



STATE OF NEW JERSEY,

DEPARTMENT OF INSTITUTIONS AND AGENCIES,

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES.

HEALTH SERVICES PROGRAM

DO NOT CIRCULATE

Proposed
SKILLED NURSING HOME SERVICES.

[Dec. 1970]

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1970

ERRATA

Page 4 - (L) add eyeglasses and hearing aids.

Page 10 - Section 202.5 - at end of section change (See 206.5) to (See 206.4)

Page 10 - Section 202.6, second line, massage and not massge.

Page 11 - Section 203.3 - at end of section put Form #33030 in parentheses.

Page 13 - Section 204.12 - in paragraph (1) change the word items to times.

Page 13 - Section 204.14 - in paragraph (1), third line, change the state to that state.

Page 18 - Section 206.4, Paragraph (6), second line, change State and local agencies to State or local agencies.

Page 18 - Section 207.3 - change second word from attendance to attendant.

Page 19 - Section 300.1, Paragraph (2) change Death, Transfer of Discharge to Death, Transfer or Discharge.

Page 21 - Section 301.8 - After the word Remarks add the following:
Indicate in the space provided, if adequate, supplemental information such as; 1. name of hospital or nursing home that patient was transferred from; 2. dates of physical therapy treatments (if authorized); 3. changes in patients available income; 4. any other information that will clarify unusual occurrences and expedite billing procedures.

Page 23 - Section 302.5, next to last line, change the word unexpected to unexpended.

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CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Aid to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal Law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

100.1 FINANCIAL ELIGIBILITY

For a person in a nursing home, income and resources must be identified and evaluated in accordance with the currently effective provisions of the Categorical Assistance Budget Manual as promulgated by the State Division of Public Welfare. Such a person has financial eligibility when his cash resources do not exceed \$500.00, and when his monthly income does not exceed \$160.00 or \$175.00 if blind.

101. HOW TO IDENTIFY A COVERED PERSON

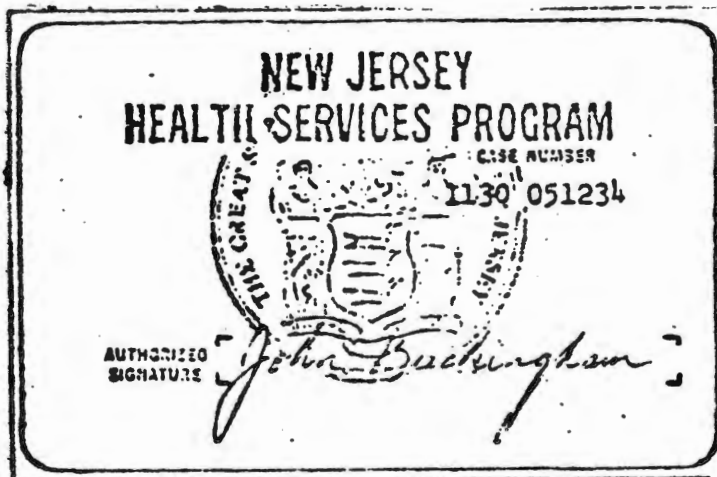
101.1 Plastic Identification Card (Exhibit I)

This card is presently issued to an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies.

It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OR THE STATE OF NEW JERSEY (SEE SECTION 101.2).

EXHIBIT I



101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: THIS FORM IS THE SOLE INDICATOR OF ELIGIBILITY. THE PLASTIC IDENTIFICATION CARD ALONE IS NOT SUFFICIENT.

The sample shown contains all the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, HSP Case Number, and Person Number, EXACTLY as it appears on the Validation form on all Requests for Authorization and claim forms.

_____ COUNTY WELFARE BOARD
VALIDATION FOR HEALTH SERVICES PROGRAM

Valid Only for Month of Jan. 1970

EXHIBIT II	Buckingham	11 30 051234
	01 John	24 Olive
	02 Mary	25 Sarah
	20 Emma Jones	26 Adolph
	21 Lila	
	22 James	
	23 Belinda Smith	

- (a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;
- (b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;
- (c) Outpatient hospital services;
- (d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;
- (e) Laboratory and x-ray services;
- (f) Skilled nursing home services;
- (g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;
- (h) Other practitioners' services, limited by State law to podiatrists and optometrists;
- (i) Dental services, including dentures;
- (j) Home health care services;
- (k) Pharmaceutical services - prescribed drugs (legend and non-legend);
- (l) Prosthetic devices and appliances, medical supplies and equipment;
- (m) Rehabilitation services;
- (n) Transportation, i.e., ambulance services to and from a medical facility when the patient's condition precludes the use of other means of transportation.

