

CHAPTER 85

LONG-TERM CARE SERVICES

Authority

N.J.S.A. 30:4D-6(a)(4)(a), 6b(14), 6.7, 6.8, 7, 7(a), 7(b), 7(c) and 12;
42 U.S.C. §1396a(a)(13)(A) and 42 U.S.C. §1396r; and
Executive Reorganization Plan 001-1996.

Source and Effective Date

R.2005 d.389, effective October 18, 2005.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Chapter Expiration Date

Chapter 85, Long-Term Care Services, expires on October 18, 2010.

Chapter Historical Note

Chapter 63, Skilled Nursing Home Services Manual, was adopted as R.1971 d.163, effective September 22, 1971. See: 3 N.J.R. 206(b).

Chapter 63, Skilled Nursing Home Services Manual, was repealed and Chapter 63, Long-Term Care Services Manual, was adopted as new rules by R.1979 d.126, effective March 29, 1979. See: 10 N.J.R. 190(b), 11 N.J.R. 248(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, General Provisions, was readopted as R.1984 d.123, effective March 21, 1984. See: 16 N.J.R. 204(a), 16 N.J.R. 896(a).

Pursuant to Executive Order No. 66(1978), Subchapter 3, Cost Study, Rate Review Guidelines and Reporting System for Long-Term Care Facilities, was readopted as R.1984 d.573, effective November 29, 1984. See: 16 N.J.R. 2484(a), 16 N.J.R. 3437(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services Manual, was readopted as R.1989 d.622, effective November 29, 1989. See: 21 N.J.R. 2752(a), 21 N.J.R. 3918(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services, was readopted as R.1994 d.624, effective November 23, 1994, and former Subchapters 1, 2, 2A and 4, and Appendix I were repealed and Subchapter 1, General Provisions, Subchapter 2, Nursing Facilities Services, and Appendices A through Q were adopted as new rules, and Subchapter 5, Audits, was recodified as Subchapter 4 by R.1994 d.624, effective January 3, 1995. See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

Pursuant to Executive Order No. 66(1978), Chapter 63, Long-Term Care Services, was readopted as R.1999 d.364, effective September 24, 1999. See: 31 N.J.R. 1759(a), 31 N.J.R. 3116(a).

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 63 Long-Term Care Services, was extended by gubernatorial order to March 23, 2006. See: 37 N.J.R. 1185(a).

Chapter 63, Long-Term Care Services, was readopted by R.2005 d.389, effective October 18, 2005. Chapter 63 was recodified as Chapter 85, Long-Term Care Services in Title 8, by R.2005 d.389, effective October 18, 2005. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:85-1.1 Scope

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible children and adults in a nursing facility (NF) and addresses the provision of and reimbursement for services required to meet the individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. The following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement continues to apply to all government psychiatric hospitals, inpatient psychiatric services and programs in long term care facilities. These other types of facilities are addressed for regulatory and administrative matters in the appropriate chapters elsewhere in Title 10 of the New Jersey Administrative Code.

Recodified from N.J.A.C. 10:63-1.1 and amended by R.2005 d.389, effective January 17, 2006.
 See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).
 Rewrote the section.

Case Notes

Radioactive application of regulation valid. In re: Medicaid Long Term Care Services Bulletin 84-2, 212 N.J.Super. 48, 513 A.2d 967 (App.Div.1986), certification denied 526 A.2d 125, 107 N.J. 31.

Denial of request for reclassification from low to medium salary region assignment not inequitable. *Rosewood Manor, Inc. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 20.

8:85-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

“Advance directive” means a written instruction relating to the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney for health care.

