

1. The transfer of resource provisions of N.J.A.C. 10:71-4.7 apply to persons seeking hospice services while residing in a nursing facility as well as to persons seeking eligibility for hospice services in the community but whose income disqualifies them from New Jersey Care ... Special Medicaid Programs.

2. Persons not already eligible for Medicaid but who express interest in hospice services should be referred to the county welfare agency for a determination of eligibility. Persons already residing in a nursing facility should be referred to a county welfare agency of the county in which the facility is located. Persons in the community or waiting for placement in a nursing home should be referred to the county welfare agency in their county of residence.

3. When providing services to members of the Garden State Health Plan (GSHP), an authorization number shall be obtained from the applicant's GSHP physician case manager prior to providing hospice services. Hospice agencies shall use this authorization number when billing for services provided to a GSHP member.

4. The providers of hospice services to Medicaid recipients enrolled in a managed care organization or HMO shall comply with the procedures of that managed care organization or HMO, including, but not limited to, any prior authorization or other utilization control procedure required.

(c) In addition to financial eligibility, the individual applying for Medicaid hospice eligibility shall meet the following conditions:

1. He or she shall voluntarily elect the hospice services (see N.J.A.C. 10:53A-3.2);

2. If eligible for Medicare, he or she shall elect his or her Medicare Part A benefits for hospice care. For dually eligible Medicare and Medicaid hospice recipients, the hospice benefits election applies simultaneously under both the Medicare and Medicaid programs. Thus, Medicare is responsible for the payment of claims for services provided, as first payer of the hospice benefit. Medicaid is responsible for payment for services not covered under the Medicare hospice benefit when those services are Medicaid covered services, such as any co-payment, co-insurance deductibles, if applicable, and those Medicaid covered services listed in N.J.A.C. 10:53A-3.4(g).

3. He or she shall be certified or recertified as terminally ill by the attending physician (see N.J.A.C. 10:53A-2.3) and be certified by the attending physician that hospice services are reasonable and necessary for the palliation or management of the terminal illness or related conditions by the completion of the Physician Certification/Recertification for Hospice Benefits Form FD-385 (6/92). A copy of this form shall be part of the medical record at the hospice agency;

4. He or she shall have a plan of care for hospice services established prior to and consistent with the provision of hospice services. (For information on the plan of care, see N.J.A.C. 10:53A-3.6); and

5. He or she shall waive all rights to the following:

i. Those hospice services provided by a hospice other than the one designated by the recipient (unless provided under written arrangements made by the designated hospice); and

ii. Any Medicaid services that are related to the treatment of the terminal condition for which hospice services were elected, or for a related condition, or for services equivalent to hospice care, except for the following services:

(1) Those provided (either directly or under arrangement) by the designated hospice; and

(2) Those provided by the recipient's physician or consulting physician in treatment of the terminal condition, if that physician is not an employee of the designated hospice receiving compensation from the hospice for those services.

(d) Applicants in eligibility categories listed in N.J.A.C. 10:71 and 10:72, incorporated herein by reference, may be eligible for hospice if the applicant meets the criteria listed in (b) and (c) above.

Amended by R.1997 d.479, effective November 17, 1997.

See: 29 N.J.R. 3441(a), 29 N.J.R. 4853(a).

Added (b)4; in (c)2, added the third and fourth sentences; rewrote (d); and deleted (d)1 through (d)6.

10:53A-3.2 Application procedure for medical and financial eligibility for hospice services

(a) The application procedure for completion of the medical criteria for receiving hospice services is as follows:

1. Individuals requesting or initiating hospice eligibility should be referred to a Medicaid approved hospice to complete the hospice medical eligibility requirements for hospice services through the completion of the Physician Certification/Recertification for Hospice Benefits Form, FD-385 (6/92) and the Election of Hospice Benefits Statement, FD-378 (6/92).