103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, institution, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;

Certified Independent Clinical Laboratories;

Dentists;

Hearing Aid Dealers;

Home Health Agencies;

Hospitals;

Skilled Nursing Homes;

Opticians;

Optometrists;

Approved Clinic (Independent Outpatient Health Facilities);

Certified Orthotists;

Pharmacies;

Physicians;

Podiatrists;

Certified Prosthetists; (excluding dental)

Providers of Medical Transportation.

104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the Local Medical Assistance Unit may assist in obtaining an appropriate practitioner or health resource.

105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical service claims (i.e., legend and non-legend drugs), and claims for out-of-state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to the Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the Program.

106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

107. POLICY ON OUT-OF-STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.
2. When it is customary for persons in the area generally to use medical care resources and facilities outside the State of New Jersey.
3. When out of state care was provided in an emergency.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;
2. Any services or items furnished in connection with elective cosmetic procedures;

NOTE: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the practitioner to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;
4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;
5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;
6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy, any other private or governmental health benefit system, or through any similar third party liability;
7. Services or items furnished prior to January 1, 1970 or prior to the period for which the patient presents evidence of eligibility for coverage;
8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;

9. Any services or items furnished for which the Provider does not normally charge;
10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person's household.

109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which the covered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

1. Title XVIII

The Program, in most instances, shall cover the amount of any deductible or co-insurance liability under Title XVIII of the Social Security Act for all covered persons 65 years of age or older.

2. Workmen's Compensation

No Program payments shall be made for a patient covered by workmen's compensation.

3. Other Health Insurance

When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

111. MEDICAL REVIEW AND EVALUATION (by Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials' situations in which there is valid reason to suspect that fraud has been practiced.

114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

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SKILLED NURSING HOME MANUAL

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CHAPTER II

SKILLED NURSING HOME MANUAL

200. SCOPE

This chapter is concerned with the provision of quality health care services available to eligible recipients of the New Jersey Health Services Program in a Skilled Nursing Home.

201. DEFINITIONS

- 201.1 Skilled Nursing Home: Whenever the term "skilled nursing home" is used in this Manual it shall mean: (1) a medical facility, or portion thereof, which is licensed by the State, and which, through its Administrator, has signed an Acceptance of Participation in the New Jersey Health Services Program (Form MC-NH 2) and (2) which is certified to meet, and which conducts its operations in conformity with, standards established by the Federal Department of Health, Education and Welfare, as administered through the Bureau of Community Institutions of the Department of Institutions and Agencies.
- 201.2 Skilled Nursing Home Patient: A person admitted to a skilled nursing home upon the recommendation of a physician because of illness, injury, incapacity or other defect and for whom there is planned continuing medical and skilled nursing care directed toward improvement in health; the assessment of health care needs or level of care of this person must, in the professional judgment of the attending physician and a medical evaluation team of the Local Medical Assistance Unit (i.e., Medical Consultant, Regional Staff Nurse, and direct service caseworker) have determined that:
- (1) Essential health care and active treatment in a general or special hospital is not required, and
 - (2) Essential health care cannot be met satisfactorily in the recipient's own home or other place of residence, substitute or alternate arrangements, or through the provision of home health services in or near his community, and
 - (3) Essential health care cannot be met satisfactorily in a physician's office, clinic, hospital out-patient department, or other ambulatory care setting because of unavailability or inaccessibility of medical and other health and health related services in or near his community.
- 201.3 Skilled Nursing Services: Nursing services which must be furnished by or under the direct supervision of a professional registered nurse to assure the safety of the patient and to achieve the medically desired result. Such services generally require specialized health care knowledge and include but are not limited to the following:

- (1) Evaluation and reevaluation of the nursing needs of the patient;
- (2) Developing and implementing the nursing care plan for the patient;
- (3) Providing nursing services, treatments, and diagnostic and preventive procedures requiring substantial specialized skill;
- (4) Initiating preventive and rehabilitative nursing procedures as appropriate for the patient's care and safety;
- (5) Observing signs and symptoms and reporting to the physician reactions to treatments, including drugs, and changes in the patient's physical or emotional condition;
- (6) Teaching, supervising and counseling the patient and family members regarding the nursing care needs and other related problems of the patient;
- (7) Supervising and training other nursing service personnel.

201.4 Prior Authorization: Whenever the term "prior authorization", "authorization", or "re-authorization" is used in this Manual, it shall mean approval granted by a Medical Consultant of the Division of Medical Assistance and Health Services for payment for skilled nursing home services rendered to an eligible patient for a specific time period.