“AIDS” means acquired immunodeficiency syndrome, a disease that meets the criteria for the diagnosis specified by the CDC, in the “1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults,” as published by the CDC in the *Morbidity and Mortality Weekly Report* 1992, Volume 41, No. RR-17, incorporated herein by reference, as amended and supplemented, and available for download at

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm> (hereinafter referred to as the “1993 Revised Classification System”), and the “Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome,” as published by CDC in the *Morbidity and Mortality Weekly Report* 1999, volume 48, No. RR-13; 1 through 28, incorporated herein by reference, as amended and supplemented, and available for download at <http://www.cdc.gov/mmwr/PDF/rr/rr4813.pdf> (PDF format) and at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4813a1.htm> (main document in HTML format) and www.cdc.gov/mmwr/preview/mmwrhtml/rr4813a2.htm (appendix in HTML format) (hereinafter collectively referred to as the “1999 Guidelines”).

1. Both of these publications are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

“AIDS-defining illness” means the 26 clinical conditions that affect people with advanced HIV disease listed in Categories B and C of the 1993 Revised Classification System, including, but not limited to, pneumocystis carinii pneumonia or PCP, toxoplasmosis, cytomegalovirus or CMV, oral-esophageal candidiasis, wasting, bacterial pneumonia, lymphoma, cryptococcal meningitis, mycobacterium avium complex or MAC, and Kaposi's sarcoma.

“Air fluidized therapy bed” means a device employing the circulation of filtered air through ceramic spherules (small, round ceramic objects).

“Bed” or “licensed bed” means “bed” or “licensed bed” as those terms are defined at N.J.A.C. 8:39-1.2.

“Beneficiary” means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

“Care management” means a process by which professional staff designated by the Department monitor the provision of NF care to:

1. Assure that services are rendered as recommended by the HSDP and in accordance with the NF's evaluation of the individual's health service needs;
2. Assure the delivery of timely and appropriate provider responses to changes in care needs;
3. Provide, direct or secure needed consultations with Medicaid professional or NF staff so that services are delivered in a coordinated, effective, and cost-prudent manner; and
4. Facilitate discharge planning and promote appropriate placement to alternate care settings.

“Case mix” means a system of staffing and reimbursement for nursing services based on variation in patient acuity and

individual with MI or MR, to the LTCFO for PAS and, if appropriate, to the CWA for a determination of financial eligibility by submitting to the LTCFO a completed Certification of Need for Patient Care in Facility other than Public or Private General Hospital, also known as a PA-4 form, provided at Appendix H, incorporated herein by reference, and available for download at <http://nj.gov/health/forms/index.shtml>.

i. Upon receipt by the LTCFO of a PA-4 form or a physician statement that substantiates the individual's diagnosis and describes the individual's care needs, professional staff designated by the Department will conduct PAS in accordance with the procedure provided in (d) above and by completing the standardized assessment.

(1) Upon conclusion of PAS, the professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, as to whether the individual is clinically eligible for NF services, and the LTCFO will mail either the approval letter in the form provided in Appendix M, or the denial letter in the form provided in Appendix N, to the individual or, if applicable, the individual's legal representative, and will send a copy of the letter to the CWA.

ii. For individuals residing in the community with MI, professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, at the conclusion of PAS whether the individual is clinically eligible for NF placement.

(1) If the individual is not clinically eligible for NF placement, the LTCFO will mail an executed denial letter in the form provided at Appendix N to the individual or, if applicable, the individual's legal representative.

(2) If the individual is clinically eligible for NF placement, the professional staff designated by the Department will provide the individual or, if applicable, the individual's legal representative, with an executed form LTC-L6a advising the individual or representative, of the need to have the Psychiatric Evaluation form provided at Appendix I completed by a psychiatrist, physician (doctors of medicine or osteopathy), certified nurse practitioner certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health or clinical nurse specialist certificated pursuant to N.J.S.A. 45:11-45 et seq., and certified in the advanced practice of psychiatric nursing or mental health pursuant to N.J.S.A. 45:11-45 et seq. and the need to forward the form to the DMHS.

(3) If PASRR by the DMHS results in a determination that the individual requires specialized

services for MI, then NF placement is not appropriate and the LTCFO will mail an executed denial letter in the form provided at Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and the DMHS will assist the individual in securing appropriate placement and/or services.