2. The hospice shall notify the agency (that is, the county welfare agency (CWA), the Division of Youth and Family Services (DYFS), or the Medicaid District Office (MDO) (for SSI recipients), as applicable), that is responsible for maintaining the hospice "indicator" (Special Program Number 15) of the completion of the medical eligibility requirements in (a)1 above. The notification must be done through the use of the Hospice Eligibility Form, FD-383 (6/92). The form shall also be sent to the address listed below to indicate to the Division of the completion and/or change in the medical eligibility:

Hospice Program
 Division of Medical Assistance and Health Services
 PO Box 712, Mail Code #35
 Trenton, New Jersey 08625-0712

i. The date of the signing of the Election of Hospice Benefits Statement, FD-378 (6/92) determines the date of eligibility for hospice services if the applicant is eligible for Medicaid.

3. For those cases in which the disability determination for Medicaid eligibility is within the jurisdiction of the Disability Review Section, Division of Medical Assistance and Health Services, the determination of disability for the first six months of hospice services will be based solely on the physician's certification of terminal illness. (See also N.J.A.C. 10:71-3.11 through 3.13).

i. To ensure the continuity of hospice services after six months, the agency responsible for the eligibility determination (that is, the county welfare agencies (CWA's)), shall inform the Disability Review Section of the recipient's eligibility for hospice services based upon the physician's certification of terminal illness and the determination of financial eligibility.

ii. After the initial six-month period, if it appears that such a recipient will require and elects to continue to receive hospice services, the Disability Review Section of the Division shall require medical documentation to validate the disability status based on terminal illness as part of the medical recertification. This documentation is in addition to the Physician's Certification/Recertification for Hospice Benefits Form (FD-385) required under N.J.A.C. 10:53A-2.3.

(1) The required additional documentation consists of the following:

(A) A statement from the attending physician of the diagnosis(es), prognosis and the stage of illness;

(B) Copies of laboratory test results, biopsy and/or pathology reports, Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CAT) results; and

(C) Copies of any other objective medical documentation which supports the diagnosis(es).

(2) Individuals who are over 65 years of age, or receiving Medicare, or receiving Social Security Disability Insurance Benefits under Title II or Supplemental Security Income (SSI) under Title XVI or who could have met the eligibility criteria for Aid to Children with Dependent Children (AFDC) that were in place on July 16, 1996, as set forth in N.J.A.C. 10:81 and 10:82, are not required to be evaluated by the Medicaid Disability Review Section.

(3) The Disability Review Section will identify and track individuals who are required to be evaluated for continuing disability and will contact the provider to initiate the enhanced recertification process.

(b) The application procedure for financial eligibility is as follows:

1. After medical eligibility has been determined, all applicants (whether previously eligible for Medicaid or not) should be referred to the CWA, DYFS or the MDO, as applicable, for hospice financial eligibility processing. If the applicant's Medicaid eligibility status has not been established, is not known, or is uncertain, the hospice agency shall contact the MDO to determine where to refer the potential applicant.

2. For the recipient who had been eligible for regular Medicaid benefits (such as those who would have met the eligibility criteria for Aid to Families with Dependent Children (AFDC) that were in place on July 16, 1996 as set forth in N.J.A.C. 10:81 and 10:82, Medicaid Only or New Jersey Care . . . Special Medicaid Programs), the CWA is responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD-383) (6/92).

3. Exceptions: The instructions in (b)1 and 2 above do not apply if the applicant is eligible through DYFS or SSI. For instructions for those eligible through DYFS or SSI, see (b)4 or 5 below, respectively.

4. If the applicant for hospice services is under the supervision of DYFS, DYFS shall be responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of the Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD-383) (6/92).

5. If the applicant for Medicaid hospice services is SSI eligible, the MDO is responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of the Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD-383) (6/92). (See N.J.A.C. 10:49, Administration, (Appendix Form # 17), for the list of Medicaid District Offices.)

6. The medical eligibility materials (copies of the Physician Certification/Recertification for Hospice Benefits, FD-385 (6/92) form and the Election of Hospice Benefits Statement, FD-378, (6/92)) shall be forwarded by the hospice to the MDO, CWA or DYFS, as applicable.

7. All other applicants for room and board services, including those who would lose SSI because of monthly income shall be referred to the CWA. For individuals determined eligible, see (b)2 above for processing responsibilities.

(c) Rules for retroactive Medicaid eligibility in N.J.A.C. 10:49, Administration, apply to those recipients eligible for Medicaid prior to their Medicaid application for hospice. In addition, the following retroactive eligibility rule applies:

1. No retroactive eligibility payment will be authorized for hospice services prior to the date the Election of Hospice Benefit Statement, FD-378 (6/92) is signed. Retroactive eligibility for hospice services may be established for up to three months prior to Medicaid eligibility provided the Election of Benefit Statement, FD-378 (6/92) had been signed. Such cases shall be referred to the following address for determination of retroactive eligibility:

Retroactive Eligibility Unit
Division of Medical Assistance and Health Services
PO Box 712, Mail Code #10
Trenton, New Jersey 08625-0712

2. For an applicant who becomes initially eligible for Medicaid, solely because of his or her hospice status, Medicaid eligibility begins with the date the Election of Hospice Benefits Statement, FD-378 (6/92) was signed by the applicant, or his or her representative. In these cases, retroactive eligibility is not available prior to the date on the Election of Hospice Benefits Statement, FD-378 (6/92).

(d) The hospice shall notify the agency determining eligibility (MDO, CWA or DYFS) through a copy of the Hospice Eligibility Form, FD-383 (6/92) of a change in the recipient's status which could affect the eligibility for Medicaid and/or for hospice services, a change in the hospice provider status, or a change in a recipient's address.

(e) A limited access Medicaid Eligibility Identification Card (MEI) with the statement "Except for hospice and physician services, CHECK WITH HOSPICE PROVIDER for other services" shall be issued to a fee-for-service Medicaid recipient who is eligible for hospice services. The hospice shall provide the name and telephone number of the contact person within the hospice so that other providers may obtain approval from the hospice for other than hospice and physician services.

1. When the hospice applicant is also a Garden State Health Plan member, the following process shall be followed by the hospice:

i. A member of the Garden State Health Plan has a message on his or her Medicaid Eligibility Identification Card (MEI) which states, "HMO-Check GSHP ID Card". Each member of the GSHP will also have a gold-colored GSHP-ID card which lists the name and telephone number of the member's physician case manager. The hospice provider shall obtain from the member of the Garden State Health Plan who requests hospice services, a Garden State Health Plan Authorization Form (GSHP-7) (9/91) which is completed by

the member's physician case manager and specifically authorizes hospice services.

ii. The hospice provider shall use the authorization number which is imprinted on the top right hand corner of the GSHP-7 form when billing for services provided to a member of the GSHP.

(f) For Medicaid recipients enrolled in a managed care organization or HMO, the MEI card shall list the name and telephone numbers of the contact person at the HMO so that other providers may obtain approval from both the HMO and the hospice for services other than hospice or physician services.

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).

In (a)3ii(2) and (b)2, added reference to eligibility for AFDC prior to July 16, 1996; and added (f).

10:53A-3.3 Benefit periods

(a) There are two 90-day benefit periods, one 30-day period, and a fourth unlimited period. The two 90-day periods must be used before the 30-day period and all three periods must be used before the fourth unlimited benefit period. The benefit periods shall be recorded on a Hospice Benefits Statement, FD-379 (6/92) Form # 2 in the (Appendix, incorporated herein by reference) and filed in the recipient's medical record.

(b) Contents of the Election of Hospice Benefits Statement, FD-378 (6/92) (Appendix Form # 1) shall include the following:

1. The identification of the particular hospice that will provide the care to the applicant;

2. The applicant's or his or her representative's acknowledgment, that he or she has been given a full understanding of hospice services;

3. The applicant's or his or her representative's acknowledgment that he or she understands that the regular Medicaid services other than hospice services are waived by the signing of the Election of Hospice Benefits Statement, FD-378 (6/92) and/or the Representative Statement for the Election of Hospice Benefits, FD-380 (Form # 3 in the Appendix, incorporated herein by reference), unless the services are prior authorized;

4. The effective date of the election statement; and

5. The signature of the applicant or the applicant's representative.

(c) The hospice applicant is eligible for three benefit periods of hospice services (90 days, 90 days, and 30 days, totaling 210 days) and a fourth unlimited benefit period with the approval of the hospice provider, if the applicant or his or her representative files an Election of Hospice Benefits Statement, FD-378 (6/92) with a particular hospice.

1. A hospice recipient shall designate an effective date for the beginning of hospice services which shall not be earlier than the date the election is made.

(d) Revocation of election of hospice services shall be as follows:

1. The recipient may choose at any time to institute a "break" (a time period when care other than hospice care is given) between benefit periods or by a revocation of hospice services.

2. The Election of Hospice Benefits Statement, FD-378 (6/92) shall be considered to be valid through subsequent benefit periods if there is no "break" in care.

3. A new Election of Hospice Benefits Statement, FD-378 (6/92) is required to be filed following a break or revocation of hospice service.

i. The recipient or his or her representative shall file a signed statement with the hospice provider that indicates the recipient revokes the election for Medicaid coverage of hospice services for the remainder of the election period with the date that the revocation is to be effective.

ii. When revoked, the recipient forfeits hospice services for any remaining days in the benefit period. A recipient may not receive hospice services later than the effective date that the revocation is signed.

iii. The hospice shall immediately notify the agency that determined hospice eligibility (either CWA, DYFS or the MDO) of the revocation of hospice, verbally if possible, and also by filling out and submitting the Hospice Eligibility Form, FD-383 (6/92) to the eligibility source (CWA, MDO or DYFS, as applicable) so that the recipient's hospice eligibility may be terminated. The hospice shall also fill out the Termination of Hospice Benefits, FD-382 (6/92) (Form # 5 in the Appendix, incorporated herein by reference) and retain this form in the recipient's medical record.

(e) Entitlement to all other Medicaid services may be restored if the recipient continues to be Medicaid eligible, under the following circumstances:

1. When the 210 days of hospice entitlement has expired, and the recipient does not choose the fourth unlimited benefit period; or

2. When the recipient revokes hospice services.

(f) When a hospice recipient residing in a nursing facility revokes the hospice benefits and returns to the status of a patient of the NF, the hospice shall proceed, as follows:

1. The Hospice Eligibility Form, FD-383 (6/92) shall be completed and submitted to the MDO after the recipient has signed the Revocation of Hospice Benefits, FD-381 (6/92) form indicating he or she has revoked the Medicaid hospice benefit.

2. The nursing facility shall conform to the nursing facility rules and regulations in N.J.A.C. 10:63, Long Term Care Services, for admission and placement and shall treat this recipient in the same manner as other persons being admitted or placed in 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).

Deleted (f)2i

10:53A-3.4 Covered hospice services

(a) The amount, character, and scope of New Jersey Medicaid hospice services shall be the same for all hospice recipients and shall not be less than the hospice services provided under Medicare (Title XVIII) (Section 1861(dd) et seq. of the Social Security Act, codified as 42 U.S.C. Section 1395x(dd)1).

(b) The Division reimburses for covered hospice services that are reasonable and necessary for the palliation and management of the terminal illness, and which are provided to a hospice recipient consistent with the recipient's individualized plan of care.

1. Required hospice services which shall be available to the hospice recipient include nursing care, medical social services, supervisory physician services, counseling services, durable medical equipment and supplies including drugs and biologicals, homemaker/home health aide services, physical therapy, occupational therapy and speech-language pathology services.

i. The following services are considered "core" hospice services: nursing care, medical social services, physician services and counseling services.

(1) A hospice provider shall ensure that substantially all core services are routinely provided directly by hospice employees.

(2) A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of hospice recipients during periods of peak patient loads or under extraordinary circumstances or to obtain physician specialty services.

(3) If contracted staff is used, the hospice shall maintain professional, financial and administrative responsibility for the services and shall assure the qualifications of the staff and that services meet all requirements under each level of care.