202. BASIC SERVICES

Basic services and items which must be provided and/or available to patients in a skilled nursing home include but are not limited to:

- 202.1 Board and bed in semi-private accommodations. This includes linens for bed and bathroom.
- 202.2 Laundry of personal clothing (excluding dry cleaning).
- 202.3 Special diets as prescribed by the patient's attending physician.
- 202.4 Professional Registered Nurse supervision 24 hours daily. Nursing Services must be under the direction of a full-time professional Registered Nurse.
- 202.5 Restorative nursing and auxiliary personnel, as required, to maintain function or improve patient's ability to carry out the activities of daily living, including ambulation; and nursing supervision and care as required by the nature of the patient's illness (See 206.5).
- 202.6 All non-legend medications including medicine chest supplies and personal comfort items (e.g. mouthwash, talcum powder, massage lotions, etc.)

EXCEPTION: Insulin

- 202.7 Medical supplies including incontinency pads, bandages, dressings, compresses, sponges, plasters, tapes, cellucotton or other types of pads used to save labor or linen, and other disposable items (e.g. colostomy bags). Also, hot water bags, thermometers, catheters, rubber gloves, and supplies required in the administration of medication, including disposable syringes.
- 202.8 Skilled nursing services commonly performed by members of the staff concerned with patient care (e.g. administration of intravenous, subcutaneous and/or intramuscular injections, infusions, etc.).
- 202.9 Durable medical equipment (e.g. walkers, wheelchairs, bedrails, crutches, traction apparatus) and other therapeutic equipment and supplies essential to furnish the services offered by the facility in the care and treatment of its patients.

203. ADDITIONAL SERVICES

The following must be provided and/or available to patients in a skilled nursing home but are not necessarily a part of the per diem rate paid to the skilled nursing home unless included in the cost study of the skilled nursing home by the Bureau of Claims and Accounts of this Division:

- 203.1 Laboratory and x-ray services.
- 203.2 Reimbursement for oxygen, but not equipment for its administration is allowable under the following conditions:
- (1) No prior authorization is required for oxygen when the amount purchased is less than \$20. It is supplied for the eligible recipient as a separate vendor item and billed by the vendor to the contractor as medical supplies.
 - (2) Amounts of oxygen costing more than \$20 require prior authorization from a Medical Consultant of the Local Medical Assistance Unit of the Division of Medical Assistance and Health Services.
- 203.3 When unusual circumstances require a special wheelchair, such as one operated by a single hand, it must be prescribed by a physician; the prescription must describe the equipment needed and give the reason for its need.

Prior authorization is required for the rental or purchase of such equipment regardless of price. Prior authorization for such items is issued only by the Central Office of the Division of Medical Assistance and Health Services. The prescription must be attached to the Request for Authorization Form #33030.

204. GENERAL POLICIES

- 204.1 The State Administering Agency, the Division of Medical Assistance and Health Services, is responsible for authorizing initial and continuing

services in a skilled nursing home. Thus, payment for skilled nursing home care shall not be approved in the absence of prior authorization by a Medical Consultant of the Local Medical Assistance Unit for placement or continuing care in a skilled nursing home, except where transferred from a general hospital in accordance with 205.1 (1).

The attending physician will be consulted by the Medical Consultant of the Local Medical Assistance Unit when evaluation by agency staff determines that alternate care arrangement may more appropriately meet patient need, prior to final determination. In instances where the individual is receiving skilled nursing home care, and evaluation determines that a lower level of care may be more appropriate, continued payment of the cost of skilled nursing home care will be permitted for a reasonable period, not to exceed 30 days following written notice to the County Welfare Board. This period of time is allowed to enable an alternate plan of care to be worked out by the recipient, his next of kin, the attending physician and the responsible welfare board, as appropriate. Copies of the written notice to the County Welfare Board shall also be sent to the attending physician and to the skilled nursing home.

- 204.2 Payment for skilled nursing home care may be made only on behalf of a recipient who is placed within an identified area certified as a skilled nursing home. When justified by individual circumstances, payment for a temporary period may be made for skilled nursing home services provided to a patient who is placed in an area licensed, approved, or certified as a hospital or extended care facility.
- 204.3 Each Medicaid patient in a skilled nursing home must be seen by his attending physician at least every 30 days and an appropriate medical record of the physician's visit recorded on the chart by the physician.
- 204.4 Placement of Medicaid recipients in a defined area (floor, wing, section or building) of the skilled nursing home separate and apart from other patients, is discriminatory and prohibited by State and Federal Law, unless justified by medical necessity in making maximum use of the facilities of the skilled nursing home.
- 204.5 Providers participating in the Program have agreed to accept as payment in full the reimbursement rate established for the facility. The total payment received by the skilled nursing home on behalf of the recipient, from any and all sources (including the Health Services Program), may not exceed this reimbursement rate. Separate charges for care and services listed in Section 202 are prohibited.
- 204.6 Although there may be a higher reimbursement rate established for the facility by the Division, payment cannot exceed the rate charged by the skilled nursing home to private patients.
- 204.7 Signed physicians' orders for medications, drugs, tests and treatment administered to eligible recipients must be accurately recorded in the patient's chart.

- 204.8 Services of physician consultants, dentists, podiatrists, etc., must be requested by the attending physician and the reason for the request recorded on the patient's chart by the physician. A report of the consultant's findings must also be recorded on the chart by the consultant.
- 204.9 Unless the facility has a licensed pharmacy, a stock supply of legend drugs in the skilled nursing care facility is prohibited. Non-legend drugs, such as aspirins, milk of magnesia, etc., may be separately stocked in the drugroom of the skilled nursing care facility. This will permit the skilled nursing home to maintain a supply of non-legend drugs to be administered as directed by the prescribing physician under the supervision of a Consultant Registered Pharmacist in keeping with established stop order policies. In such instances, the non-legend drugs may be dispensed and labeled from the stock supply at the skilled nursing home by the Consultant Registered Pharmacist. However, it is to be emphasized that the Pharmacist is the only person, other than a physician or dentist, legally authorized to perform this activity.
- 204.10 "Stop Orders" are internal policy regulations of the skilled nursing home and unrelated to the Health Services Program regulations. Thus, such "orders" do not supersede Program regulations concerning the prescribing of drugs and pharmaceutical services as outlined in the Pharmacy Manual.
- 204.11 Skilled nursing home services under the Health Services Program do not include outpatient services furnished by the skilled nursing home (or extended care facility). Thus, the "co-insurance" liability of aged (65 years and over) Medicare-Medicaid recipients is not payable by the Health Services Program when the health care is rendered as an outpatient service of a skilled nursing home (or extended care facility).
- 204.12 All prescriptions and orders for patient services written by the attending physician shall be in effect:
- (1) Only for the dosage number of items or days specified in the written order; and
 - (2) In no event for more than 30 days, at the end of which period of time each new order intended to be continued shall be renewed in writing by the physician.
- 204.13 Transfers of recipients between distinct parts of an institution (extended care facility, skilled nursing home, intermediate care facility) requires prior authorization of a Medical Consultant of the Local Medical Assistance Unit. The only exception is a transfer from or to a general hospital.
- 204.14 Out-of-State Placement in a Skilled Nursing Home is limited to emergency situations.
- (1) When payment for out-of-state skilled nursing home care is required for any reason, the facility must be licensed as a skilled nursing home by the State and the rate of reimbursement may not exceed that authorized by the Title XIX program in the State in which the institution is located or the maximum reimbursement rate authorized to New Jersey skilled nursing homes, whichever is lower.

- (2) Claims on behalf of patients in out-of-state skilled nursing homes will not be approved until a review of the complete medical record has been made to determine need for skilled nursing home services and to determine appropriateness of moving the patient to a skilled nursing home in New Jersey. The complete medical record must be submitted to the

Department of Institutions and Agencies
Division of Medical Assistance and Health Services
Bureau of Long Term Care
P. O. Box 2486
Trenton, New Jersey 08625

204.15 Medicare-Medicaid Recipients

- (1) Medical Assistance (Medicaid) recipients age 65 or over are also covered by the Medicare (Title XVIII) program.
- (2) Medicaid eligible recipients receiving Medicare Part A benefits in a skilled nursing home certified as an extended care facility incur a "co-insurance liability" obligation after the first 20 days of such care for each benefit period. The Health Services Program may assume this obligation for all or a portion of the co-insurance if the recipient is financially unable to pay it himself provided the total amount to be received by the Extended Care Facility from Medicare, Medicaid and any other sources (including the recipient's available income) does not exceed the established Medicaid reimbursement rate authorized for the facility.
- (3) Medicaid eligible recipients aged 65 and over who are eligible for Extended Care benefits under Medicare Part A (Title XVIII) are required to exhaust applicable benefits prior to the availability of skilled nursing home service benefits under the Medicaid (Title XIX) program.

204.16 Whenever a recipient of medical assistance is absent on leave from a skilled nursing home payment for skilled nursing home care for this recipient during such absence will not be allowed. Such leaves may necessitate re-assessment of need for skilled nursing home care.

204.17 Whenever a recipient of medical assistance must be removed from a skilled nursing home to receive hospitalization, payment of medical assistance for skilled nursing home care for this recipient will not be allowed during such absence from the skilled nursing home.

204.18 Notification of any absence of a recipient from a skilled nursing home when such absence amounts to 24 hours must be shown on the monthly bill for that recipient. Unreported absences constitute a discharge and therefore termination of authorization for payment.

205. ADMISSION PROCEDURES

An eligible recipient may be admitted to a skilled nursing home only upon the recommendation of a physician which includes a written plan of care, and where applicable a plan of rehabilitation. In order for payment to be made each recipient admitted to a skilled nursing home must have been authorized by a Medical Consultant of the Local Medical Assistance Unit, except as indicated in 205.1.

205.1 Hospital to Skilled Nursing Home

- (1) Transfer of an eligible recipient from an approved hospital to a Skilled Nursing Home does not require an authorization for the first 30 days of skilled nursing home care, provided the eligible recipient has been duly admitted as a bed-patient in the hospital for 3 days immediately preceding the transfer.
- (2) When an inpatient is to be discharged from the hospital and continuing medical care is required in another medical facility (i.e. extended care facility, skilled nursing home, etc.), or by a community health agency (e.g. home health agency), a legible abstract or summary must be prepared by either the attending physician or the hospital, signed by the attending physician, covering the patient's care in the hospital with recommendations for further medical care, and made available to the institution or agency to which the patient has been referred. A copy of the transfer form shall also be sent to the Local Medical Assistance Unit serving the county wherein the Skilled Nursing Home is located, and it is the responsibility of the Skilled Nursing Home to see that this is done. The Patient Information Form, Hospital and Nursing Home (Form 766) or equivalent transfer form may be used.
- (3) The Skilled Nursing Home is responsible for notification of the Local Medical Assistance Unit serving the county wherein the skilled nursing home is located of the admission of a Medicaid eligible recipient by transfer from a licensed and accredited hospital within 48 hours or two working days.

205.2 Admission to a Skilled Nursing Home from Recipient's Home, Other Place of Residence, or Institution other than a General Hospital.

- (1) Prior authorization by a Medical Consultant of the Division of Medical Assistance and Health Services is required. The following procedures are completed before authorization can be approved:
 - (a) The County Welfare Board will furnish a completed Form PA-4 (certification of physician) to the Local Medical Assistance Unit.
 - (b) A regional staff nurse visits the recipient and makes an assessment of the level of care required.
 - (c) A medical evaluation team (medical consultant, regional staff nurse and direct service caseworker) reviews the medical-social information and other supporting data to evaluate need and determine appropriateness of placement in a skilled nursing home.
 - (d) If skilled nursing home placement is approved, a copy of the authorization is sent to County Welfare Board, Skilled Nursing Home and Bureau of Claims and Accounts of this Division. The maximum duration approved on the basis of a single authorization is six months.

- (e) The County Welfare Board shall furnish the Bureau of Claims and Accounts, Division of Medical Assistance and Health Services, a statement of the recipient's budgetary information using the appropriate format.
- (f) If the decision is to deny the request for Skilled Nursing Home placement, the Medical Consultant of the Local Medical Assistance Unit shall discuss with the attending physician the basis of the decision and suggestions for alternate care or placement.
- (g) The attending or referring physician, County Welfare Board and the Skilled Nursing Home when appropriate, shall be sufficiently notified in writing of the decision to approve or deny skilled nursing home placement.

205.3 Reauthorization Procedures

- (1) Thirty days before the expiration of an authorized period of Skilled Nursing Home Services, a regional staff nurse shall assess the needs of the patient-recipient to determine the current health status, continuing need for Skilled Nursing Home care and/or other appropriate alternatives.
- (2) The medical evaluation team will re-evaluate the available data to determine need of continued Skilled Nursing Home placement, or the appropriateness of alternatives.
- (3) If the decision is to deny authorization for continued skilled nursing home care, the Medical Consultant of the Local Medical Assistance Unit shall discuss with the attending physician the basis of the decision, and recommendations for alternate care or placement.
- (4) The attending physician, the County Welfare Board, Skilled Nursing Home, and Bureau of Claims and Accounts shall be officially notified in writing of the decision.

205.4 Transfer from a Skilled Nursing Home (including an Extended Care Facility) to Another Skilled Nursing Home

- (1) Upon receipt of a Request for Authorization (30330) for transfer, a regional staff nurse shall assess the needs of the patient-recipient to determine the current health status and appropriateness of the transfer.
- (2) The medical evaluation team will evaluate the appropriateness of the transfer, and if approved will authorize the transfer.
- (3) If the decision is to deny authorization for the transfer, the Medical Consultant of the Local Medical Assistance Unit shall discuss with the attending physician the reason for the decision before a final determination is made.

206. REHABILITATION SERVICES

206.1 These are defined as including physical therapy, occupational therapy, speech therapy and hearing services, and the use of such supplies and equipment as are necessary in the provision of such services.

206.2 Scope

Services provided are for the purpose of attaining maximum reduction of physical or mental impairment and restoration of the patient to his best functional level. It does not include therapies which are purely palliative, such as the application of heat per se in any form, massage, routine calisthenics or group exercises, assistance in any activity or use of simple mechanical devices not requiring the special skill of a qualified therapist. Rehabilitation services shall be made available to eligible recipients as an integral part of a comprehensive medical program.

206.3 Providers of Service

- (1) Rehabilitation service shall be provided by qualified therapists. If the qualified therapist is employed by the skilled nursing home, his salary shall be considered in the cost survey and the services included in the per diem rate of the facility. Authorization for physical therapy is not then required.

Records shall show the prescription, date and type of therapy given, and a progress note of results.

- (2) If the skilled nursing home does not employ a qualified therapist, the service shall be provided by a qualified therapist employed by or under contract to a certified Home Health Agency. Prior authorization by the Medical Consultant of the Local Medical Assistance Unit is then required, and it is the responsibility of the Home Health Agency to obtain the Prior Authorization.
- (3) Authorization shall be considered only when the request includes a written prescription by a fully licensed physician, substantiating the need, type of therapy, objective of treatment, and an estimate of the number of treatment days. Prescriptions must be definitive as to type and scope. Orders such as "Physical Therapy three times a week" will not be accepted. Prior authorization may be for a period not exceeding 60 days. Subsequent authorizations for periods not exceeding 60 days may be issued by the Medical Consultant of the Local Medical Assistance Unit when the request is supported by the written prescription of the attending physician, including a statement of the anticipated number of treatments required, and a progress report of the recipient's condition.

206.4 Restorative Nursing Care

Nursing personnel are taught restorative nursing measures and practice them in their daily care of patients. These measures include but are not limited to:

- (1) Maintaining good body alignment and proper positioning of bedfast patients;

- (2) Encouraging and assisting bedfast patients to change positions at least every two hours day and night to stimulate circulation and prevent decubiti and deformities;
- (3) Making every effort to keep patients active and out-of-bed for reasonable periods of time, except when contraindicated by physicians' orders, and encouraging patients to achieve independence in activities of daily living by teaching self care, transfer and ambulation activities;
- (4) Assisting patients to adjust to their disabilities, to use their prosthetic devices, and to redirect their interest if necessary;
- (5) Assisting patients to carry out prescribed physical therapy exercises between visits of the physical therapist;
- (6) Consultation and instruction in restorative nursing available from State and local agencies (e.g. State Department of Health) are utilized by the Nursing Staff of the Skilled Nursing Home.

207. NON-COVERED SERVICES

Services for which reimbursement is not made include, but are not limited to, the following:

- 207.1 Admission or continued care primarily for diet therapy of exogenous obesity, bed-rest, rest cure, or care of non-medical nature.
- 207.2 Private duty nursing.
- 207.3 Private attendance services for personal care.
- 207.4 Services and supplies not directly related to the care of the patient (e.g. guest meals and accommodations, television, telephone, etc.).
- 207.5 Practitioner or therapy services furnished on a fee-for-service basis by an owner, partner, administrator, stockholder, or others having a direct or indirect financial interest in the institution.

208. TERMINATION OF AUTHORIZATION

When termination of authorization for skilled nursing home occurs because of discharge, death, or transfer, Form MCNH-8 is completed in triplicate by the County Welfare Board or Local Medical Assistance Unit, whichever receives notification of such termination first. The original is sent to the Bureau of Claims and Accounts, Division of Medical Assistance and Health Services; the second copy is sent to the County Welfare Board, and the third copy to the Local Medical Assistance Unit.

It is the responsibility of the Skilled Nursing Home to notify the Local Medical Assistance Unit and the County Welfare Board of such termination of service.

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CHAPTER III

BILLING

300. BILLING PROCEDURES

Instructions for billings on EDP Billing Sheet and State Form 100 (original invoice) for New Admissions, Death, Transfer, Discharge, and Separate Charges for Clothing, Insurance, etc.

300.1 Procedures to be Followed for Adjustments

- (1) New Admissions - Record case number, person number, name, date admitted, number of days care received, per diem rate, patient's available income, and amount due for the current month. The Form PA-3L received from the County Welfare Board will show the effective date for availability of income. New Admissions from other than a hospital should be accompanied by a copy of the Authorization Form (MCNH-7).
- (2) Death, Transfer of Discharge - Show date of departure and correct number of days care received. The difference between the preprinted number of days care received and the corrected number inserted by the nursing home, multiplied by the per diem rate will give the nursing home the proper adjustment to the billing total. This amount will be shown in the "Deduction" column on the same line with the preprinted "net payment" for that recipient. For example - If a patient was discharged on January 22, 1970, the preprinted 31 in the Days of Care Received column would be crossed out and a 21 inserted above ~~(31)~~ (21). The difference (10 days) multiplied by the per diem rate would be shown in the "Deduction" column.
- (3) Separate Charges for Clothing, Insurance, etc. - Insert these charges in the "Additions" column of the invoice. Billings showing charges for these items must be accompanied by a Form PA-3L approving the transaction. The special charges for clothing, insurance, etc. cannot exceed the amount shown in the patient's monthly income column.

Add and total the "Additions" and "Deduction" columns under "Adjustments". Add or subtract the difference from the preprinted billing total for the month. This total should be shown on the Form 100 submitted to the Bureau of Claims and Accounts for the month.

300.2 Form 100

The adjusted amount from the billing should be carried over into the amount column of the Form 100. The Form 100 must be submitted in duplicate and be properly signed in the lower left-hand corner by the Administrator or some similar officer of the facility. Please do not submit invoices signed by clerical personnel. Additional invoice forms may be obtained upon request. Please submit billings prior to the 16th of each month to:

Department of Institutions and Agencies
Division of Medical Assistance and Health Services
Bureau of Claims and Accounts
P. O. Box 2486
Trenton, New Jersey 08625

Questions concerning billing procedures should be directed to above or telephone 609-292-7410.

301. EXPLANATION OF COLUMNS ON EDP BILLING SHEET

301.1 Case Number and Person Number

The Case Number for each recipient should be copied from the monthly validation form (check stub). It is necessary to check the latter, monthly, to determine the continuing eligibility of the recipient from month to month.

301.2 Date of Admission or Discharge

These columns are to be completed for each admission, death, transfer or discharge during the month and should also be used to indicate the beginning date of Medicare co-insurance when applicable.

Transfers to the nursing facility directly from a hospital or another nursing facility should be so indicated and the name of the transferring institution should be shown in the "Remarks" column.

301.3 Number of Days Care Received

This column will be preprinted with the number of days in the current month. If the patient has expired, or been discharged or transferred, during the month, cross out the number of days shown in this column and insert the correct number. In the case of new admissions, insert the number of days to be billed. In computing the number of days care received, always count the day of admission, but do not count the date of expiration, transfer or discharge.

301.4 Rate

Per Diem - The rate shown in this column is the rate established for your facility on the basis of the Cost Study submitted.

Medicare - The Medicare co-insurance rate is calculated as follows: the net Medicare rate (after subtraction of the co-insurance factor), if less than the rate established for your facility, is subtracted from your Medicaid reimbursement rate and the difference is shown in the rate column when billing for Medicare co-insurance. If the patient has income during the co-insurance period of Medicare eligibility that may be applied to the cost of his or her medical services, this income must be first applied against the portion of co-insurance payable from medical assistance. Income received after the period of co-insurance must not be applied retroactively to amounts remaining due from the period of co-insurance.

When co-insurance is to be claimed:

- (1) Insert the effective date in the column provided for admission date,
- (2) Insert the number of co-insurance days in the "Medicare" column under "Days-Care",
- (3) Indicate the per diem co-insurance rate claimed, computed as indicated in the above paragraph, in the "Medicare" column under "Daily-Rates",
- (4) Multiply the number of days in (2) by the per diem rate in (3) and insert the total in the "Gross Payments" column,
- (5) Indicate income available for application toward the cost of medical services in the "Monthly Resource" column,
- (6) Extend the net amount, Item (4) minus Item (5) into the "Add" column under "Adjustments", and
- (7) Enter the current gross Medicare rate for your facility in the "Remarks" column.

301.5 Gross Payments

The amount in this column should represent the number of days care received, multiplied by the daily rate.