(4) If PASRR by the DMHS results in a determination that the individual does not require specialized services for MI, the LTCFO will mail the approval letter in the form provided in Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and will transmit a copy of the approval letter to the CWA.

iii. For individuals residing in the community with MR, professional staff designated by the Department will verbally advise the individual or, if applicable, the individual's legal representative, at the conclusion of PAS whether the individual is clinically eligible for NF placement.

(1) If the individual is not clinically eligible for NF placement, the LTCFO will mail, an executed denial letter in the form provided at Appendix N to the individual, or if applicable, the individual's legal representative.

(2) If the individual is clinically eligible for NF placement, professional staff designated by the Department will provide the individual or the individual's legal representative, with an executed form LTC-L7a advising the individual or representative, of the need for the DDD to conduct PASRR.

(3) If PASRR by the DDD results in a determination that the individual requires specialized services for MR, then NF placement is not appropriate and the LTCFO will mail an executed denial letter in the form provided at Appendix N and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative and the DDD will assist the individual in securing appropriate placement and/or services.

(4) If PASRR by the DDD results in a determination that the individual does not require specialized services for MR, the LTCFO will mail the approval letter in the form provided in Appendix M and a copy of the PASRR determination to the individual or, if applicable, the individual's legal representative, and will transmit a copy of the approval letter to the CWA.

iv. In the case of an individual dually diagnosed with MI and MR, the conduct of PASRR by the DMHS shall precede the conduct of PASRR by the DDD.

(f) Authorization of out-of-State NF placement is subject to the following additional conditions:

1. Prior authorization shall be obtained from the Department for out-of-State NF services and shall be considered only when a required long-term care service is not available in New Jersey.

2. The out-of-State facility shall be licensed under the laws of that state as a NF or SCNF or equivalent entity, howsoever labeled by that state, and the rate of reimbursement shall not exceed that authorized by the Medicaid program of the state in which the facility is located, or the reimbursement rate authorized by the New Jersey Medicaid Program, whichever is lower.

3. Requests for prior authorization for out-of-State placement shall be accompanied by sufficient evidence that the service is medically necessary and not available in New Jersey. The Department will review the records provided to determine the need for long-term care services and to determine the appropriateness of placing the beneficiary in a NF outside of New Jersey. The request must be submitted to:

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

4. Prior to submitting a request for out-of-State placement, the beneficiary shall comply with the requirements of PAS as specified in this subchapter.

(g) The procedure for Department authorization of Medicaid reimbursement for NF continued stay or alternative care is as follows:

1. The professional staff designated by the Department shall periodically assess Medicaid beneficiaries to review the NF's assessments, patient classifications, and case mix reporting, and may recommend continuation of NF stay or, if appropriate, deny continued NF stay and shall recommend discharge to an alternative to NF stay.

2. Professional staff designated by the Department shall provide care management on an ongoing basis to Medicaid beneficiaries following placement in a NF.

3. Professional staff designated by the Department shall examine resident records for proof of continued vigilance and effort by the NF to utilize alternative means of care for all residents.

i. Beneficiaries designated as Track II (short-term) shall be monitored closely by the Department to assure active participation by the NF in the discharge planning process.

(h) If a NF resident with MI or MR shows a significant change in condition as defined by the MDS, the NF shall

initiate treatment to meet immediate needs. The NF shall arrange for the conduct and completion of a comprehensive reassessment by the end of the 14th day of the documented change in condition. If the reassessment results in a finding that a significant change in the resident's condition has occurred, the NF shall revise the resident's care plan based on that reassessment within seven days of the completion of the reassessment, shall make a clinical judgment, based on the clinical data, as to whether or not PASRR by DMHS or DDD is needed, and if so, shall notify the DMHS and/or the DDD, as appropriate, of the need for PASRR.

(i) Professional staff designated by the Department, after considering and rejecting all possible means of alternative care, shall approve conventional NF placement for Medicaid beneficiaries residing in a NF approved for a SCNF rate of reimbursement who continue to require NF level of nursing care, but who no longer require SCNF level of nursing care.

