Medicaid-eligible individual has valid financial coverage to receive services available at the pediatric day health services facility pursuant to N.J.A.C. 8:86-1.6(g).

Amended by R.1994 d.427, effective August 15, 1994.
See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).
Amended by R.2001 d.5, effective January 2, 2001.
See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).
New Rule by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).
See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).
Former N.J.A.C. 8:86-1.5, Staff, repealed.
Amended by R.2008 d.1, effective January 7, 2008.
See: 39 N.J.R. 2424(a), 40 N.J.R. 177(a).
Rewrote (b) through (g).

8:86-1.6 Basis of payment

(a) The facility providing adult or pediatric day health services shall agree to accept the reimbursement rates established by the Department as the total reimbursement for services provided to eligible Medicaid beneficiaries and to eligible beneficiaries enrolled in the HCEP or in the JACC. In a nursing facility-based program, the adult or pediatric day health services per diem rate is 45 percent of that nursing facility's per diem rate. In freestanding facilities, the adult or pediatric day health services per diem rate is based on an average of the rates paid to nursing facility adult or pediatric day health services providers in effect as of July 1 each year. For hospital-affiliated facilities, the adult or pediatric day health services rate is a negotiated per diem rate, which shall not exceed the maximum adult or pediatric day health services per diem rate paid to nursing facility-based providers. The reimbursement rate set for any Medicaid beneficiary or any JACC or HCEP beneficiary in an adult or pediatric day health services facility shall not exceed the rate charged by the facility to individuals who are not enrolled in the Medicaid, JACC, or HCEP programs. The per diem reimbursement shall cover the cost of all services required as a condition of licensure at N.J.A.C. 8:43F, except as noted below:

1. Physical therapy, occupational therapy and speech-language pathology services shall not be included in the per diem rate reimbursed for adult or pediatric day health services. These therapies, when provided by the facility, shall be billed separately on the Health Insurance Claim Form, CMS-1500 (Appendix D, incorporated herein by reference), or third party insurance form, as applicable. The CMS-1500 can also be found at cms.hhs.gov/forms.

2. It is only in the role of attending physician that the medical consultant may bill the New Jersey Medicaid Program on the Health Insurance Claim Form, CMS-1500, for services provided to a Medicaid beneficiary. The medical consultant shall not bill the New Jersey Medicaid Program separately for any service performed for any Medicaid beneficiary in an adult or pediatric day health services facility while serving solely in his or her capacity as medical consultant.

(b) The cost of transportation services provided by the facility shall be included in the per diem reimbursement rate for adult or pediatric day health services. Transportation shall not be reimbursed as a separate service by the Department.

(c) Physician services for Community Care Program for the Elderly and Disabled beneficiaries or Home Care Expansion Program or Jersey Assistance for Community Caregiving Program participants shall not be reimbursed by those programs.

(d) The Department shall not reimburse for adult day health services when partial care/partial hospitalization program services are provided to a beneficiary on the same day.

(e) For Medicare coverage, the only services that are considered for payment under Medicare are physical therapy and speech-language pathology services since adult day health services is not a covered Medicare service. When the beneficiary is covered under Medicare, only the Medicare Form UB-92/CMS-1450 shall be completed for physical therapy and speech-language pathology services showing the Eligibility Identification Number.

(f) For third party liability, some insurance companies currently offer adult or pediatric day health services as a benefit. The facility shall review the beneficiary's and family's insurance plans before submitting claims to assure that insurance companies are billed before submitting to the fiscal agent.

(g) The facility administrator shall verify that a beneficiary has valid financial coverage as of the time services are rendered to the beneficiary.

1. The facility administrator shall verify coverage for Medicaid beneficiaries and HCEP participants by using one of the eligibility verification systems or tools identified at N.J.A.C. 10:49-2.11, such as the Recipient Eligibility Verification System.

2. The facility administrator shall verify coverage for beneficiaries who participate in a program listed at N.J.A.C. 8:86-1.1(b), which requires case or care management, with the exception of JACC participants, by using the Recipient Eligibility Verification System and by contacting the beneficiary's case or care manager for verification of the beneficiary's financial coverage.

3. The facility administrator shall verify coverage for JACC participants by contacting the beneficiary's case or care manager for verification of the beneficiary's financial coverage.

(h) Distributions of assessments collected pursuant to the Nursing Home Quality of Care Improvement Fund Act, N.J.S.A. 26:2H-92 to 101, shall not be included in the calculation of adult or pediatric day health services facility reimbursement rates pursuant to (a) above.