301.6 Patient's Monthly Income

This represents the balance of the patient's income that is available to be applied against the cost of medical assistance after providing \$9.00 per month to the patient for his or her personal incidental expenses. The amount of income available from each patient will be determined by the county welfare boards and communicated to the nursing facility on Form PA-3L (Statement of Income Available for Nursing Home Payment). If the amount of the check received by the facility, adjusted by the \$9.00 for personal incidental expenses, does not agree with the amount off-set on the billing, the facility should request the County Welfare Boards to initiate an amended Form PA-3L.

301.7 Adjustments to Billing Total

These columns are to be used by the facility to record adjustments to the preprinted "net payments" amount for individuals listed on the billing. After all adjustments are recorded, the columns should be added and the net difference subtracted or added to the preprinted billing total.

301.8 Remarks

302. Factors Affecting Billings

302.1 Supplementary Medical Insurance Benefits Refund

Supplementary Medical Insurance Benefits (Medicare Part B) premium refunds will occur as this Division assumes responsibility of payment for recipients on a group basis. The refund for each patient should be shown on the

nursing home billing as an addition to income available for application against the cost of medical services.

302.2 Status Reports - Admissions to Extended Care Facilities

The Division's objective is to obtain acceptable records for our files indicating that Medicare coverage has been denied, terminated, or exhausted (with the exception of co-insurance) prior to initiating charges under our program for patients age 65 or older.

Extended care facilities will be required to submit copies or reproductions of Medicare status reports, received from their Medicare intermediaries, to this Division for all additions to billings.

These status reports will consist basically of two types:

- a. Copy of SSA Form #1453 (Final Billing)
- b. Notice to ECF of denial

Additions to billings will include those recipients added to the billing for either co-insurance or full per diem coverage. Extended care facilities must first exhaust nursing home coverage under Medicare before making claims under the New Jersey Health Services Program.

302.3 Termination of Medicare Benefits

In those instances where additions are being made to billings under this program due to the exhaustion of Medicare benefits, or cut off by Utilization Review Committee, the extended care facilities should forward a copy of SSA Form #1453E final billing to intermediary with items 23, 24 or 25 (a) completed. Where Medicare coverage has been cut off prior to exhaustion of benefits other than as a result of utilization review action, a copy of the communication from the intermediary should be submitted.

When billings are made for co-insurance, the nursing facility should continue to submit copies of SSA Form #1453E (admission copy) completed by the intermediary (Prudential) or "notice to provider of approval of admission" (Hospital Service Plan). A signed statement will be accepted from the nursing facility, in lieu of the status reports mentioned above, in those instances where it is obvious to the nursing facility that the admission cannot be billed under Medicare. This statement should contain the words that "billing has not been made and is not contemplated under Medicare for the period being billed under the New Jersey Health Services Program" and state the reasons why the billing cannot be made to Medicare; e.g., (1) patient not hospitalized for three days or more, (2) patient not admitted to extended care facility within 14 days after period of hospitalization, (3) patient absent from an extended care facility for a period of more than 14 days and/or (4) benefits exhausted during prior admission of same spell of illness.

302.4 Source of New Admissions and Additions to Billings

For all new additions to the billing, please indicate in the "Remarks" column or other suitable place the following:

- a. Admitted direct from (name of hospital)
- b. Admitted as transfer from (name of nursing home)
- c. Added to billing after expiration of Medicare eligibility (for full or co-pay days)
- d. Admitted direct from community
- e. Change in classification e.g. Private to Medicaid

302.5 Income

Income is to be applied against the billing for the month in which the income was received by either the patient or representative payee: e.g. amounts received from Social Security, pensions, etc. in January 1970, regardless of the month being paid for, would be shown in the Resources column on the billing for services rendered in January.

Explanatory notes concerning income that the facility expects to receive in a subsequent month may be made in the "Remarks" column. In the event of death, any unclaimed personal incidental funds of the patient should be returned to the Bureau of Claims and Accounts if such funds were received by the patient as a part of his or her monthly income. If the personal incidental funds were received as a public assistance money payment, any unexpected balance should be returned to the proper County Welfare Board.

302.6 Corrections

When making adjustments for patients that have been discharged, deceased, transferred, etc., please do not obliterate the preprinted information. A single line should be drawn through the amount to be changed and the corrections inserted above.

302.7 State Form 100

It is not necessary to show any detail concerning individual patients on the Form 100 provided for invoicing. It is only necessary to carry the adjusted total from the IBM billing form to the Form 100. The original IBM billing form returned to the Bureau, with the Form 100, will provide the detail necessary.