(j) The NF shall notify the LTCFO, via the LTC-2 form, of the termination of NF services due to the beneficiary's:

- i. Death while either in the NF or hospitalized;
- ii. Discharge to home or other community living arrangement;
- iii. Transfer to another NF; or
- iv. Ineligibility determination.

New Rule, R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Former N.J.A.C. 10:63-1.8, Admission, transfer and readmission; general, repealed.

8:85-1.9 Waiting list

(a) The NF shall establish a single waiting list in chronological order. The order of names shall be predicated upon the order in which a completed written application is received. Hospitalized individuals ready for readmission to the NF are to be added to the top of the list as soon as the hospital notifies the NF of the contemplated discharge. As soon as a bed becomes available, it shall be filled from this waiting list. Provisions can be made for emergency, life-threatening situations or life-care community admissions or transfers from another nursing facility.

1. The NF shall meet the following requirements:

i. Maintain only one waiting list; this list shall reflect a roster updated on a regular basis, of all individuals who have applied for admission to the facility;

ii. Reflect in chronological order the full name and address of the individual applying by the date the written application for admission is made;

iii. Utilize the waiting list to admit individuals on a first-come, first-serve basis in the order in which they apply until the provider's Medicaid occupancy level equals the Statewide occupancy level, or the Medicaid

2. The certified facility provides written documentation of a denial of Medicare coverage:

i. The certified facility shall indicate for all Medicare eligible beneficiaries through status reports, that the effort was made to apply for Medicare reimbursement prior to Medicaid billing. Status reports affirming denial shall be obtained from the Medicare Fiscal Intermediary. Status reports shall consist of:

(1) A copy of form Inpatient Hospital and Skilled Nursing Facility Admission and Billing SSA-1453; or

(2) A notice of denial of coverage form Notice of Medicare Claim Determination SSA-1954 or form Notice of Medicare Claim Determination SSA-1955; or

(3) The facility statement of non-coverage, signed by an administrator or officer, which shall be accepted only under the limitation of benefits.

(f) Medicare Part A coinsurance may be paid by the New Jersey Medicaid Program, but the total combined Medicare/Medicaid reimbursement may never exceed the facility's Medicaid Nursing Facility rate. If the Medicaid beneficiary has available income during the coinsurance period of Medicare eligibility, it shall be used to offset the coinsurance charges, prior to billing Medicaid. New Jersey Medicaid will pay Part B Medicare insurance premiums for all eligible Medicare-Medicaid beneficiaries. Claims for Part B services shall be billed to Medicaid only after Medicare benefits have been exhausted. Medicare timely filing requirements shall be met prior to the reimbursement of coinsurance by Medicaid.

1. Coinsurance and deductible payment shall be made as follows:

i. Medicaid will not assume responsibility for payment of coinsurance for certain services under Part B Medical Insurance when the basis of payment is fee for service (for example, physicians or podiatrists). However, coinsurance is paid for certain other Part B Provider services where the basis for payment is not fee for service (for example, durable medical equipment), but only in those instances where the Medicare allowable reimbursement is less than the Medicaid established reimbursement for those items.

ii. Medicaid will assume responsibility for deductible payments for Part B Medical Insurance services.

Amended by R.1998 d.177, effective April 6, 1998.

See: 29 N.J.R. 4614(a), 30 N.J.R. 1284(b).

In (a), made an internal reference change in the introductory paragraph, and added 1 and 2; inserted a new (d); recodified former (d) as (e), inserted a reference to denial of benefits in the introductory paragraph, and added a second sentence in I; and recodified former (e) as (f).

Recodified from N.J.A.C. 10:63-1.18 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Substituted "beneficiary" for "recipient" throughout; rewrote (b).

Case Notes

Medicaid reimbursement for nursing facility was in accordance with prior settlement agreement with Division of Medical Assistance and Health Services and not in accordance with subsequent nurse-staffing regulations. *Bergen Pines County Hospital v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 7.

Claim for Medicaid reimbursement denied; untimely filing. *Applewood Estates v. Division of Medical Assistance and Health Services*, 95 N.J.A.R.2d (DMA) 1.

SUBCHAPTER 2. NURSING FACILITY SERVICES

8:85-2.1 Nursing facility services; eligibility

(a) Eligibility for nursing facility (NF) services will be determined by the professional staff designated by the Department, based on a comprehensive needs assessment that demonstrates that the beneficiary requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2.

1. Individuals requiring NF services may have unstable medical, emotional/behavioral and psychosocial conditions that require ongoing nursing assessment, intervention and/or referrals to other disciplines for evaluation and appropriate treatment. Typically, adult NF residents have severely impaired cognitive and related problems with memory deficits and problem solving. These deficits severely compromise personal safety and, therefore, require a structured therapeutic environment. NF residents are dependent in several activities of daily living (bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating).

i. Children requiring NF services exhibit functional limitations identified either in terms of developmental delay requiring nursing care over and above routine parenting or are limited in terms of specific age-appropriate physical and cognitive activities, functional abilities (ADL) or abnormal behavior, as demonstrated by performance at home, school or recreational activities.

(1) Children who have achieved developmental milestones within appropriate time frames and who require only well child care and/or treatment of acute, time limited illnesses or injuries shall not be eligible for NF services.

2. NF residents shall be those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's

clinical condition demonstrates that deterioration was unavoidable.

(b) All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health and Senior Services licensing rules at N.J.A.C. 8:39. Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

(c) NF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

Recodified from N.J.A.C. 10:63-2.1 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In introductory paragraph (a), substituted "professional staff designated by the Department", substituted "beneficiary" for "recipient" and changed reference to "N.J.A.C. 8:85-2.2"; in (a)1, added "(bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating)"; in (b), added "and Senior Services" and changed reference to "N.J.A.C. 8:85-3".

Amended by R.2007 d.391, effective December 17, 2007.

See: 38 N.J.R. 4795(a), 39 N.J.R. 5338(a).

In the introductory paragraphs of (a) and (a)1, substituted "that" for "which"; and in the introductory paragraph of (a)1, deleted the last sentence.

Case Notes

Physically disabled and profoundly retarded child qualified for nursing facility care but not for placement in a specialized pediatric facility. N. C. on Behalf of her Son, W. C. v. Division of Medical Assistance and Health Services, 94 N.J.A.R.2d (DMA) 38.

8:85-2.2 Delivery of nursing services

(a) The NF shall provide 24-hour nursing services in accordance with the Department's minimum licensing standards set forth by the Standards for Licensure of Long-Term Care Facilities, N.J.A.C. 8:39, incorporated herein by reference, employing the service-specific case mix system to classify recipients with similar care requirements and resource utilization. The NF shall provide nursing services by registered professional nurses, licensed practical nurses and nurses aides based on the total number of residents multiplied by 2.5 hours per day; plus the total number of residents receiving each of the following services, as more fully described at (f) below:

- | | |
|-------------------------|--------------------|
| 1. Wound care | 0.75 hour per day |
| 2. Tube feeding | 1.00 hour per day |
| 3. Oxygen therapy | 0.75 hour per day |
| 4. Tracheostomy | 1.25 hours per day |
| 5. Intravenous therapy | 1.50 hours per day |
| 6. Respiratory services | 1.25 hours per day |

- | | |
|---|--------------------|
| 7. Head trauma stimulation; and advanced neuromuscular or orthopedic care | 1.50 hours per day |
|---|--------------------|

(b) The NF level of nursing care means services provided to Medicaid beneficiaries who are chronically or sub-acutely ill and require care for these entities, disease sequela or related deficits.

(c) The NF level of nursing care shall incorporate the principles of nursing process which consists of ongoing assessment of the beneficiary's health status for the purpose of planning, implementing and evaluating the individual's response to treatment.

1. In his or her capacity as coordinator of the interdisciplinary team, the registered professional nurse, who has primary responsibility for the beneficiary, shall perform, beginning on the day of admission, a comprehensive assessment of the beneficiary to provide, communicate and record within the SRA: baseline data of physiological and psychological status; definition of functional strengths and limitations; and determination of current and potential health care needs and service requirements.

i. In addition to clinical observations and hands-on examination of the Medicaid beneficiary, the licensed nurse shall review the HSDP and any available transfer records. The assessment data shall be coordinated by the registered professional nurse with oral or written communication and assessments derived from other members of the interdisciplinary team and shall be consistent with the medical plan of treatment. The initial comprehensive assessment (SRA) shall be completed no later than 14 days after admission and on an annual basis thereafter. If there is a significant change in the beneficiary's status, the NF shall complete a full comprehensive assessment involving the SRA. The registered professional nurse shall analyze the data and utilize the resident assessment protocols (RAPs) to focus problem identification, structure the review of assessment information and develop an interdisciplinary care plan which documents specific interventions unique to the individual, which define service requirements and facilitate the plan of treatment.

2. The interdisciplinary care plan shall identify and document the beneficiary's problems and causative or contributing factors and is derived from the comprehensive assessment. The plan shall be coordinated and certified by the registered professional nurse with active participation of the Medicaid beneficiary and/or significant other. The scope of the plan shall be determined by the actual and anticipated needs of the Medicaid beneficiary and shall include: physiological, psychological and environmental factors; beneficiary/family education; and discharge

(1) Stage III. The wound extends through the epidermis and dermis into the subcutaneous fat and is a full thickness wound. There may be inflammation, necrotic tissue, infection and drainage and undermining sinus tract formation. The drainage can be serosanguinous or purulent. The area is painful.

(2) Stage IV. The pressure wound extends through the epidermis, dermis, and subcutaneous fat into fascia, muscle and/or bone. Eschar, undermining, odor and profuse drainage may exist.

(3) Other wounds which may be categorized under wound care as defined in (f)1 above include:

(A) Open wounds which are draining purulent or colored exudate or which have a foul odor present and/or for which the individual is receiving antibiotic therapy;

(B) Wounds with a drain or T-Tube;

(C) Wounds which require irrigation or instillation of a sterile cleansing or medicated solution and/or packing with sterile gauze;

(D) Recently debrided ulcers;

(E) Wounds with exposed internal vessels or a mass which may have a proclivity for hemorrhage when dressing is changed (for example, post radical neck surgery, cancer of the vulva);

(F) Open wounds, widespread skin disease or complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies; and

(G) Complicated post-operative wounds which exhibit signs of infection, allergic reactions or an underlying medical condition that affects healing.

2. Tube feeding (1.00 hour per day), which includes nasogastric tubes, percutaneous feedings and the routine care of the tube site and surrounding skin of the surgical gastrostomy, provided that all non-invasive avenues to improve the nutritional status have been exhausted with no improvement; NF staff shall document in the clinical record the non-invasive measures provided, the individual's poor response and the medical condition for which the feedings are ordered; and the feedings are providing the individual with either 51 percent or more calories per day, or 26 to 50 percent calories and 501 milliliters or more of enteral fluid intake per day.

i. Feeding tubes that do not meet the dietary administration and nutritional support criteria as stated in (f)2i or ii above are covered under NF level of nursing care and are not counted as an additional nursing service.

3. Oxygen therapy (0.75 hours per day), which includes the provision of episodic oxygen therapy to increase the saturation of hemoglobin (Hb) without risking oxygen

toxicity in beneficiaries with airway obstructive conditions such as asthma, chronic obstructive pulmonary disease or heart failure. The beneficiary requires frequent, recurring, and ongoing pulse oximetry monitoring. The licensed nurses assess lung function and the beneficiary's symptoms that require intervention by the physician, physician assistant or advanced practice nurse.

4. Tracheostomy (1.25 hours per day), which includes:

i. New tracheostomy sites;

ii. Complicated cases involving either symptomatic infections or unstable respiratory functioning; or

iii. Frequent, recurring, and ongoing suctioning.

5. Intravenous therapy (1.50 hours per day), which includes (b)5i, ii, or iii below, provided that, when clinically indicated, intravenous medications are appropriately and safely administered within prevailing medical protocols; and, if intravenous therapy is for the purpose of hydration, NF staff shall document in the clinical record all preventive measures and attempts to improve hydration orally, and the individual's inadequate response.

i. The administration and maintenance of clinically indicated therapies by the NF, as ordered by the physician, such as total parenteral nutrition, clysis, hyperalimentation, and peritoneal dialysis;

ii. The administration of fluids or medications by the NF, as ordered by the physician, by means of lines or ports such as central venous lines, Hickman/Broviac catheters, or heparin locks and the flushing and dressing thereof; or

iii. The flushing and dressing of lines or ports such as central venous lines, Hickman/Broviac catheters, or heparin locks, by the NF, as ordered by the physician, for an identified treatment purpose and usage timeframe.

6. Respiratory services (1.25 hours per day), which includes the provision of respiratory services as to which the individual is dependent upon licensed nursing staff to administer, such as positive pressure breathing therapy, Bilevel Positive Airway Pressure (BiPAP), Continuous Positive Airway Pressure (CPAP) or aerosol therapy. The use of hand-held inhalation aerosol devices, commonly referred to as "puffers", is not included in this add-on service.

7. Head trauma stimulation; and advanced neuromuscular or orthopedic care (1.50 hours per day), as follows:

i. Care of head trauma is directed toward individuals who are stable (have plateaued) and can no longer benefit from a rehabilitative unit or unit for specialized care of the injured head. Individuals shall have access to and periodic reviews by such specialists as a neurologist,

neuropsychologist, psychiatrist and vocational rehabilitation specialist, in accordance with their clinical needs. There shall also be contact with appropriate therapies, such as physical therapy, speech-language pathology services and occupational therapy. The distinguishing characteristic for add-on hours for head trauma is the necessity for ongoing assessment and follow-up by licensed nursing personnel focusing on early identification of complications, and implementation of appropriate nursing interventions. Nursing protocols may be initiated which are specifically designed to meet individual needs of head injured individuals. The nurse may also supervise a coma stimulation program, when this need is identified by the interdisciplinary team.

ii. Advanced neuromuscular care needs will be identified by the physician for individuals during an unstable episode or where there is advanced and progressive deterioration in which the individual requires observation for neurological complications, monitoring and administration of medications or nursing interventions to stabilize the condition and prevent unnecessary regression.

iii. Advanced orthopedic care is the care of plastered body parts with a pre-existing peripheral vascular or circulatory condition requiring observations for complications and monitoring and administration of medication to control pain and/or infection. Such care also involves additional measures to maintain mobility; care of post-operative fracture and joint arthroplasty, during the immediate subacute post-operative period involving proper alignment; teaching and counseling and follow-up to therapeutic exercise and activity regimens. Individuals in this group shall be identified by the physician as needing advanced orthopedic care. If the requirement for advanced orthopedic care exceeds 30 days, clinical need must be demonstrated and clearly documented by the interdisciplinary team.

Recodified from N.J.A.C. 10:63-2.2 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

8:85-2.3 Physician services

(a) General requirements for physician services shall be as follows:

1. Each Medicaid beneficiary's care shall be under the supervision of a New Jersey licensed attending physician chosen by, or agreed to by, the Medicaid beneficiary, or if the beneficiary is incompetent, by the family or legal guardian.

2. In a NF providing care to children, the attending physician shall be board certified/eligible by the American Board of Pediatrics or the American Board of Family Practice.

3. The NF shall maintain arrangements that assure that the services of a New Jersey licensed physician who can act in case of emergency, are continuously available.

(b) Requirements for a medical director shall be as follows:

1. The NF shall retain, pursuant to a written agreement, a physician licensed under New Jersey law to serve as Medical Director on a part-time or full-time basis as is appropriate for the needs of the residents and the size of the facility. The Medical Director shall be responsible for the overall development of medical policies and coordination of the medical care in the facility to ensure the adequacy and appropriateness of medical services provided to beneficiaries and to monitor the health status of employees.

i. In a NF providing care exclusively to children, the medical director shall be certified/eligible by the American Board of Pediatrics or the American Board of Family Practice.

2. The duties of the medical director shall include, but not be limited to, the following:

i. Participation in the development of written policies, rules and regulations which are approved by the governing body of the facility;

ii. Delineation of the responsibilities of the attending physician(s) and ensuring that visits by medical consultants occur as needed;

iii. Acting as liaison between administration and medical staff for improving services and ensuring the carrying out of responsibilities of the medical staff;

iv. Surveying the execution of resident care policies, which includes a periodic evaluation of the adequacy and appropriateness of the services of health professional and supporting staff and monitoring the health status of the facility's employees;

v. Participation in the review of incidents and accidents that occur on the premises to identify hazards to health and safety of employees and residents. The Medical Director is given appropriate information to help ensure a safe and sanitary environment for residents and personnel;

vi. Ensuring that the medical regimen is incorporated in the resident care plan;

vii. Participation in the facility's quality assurance program through meetings, interviews and/or preparation or review of reports regarding infection control, pharmaceutical services, credentials, resident care, etc.;

viii. Collaboration with administration in the planning of educational programs for facility staff;

(deep tissue destruction) pressure sore which involves two of the following sites: hips, buttocks, sacrum.

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

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

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

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

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

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

(1) As a preventative measure;

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

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

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

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

(2) The physicians' written prescription;

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

(4) Physician progress notes indicating medical necessity, plan of treatment and evaluation of

response to treatment specific to the care of the wound;

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

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 10:63-2.15 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote the section.

Case Notes

Nursing home resident was not entitled to Medicaid funds for wheelchair which nursing home was obligated to provide to Medicaid resident. S.C. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 54.

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

8:85-2.16 Consultant services; general

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

Recodified from N.J.A.C. 10:63-2.16 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

8:85-2.17 Transportation services

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 10:63-2.17 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Substituted "beneficiary" for "recipient" throughout; in introductory paragraph (d), substituted "MACC" for "MDO"; in (e), added the abbreviation "(CWA)".

8:85-2.18 Bed and board

(a) Beds are provided in rooms licensed by the New Jersey Department of Health and Senior Services. A NF providing

care to children shall have available protective cribs for infants and small children, as well as appropriate furniture, sized and scaled for children.

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

Recodified from N.J.A.C. 10:63-2.18 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

In (a), added "and Senior Services".

8:85-2.19 Housekeeping and maintenance services

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

Recodified from N.J.A.C. 10:63-2.19 by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

8:85-2.20 Non-covered services

(a) Medicaid beneficiaries residing in NFs shall not be eligible to receive Medicaid reimbursement for the following services:

1. Admission or continued care primarily for diet therapy of exogenous obesity, bed rest, rest cure, or care of non-medical nature;
2. Private duty nursing;
3. Private attendant services;
4. Services and supplies not related to the care of the resident, such as guest meals and accommodations, television, telephone, and personal items;
5. Practitioner or therapy services furnished on a fee-for-service basis by an owner, partner, administrator, stockholder, or others having direct or indirect financial interest in the NF;
6. Partial care services in independent clinics; or
7. Medical/social day care.

Recodified from N.J.A.C. 10:63-2.20 and amended by R.2005 d.389, effective January 17, 2006.

See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Rewrote introductory paragraph (a) and added (a)7.

8:85-2.21 Special care nursing facility (SCNF)

(a) A special care nursing facility (SCNF) is a nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the Department of Health and Senior Services to provide care to New Jersey Medicaid beneficiaries who require intensive nursing facility services beyond the scope of