1. If the attending physician is unable to write the request on the order sheet, he or she may personally dictate, by telephone to an appropriate person at the facility, the order for the consultation or the referral for examination and treatment, indicating the supporting reason(s) for the request. The attending physician shall then, within seven days of requesting the consultation or referral for examination and treatment, countersign the order on the order sheet or sign and forward to the NF an identical order on a prescription form which will satisfy the requirements until the next visit, when he or she shall sign the order sheet.

2. In consideration of a resident's rights, a resident may request either a consultation or a referral for examination and treatment, provided it is consistent with medical necessity. The attending physician shall note the request on the order sheet and, if the physician so wishes, may note that it was made at the resident's request.

Example: Resident requests ophthalmologic consultation with Dr. Evans for significant refractive error.

Signed: A.B. Turner, M.D.

10:63–2.9 Mental health services

(a) All facilities shall assist Medicaid recipients to obtain mental health care through a licensed psychiatrist or psychologist, who shall provide, or make provision for, routine and emergency services.

(b) An initial consultation for mental health services shall be performed only upon a written order signed by the attending physician (on the order sheet) citing the reason(s) for the consultation in the progress notes.

(c) If the mental health services are recommended following initial consultation, the psychiatrist or psychologist may provide the mental health service upon the written order signed by the attending physician. If the individual who provides the mental health services is a psychiatrist, he or she shall comply with the Medicaid policies cited in N.J.A.C. 10:54 regarding the request for authorization requirements for mental health services. If the individual who provides the mental health services is a psychologist, he or she shall comply with N.J.A.C. 10:67 regarding the request for authorization requirements for mental health services.

(d) Therapeutic goals and outcomes shall be documented by the psychiatrist and/or psychologist in the clinical record and treatment provided only where there is potential for significant functional improvement within a reasonable time frame.

10:63–2.10 Dental services

(a) All facilities shall assist Medicaid recipients to obtain dental care through a licensed dentist, who shall provide, or make provision for:

1. Appropriate consulting services;
2. In-service education to the facility;
3. Policies concerning oral hygiene; and
4. Routine and emergency services.

(b) Dental examinations carried out to comply with the Department of Health's minimal requirements, as well as regular dental examinations, shall not be considered consultations and need not be brought to the attending physician's attention except as a matter of courtesy. However, treatments which involve invasive procedures such as extractions or fillings, except in an emergency, shall be brought to the attention of the attending physician who acknowledges clearance for such treatment on the order sheet.

(c) The dentist shall establish a time frame for the next periodic examination, either at the time of examination, or at the completion of treatment. The time frame entered on the clinical record may be for six months, one year, or any other time period that the attending dentist has established in accordance with his or her knowledge of the recipient.

(d) Dental care of a child residing in a NF shall be provided according to the American Dental Association Pediatric protocol available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60611.

(e) Policy and procedures regarding the provision of dental services are listed in the New Jersey Medicaid Program Manual for Dental Services. Services requiring prior authorization are listed under 202.2 (N.J.A.C. 10:56–1.3).

10:63–2.11 Podiatry services

(a) All facilities shall assist Medicaid recipients to obtain podiatry care through a licensed podiatrist who shall provide, or make provision for:

1. Appropriate consulting services;
2. In-service education for the facility;
3. Policies concerning foot care; and
4. Routine and emergency services.

(b) Once the attending physician reviews the consultation and approves the treatment plan of the podiatrist, the physician shall not be required to sign a request every time the podiatrist treats the resident; however, the attending physician shall review and approve the need for the podiatric services for residents under treatment every six months, and if continuing service is indicated, complete a request for podiatric services for each resident under treatment at least once a year. This shall be accomplished by an order on the order sheet and not by repeated requests for consultation.

1. Podiatry services provided to children shall be prior authorized by MDO professional staff.

New Jersey State Library

(c) Policies and procedures regarding the provision of podiatric services are outlined in the New Jersey Medicaid Program's Podiatry Services Manual (N.J.A.C. 10:57).