(i) Facilities shall be reimbursed for no more than a combined total of five days of treatment per week per beneficiary, even if the beneficiary receives services from multiple adult or pediatric day health services facilities during the same week. For the purposes of this subsection, "week" means seven calendar days, starting on Sunday and continuing through Saturday.

Amended by R.1994 d.427, effective August 15, 1994.
See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).
Amended by R.1996 d.6, effective January 2, 1996.
See: 27 N.J.R. 3540(a), 28 N.J.R. 184(b).
Amended by R.2001 d.5, effective January 2, 2001.
See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).
In (a), amended N.J.A.C. reference in the introductory paragraph.
Recodified from N.J.A.C. 8:86-1.8 by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).
See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).
Former N.J.A.C. 8:86-1.6, Recipient review, evaluation and identification, repealed.
Amended by R.2008 d.1, effective January 7, 2008.
See: 39 N.J.R. 2424(a), 40 N.J.R. 177(a).
Rewrote (g).

8:86-1.7 Voluntary transfer between ADHS facilities

(a) An adult beneficiary who chooses to request to transfer from one ADHS facility to another ADHS facility shall submit a transfer request, in accordance with (b) below, to:

1. The facility to which the beneficiary chooses to request to transfer; or

2. The beneficiary's case or care manager if the beneficiary is a participant of any program listed at N.J.A.C. 8:86-1.1(b) that requires case or care management.

(b) A request for transfer to another ADHS facility shall be in writing and include the following:

1. The beneficiary's name, address, and date of birth;

2. The name of the ADHS facility at which the beneficiary is receiving ADHS;

3. The valid reason(s), as identified at (c) below, upon which the requestor bases the transfer request;

4. The name of all ADHS facilities the beneficiary has attended, including dates attended; and

5. The signature of the beneficiary and/or the beneficiary's legally-authorized representative.

(c) Any one of the following is a valid reason for a transfer to another ADHS facility:

1. The beneficiary is changing his or her residence;

i. A request to transfer based on this reason shall contain the address of the beneficiary's new residence;

2. The transportation time between the beneficiary's home and the ADHS facility to which the beneficiary chooses to request to transfer is shorter than the transportation time between the beneficiary's home and the ADHS facility in which the beneficiary is enrolled as a participant, and the beneficiary prefers to have a shorter transportation time;

3. The beneficiary believes that the facility from which the beneficiary chooses to request to transfer violated his or her rights as a participant of that facility pursuant to N.J.A.C. 8:43F-4.2;

i. A request to transfer based on this reason shall describe the nature of the violation; or

4. The transfer is medically necessary as identified by the beneficiary's attending physician, physician assistant, or advanced practice nurse;

i. A request to transfer based on this reason shall include the written statement of the beneficiary's attending physician, physician assistant, or advanced practice nurse indicating the basis of the medical necessity.

(d) A case or care manager in receipt of a beneficiary's request to transfer to another ADHS facility shall forward the request to the ADHS facility to which the beneficiary wishes to transfer with written notification providing the number of days per week the beneficiary may receive ADHS pursuant to N.J.A.C. 8:86-1.3(a)3 and 1.4(a)3.

(e) Upon receipt of a beneficiary's written transfer request and, if applicable pursuant to (d) above, the written notice from the beneficiary's case or care manager providing the number of days per week the beneficiary may attend the facility if the request was made pursuant to (a)2 above, the ADHS facility to which the beneficiary chooses to request to transfer shall submit a pre-numbered prior authorization request form with the original written transfer request to the Department in accordance with N.J.A.C. 8:86-1.3(a)3, with the exception that the facility shall mail the submission to the following address:

Adult Day Health Services Program
Office of Community Choice Options
Division of Aging and Community Services
New Jersey Department of Health
and Senior Services
PO Box 807
Trenton, NJ 08625-0807

1. Prior to the submission of the pre-numbered prior authorization request form, the transferee facility shall notify the ADHS facility from which the beneficiary chooses to request to transfer of the beneficiary's pending transfer request.

(f) Within 30 days of the date the Department receives the written transfer request, the Department shall take one of the actions specified in 1 through 4 below and shall notify the beneficiary, the ADHS facility to which the beneficiary chooses to request to transfer, and if applicable, the beneficiary's case or care manager, of the Department's decision: