experience in either an acute or long-term care setting.

(1) In lieu of (e)2i above, serve as director of nursing prior to the adoption of these regulations.

(2) A SCNF unit within a conventional NF whose director of nursing does not meet the qualifications of (e)2i above shall have a nurse manager who meets the qualifications assigned full time to the unit. The SCNF unit shall have six months from the date of adoption of these rules to comply with this requirement.

ii. Registered professional nurses certified in intravenous therapy shall be available on a 24 hour basis.

iii. Two and one-half hours of basic nursing services by registered professional nurses, licensed practical nurses and certified nurse aides as defined in N.J.A.C. 10:63–2.2. Additional nursing services up to a maximum of three hours may be provided due to technically complex nursing needs and/or intensive rehabilitative/restorative nursing care needs.

iv. Provision of additional nursing services (acuities) as defined in N.J.A.C. 10:63–2.2 does not apply to nurse staffing rules in a SCNF.

(1) Sixty percent of the additional hours of care under iii above shall be provided by registered professional nurses, and forty percent shall be provided by licensed practical nurses. There shall be a minimum of one registered professional nurse, one licensed practical nurse and one certified nurse aide on each shift.

v. Responsibilities of the nursing staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1) Expertise and understanding of the physiologic impact, prognosis and treatment needs specific to the medical condition or specialized needs of the target population to enhance integration of the resident and family goals with adjustment and rehabilitation.

(2) Utilization and application of specialized equipment essential to provide services required for the care and treatment of the SCNF population.

(3) Comprehensive and coordinated program of restorative and rehabilitative nursing services to prevent complications and promote and/or restore the individual's physical, psychosocial function to a realistic level.

(4) Individual/family education and instruction of self care to promote optimum level of health in preparation for discharge to a less restrictive environment.

(5) Evaluation and management of moderate to extreme emotional and behavioral disorders related to illness.

3. A SCNF shall provide those social services as required by N.J.A.C. 10:63–2.6, with the following modifications and/or additions:

i. The social services coordinator shall possess a Master's Degree or Baccalaureate Degree in Social Work from a college or university accredited by the Council on Social Work and have at least two years of full time social work experience in a health care setting.

ii. An average of at least 50 minutes of social work services per week for each resident. This is equal to one half-time equivalent social worker for every 24 residents.

iii. In a SCNF with more than 48 beds, one of the direct care social workers shall be designated as the Director of Social Services.

iv. Responsibilities of the social service staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1) Knowledge of alternative care programs and resources in the community to assist the resident/family with appropriate discharge planning.

(2) Maintain a library of information and resources pertinent to the resident's diagnosis, educational/vocational training needs and applications to community based programs.

(3) Facilitate on-going collaboration and coordination among health care providers, the resident and the family to promote long-range social and health care planning.

(4) Coordinate SCNF programming with community-based resources to facilitate continuity of care and assimilation into community/family environment.

(5) On-going supportive intervention with the resident/family in dealing with the confusion, anger, fear, depression, guilt and conflict associated with illness.

4. A SCNF shall provide resident activities required by N.J.A.C. 10:63–2.5, with the following modifications and/or additions:

i. The director of resident activities shall possess a Master's Degree or Baccalaureate Degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, occupational therapy or therapeutic recreation. In addition, three years of experience in a clinical, residential or community-based therapeutic recreation program is required.

(1) In lieu of (e)4i above, serve as director of resident activities prior to the adoption of these rules; or

(2) In lieu of (e)4i above, hold current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, 520 Stewart, Park Ridge, Illinois 60068) or the National Council of Therapeutic Recreation Certification (National Council of Therapeutic Recreation Certification, P.O. Box 16126, Alexandria, Virginia 22302.

ii. An average of at least 100 minutes of resident activity services per week for each resident. This is equal to one full-time equivalent resident activities staff for every 24 residents. This staff person shall serve as the Director of Resident Activities.

iii. For each additional 24 beds, the facility shall provide the services of a full-time resident activities assistant.

iv. Responsibilities of the resident activities staff, in concert with other members of the interdisciplinary team, shall include, but are not limited to:

(1) Utilization of all possible community, social, recreational, public and voluntary resources to promote the resident's ties with community life.

(2) Provision of therapeutic resident activities which endorse the therapeutic plan of care.

(3) Incorporation of family-centered activities which provide a supportive, therapeutic environment to give residents and families an opportunity to work together toward achieving common goals.

5. A SCNF shall provide, directly in the facility, the rehabilitation services as required by N.J.A.C. 10:63–2.4 on an intensive level which are specifically targeted to meet the goals of the prescribed treatment plan.

i. Rehabilitative therapies shall include, but shall not be limited to:

(1) Physical therapy;

(2) Occupational therapy;

(3) Speech/language pathology; and

(4) Cognitive or remedial therapies (including neuropsychological treatment)

ii. Rehabilitation services shall focus on developing and/or restoring maximum levels of function within the limits of the resident's impairment. Through collaboration with other members of the interdisciplinary team, a comprehensive rehabilitation plan shall be developed which:

(1) Identifies rehabilitation needs and establishes realistic criteria for measuring the need for continued rehabilitative services;

(2) Projects targeted outcomes (goals) and defines the parameters to measure response to treatment goals; and

(3) Establishes realistic time frames to meet outcome criteria.

6. Mental health services provided by a licensed psychiatrist, psychologist or other appropriately credentialed professional shall be provided to residents with mental health disorders in accordance with N.J.A.C. 10:63–2.9.

7. A SCNF that provides ventilator management of New Jersey Medicaid eligible children or adults, shall provide respiratory therapy services beyond the scope of N.J.A.C. 10:63–2, which shall include, but not be limited to:

i. A respiratory care practitioner who is currently licensed by the New Jersey State Board of Respiratory Care be available on the premises on a 24 hour basis.

ii. Respiratory life support systems must be provided inclusive of, but not limited to:

(1) Mechanical ventilators (pressure/volume/time cycled), (portable/stationary); and

(2) Oxygen therapy delivery systems.

iii. Administration of medically prescribed respiratory care which includes, but is not limited to:

(1) Nasopharyngeal aspiration;

(2) Maintenance of natural and mechanical airways;

(3) Insertion and maintenance of artificial airways;

(4) Aerosol treatment;

(5) Administration of nebulized bronchodilators;

(6) IPPB;

(7) Oxygen therapy;

(8) Mechanical ventilation with/without supplemental oxygen;

(9) Monitoring of blood gases;

(10) Under the direction of the pulmonologist, the respiratory therapist applies weaning parameters and provides direct supervision during the weaning process;

(11) Postural drainage and chest percussion; and

(12) Breathing exercise and respiratory rehabilitation.

iv. Medically prescribed respiratory therapy may be provided to non-ventilator dependent children or adults who, due to cardio-respiratory deficiencies and/or abnormalities, require:

(1) Apparatus for cardio-respiratory support and control;

(2) Respiratory rehabilitation/chest physiotherapy;

(3) Maintenance of natural airway patency;

(4) Insertion and maintenance of artificial airway;

(5) Measurement of cardio-respiratory volume, pressure and flow;

(6) Drawing and analyzing samples of arterial, capillary and venous blood; and/or

(7) Administration of aerosolized respiratory medications such as nebulized bronchodilators or antiprotozoals.

Amended by R.1996 d.147, effective March 18, 1996.
See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

## SUBCHAPTER 3. COST STUDY, RATE REVIEW GUIDELINES AND REPORTING SYSTEM FOR LONG–TERM CARE FACILITIES

### 10:63–3.1 Purpose and scope

(a) These rules describe the methodology to be used by the State of New Jersey to establish prospective per diem rates for the provision of nursing facility services to residents under the State's Medicaid program. These rules have been developed jointly by the State Department of Human Services and the State Department of Health ("the departments").

(b) The departments believe that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The departments recognize, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c) Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the departments are prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d) On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the departments reserve the right to question and exclude from any unreasonable costs, consistent with the provision of N.J.S.A. 30:4D–1 et seq.

(e) All rates established pursuant to these rules will be subject to onsite audit verification of costs and statistics reported by NFs.

(f) The nursing facility reimbursement formulae contained in this subchapter have been developed to meet the following overall goals:

1. To comply with Federal requirements that rates are reasonable and adequate to meet the cost that efficiently and economically operated facilities must incur to provide care in conformity with applicable State and Federal laws, rules, regulations and quality and safety standards.

2. To provide sufficient incentive to attract nursing facility investment, thereby reducing the reported Medicaid bed shortage; and

3. To end opportunities for excessive property cost reimbursement.

Amended by R.1985 d.705, effective January 21, 1986.
See: 17 N.J.R. 2331(a), 18 N.J.R. 189(a).
Old 1 and 2 deleted; new 1 added; old 3 and 4 recodified to 2 and 3.
Petition for Rulemaking: Notice of receipt of petition on Medicaid reimbursement system for long-term care facilities.
See: 22 N.J.R. 672(d).
Recodified from Subchapter Foreword and amended by R.1994 d.624, effective January 3, 1995.
See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).
Amended by R.1996 d.147, effective March 18, 1996.
See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).

**Case Notes**

Discussion of reimbursement to long-term care facilities for services rendered to Medicaid patients. In re: Medicaid Long Term Care Services Bulletin 84–2, 212 N.J.Super. 48, 513 A.2d 967 (App.Div.1986), certification denied 526 A.2d 125, 107 N.J. 31.

Settlement agreement did not allow long-term care facility to receive excess nursing costs. Bergen Pines County Hospital v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 95.

Administrator's salary as calculated using the N.J.A.C. 10:63–3.5 regression analysis formula was reasonable; actual salary paid was unreasonable; management fee payments to individual not actively engaged in day-to-day facility operation disallowed as not shown to be cost of doing business or an expense related to facility activities. In re: Cranford Hall Nursing Home, 8 N.J.A.R. 463 (1982), affirmed per curiam Dkt. No. A–1641–82 (App.Div.1984).