10:63–2.12 Chiropractic services

All facilities shall assist Medicaid recipients to obtain chiropractic care through a licensed chiropractor who shall provide, or make provision for routine and emergency services.

10:63–2.13 Vision care services

(a) All facilities shall assist Medicaid recipients to obtain vision care through a licensed ophthalmologist or optometrist who shall provide, or make provision for, routine and emergency services.

(b) Policies and procedures regarding the provision of Vision Care services are outlined in the New Jersey Medicaid Program's Vision Care Manual (N.J.A.C. 10:62).

10:63–2.14 Laboratory; X-ray, portable X-ray and other diagnostic services

(a) A NF shall have written agreements with one or more general hospitals or one or more clinical laboratories so that the facility can obtain laboratory services, including emergency services promptly. If the facility has its own laboratory capabilities, the services may not be billed on a separate fee-for-service basis. A laboratory must be:

1. Licensed and/or approved by the New Jersey State Department of Health and the State Board of Medical Examiners which includes meeting Certificate of Need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey Sanitary Code; and

2. Certified as an independent laboratory under the Title XVIII Medicare Program; and

3. Approved for participation as an independent laboratory provider by the New Jersey Medicaid program.

(b) A NF shall have written agreements with one or more general hospitals or one or more Board certified or Board eligible radiologists so that the facility can obtain radiological services, including emergency services promptly.

1. Portable X-ray may be used when medically indicated. The mechanical portion of the services (obtaining the films) may be done by personnel of either the hospital or radiologist, but the interpretation of the film will be by a Board certified or Board eligible radiologist only.

2. X-ray services offered directly by the facility must be in adherence with the standards of the New Jersey Radiological Society.

(c) A NF shall have written agreements with one or more general hospitals or one or more qualified providers so that the facility can obtain other diagnostic services, such as ECG, EEG, CAT scan, MRI and ultrasonogram, including emergency services, promptly.

1. All diagnostic services shall be ordered by a physician, who shall be promptly notified of the test results.

2. All findings and reports shall be recorded in the recipients clinical record.

10:63–2.15 Medical supplies and equipment

(a) Medical supplies include incontinency pads, bandages, dressings, compresses, sponges, plasters, tapes, cellu-cotton or other types of pads used to save labor or linen, and other disposable items (for example, colostomy bags), hot water bags, thermometers, catheters, rubber gloves, and supplies required in the administration of medication including disposable syringes. Routinely used medical supplies are considered part of the institution's cost and cannot be billed directly to the program by the supplier.

(b) Equipment for administration of oxygen for residents in a NF is a required service. Oxygen itself must conform to United States Pharmacopoeia Standards in order to be used as a medicinal gas. (United States Pharmacopoeia Convention, 12601 Twinbrook Parkway, Rockville, MD 20852.)

(c) Routinely used durable medical equipment ordered for Medicaid recipients in a participating NF (for example, walkers, wheelchairs, bed-rails, crutches, traction apparatus, IPPB machine, electric nebulizers, electric aspirators, low-end pressure relief systems such as mattress overlays and mattress replacements, powered mattress systems and powered flotation beds) and other therapeutic equipment and supplies essential to furnish the services offered by the facility for the care and treatment of its residents shall be considered part of the NF's cost, and shall not be billed directly to the program by the supplier.

(d) When unusual circumstances require special medical equipment not usually found in a NF, such special equipment may be reimbursable, with prior authorization from the Medicaid District Office serving the county where the facility is located.

1. When special medical equipment is authorized and purchased on behalf of a Medicaid recipient, ownership of such equipment shall vest in the Division of Medical Assistance and Health Services. The recipient shall be granted a possessory interest for as long as the recipient requires use of the equipment. When the recipient no longer needs such equipment, possession and control shall revert to the Division. The recipient shall agree to this when he or she signs the "patient's certification" section on the claim form. The NF shall notify the MDO in writing when such equipment is no longer in use.

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.

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.