(c) Covered hospice services are reimbursed at predetermined, prospective, inclusive rates corresponding to one of four levels of care. Two of the levels of care are reimbursed for services provided in the home: Routine Home Care and Continuous Home Care; and two levels of care are reimbursed for services provided on an inpatient basis: Inpatient Respite Care and General Inpatient Care in either a hospital or nursing facility (see also, N.J.A.C. 10:53A-4.1). The provisions at (c)1 through 4 below apply to the levels of care provided by the hospice.

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

ii. For the hospice recipient 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 PA-3L form by the CWA. When the PA-3L form does not reflect the reduction, contact the CWA to effect the change.

iii. For the hospice recipient 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 HCFA 1500 claim shall be so annotated in the "REMARKS" area stating "Recipient 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 recipient's estate.

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

v. For the hospice recipient who is admitted to nursing facility care (in the same or in a different NF) after being discharged from the hospice, the hospice shall provide the NF with a copy of the HCFA 1500 claim indicating 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 MCNH-33 form and attach a copy of the HCFA 1500 claim (copy only to CWA) to notify the

CWA, MDO, 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 HCFA 1500 claim form so that a new PA-3L 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.

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 recipient's plan of care according to the methodology and indices in section 1814(i)(1)(C)(ii) and 1814(i)(2)(B) 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 recipient 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 recipient 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 recipient's acute medical symptoms and only as necessary to maintain the recipient 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 continuous 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 recipient is in an approved inpatient facility (nursing facility or general hospital) receiving respite care. The recipient 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 recipient dies as an inpatient. When the recipient 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 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 hospice patients of a Medicaid participating hospice. Thus, even though the hospice patients are residing in a nursing facility, the provider shall consider the recipient, 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 recipients 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 recipient's condition is such that it is no longer possible to maintain the recipient 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 recipient dies as an inpatient. In this situation, when the recipient 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 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 hospice recipients at the specific Medicaid participating NF where the hospice recipient 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 hospice patient residing in a NF is not a Medicaid recipient of nursing facility care but a hospice recipient.)

i. The room and board rate is calculated at 95 percent of the highest 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. 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 recipient based on actual room and board components provided to the recipient by the NF. The provider number and name of the nursing facility where the recipient resides and with whom the hospice contracts must be placed in the "REMARKS" area of the HCFA 1500 claim.

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

Administrative and Financial Services
Division of Medical Assistance and Health Services
PO Box 712, Mail Code #25
Trenton, New Jersey 08625-0712

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 recipients 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 recipients 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 Health Care Financing Administration (HCFA) (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 HCFA.

1. The regional designation of a provider for wage adjustment purposes will be determined by the location of the main business office of the hospice provider.

2. 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 recipient. 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 recipients during the period of election, regardless of the setting in which the services are provided.

1. Hospices shall not charge Medicaid recipients directly for Medicare coinsurance amounts.

(f) For recipients 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 HCFA 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 HCFA 1500 claim filed in the recipient'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 HCFA 1500 claim submitted to the Medicaid fiscal agent.

(g) For recipients 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 HCFA 1500 claim filed in the recipient'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 HCFA 1500 claim to the fiscal agent.

(h) In addition, for dually eligible Medicare and Medicaid hospice recipients, 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 HCFA 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.

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 hospice recipients 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 an employee of the hospice agency shall be submitted on the HCFA 1500 claim by the physician to the Medicaid fiscal agent.

1. Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement.

2. The physician may bill for services which are not provided on a volunteer basis. However, the physician shall treat Medicaid recipients on the same basis as other recipients 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 recipients.

(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 (when the attending physician is not a hospice employee) in the plan of care and on the Election of Hospice Benefits Statement, FD-378 (6/92); and specify whether the attending physician services are either related or unrelated to the recipient'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).

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 recipients 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 recipients during that same period.

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

ii. If the total number of days of inpatient care furnished to Medicaid hospice recipients 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: 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); multiplying the excess inpatient care days by the routine home care rate; adding the amounts determined in the calculations of (b)1iii(1) and (2) above; and comparing the amount in (b)1iii(3) above with interim payments made to the hospice for inpatient care during the "cap period."

(1) 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 recipients 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).