

CHAPTER 86

ADULT AND PEDIATRIC
DAY HEALTH SERVICES

Authority

N.J.S.A. 30:4D-6b(12), 6b(17), 7, 7a, 7b and 7c; 30:4D-12;
Reorganization Plan 001-1996; 42 U.S.C. § 1396a;
42 CFR § 440.90.

Source and Effective Date

R.2001 d.5, effective November 30, 2000.
See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 86, Medical Daycare Services, was extended by gubernatorial directive from November 30, 2005 to November 30, 2006. See: 38 N.J.R. 294(c).

Chapter Historical Note

Chapter 86, Medical Day Care Services, originally codified in Title 10 as Chapter 65, Intermediate Care Standards. Chapter 65 was adopted as R.1973 d.132, effective July 1, 1973. See: 5 N.J.R. 10(a), 5 N.J.R. 190(a).

Chapter 65, Intermediate Care Standards, was repealed by R.1979 d.126, effective March 29, 1979. See: 10 N.J.R. 190(b), 11 N.J.R. 248(b).

Chapter 65, Medical Day Care Services Manual, was adopted as new rules by R.1979 d.325, effective August 16, 1979. See: 11 N.J.R. 280(a), 11 N.J.R. 448(e).

Pursuant to Executive Order No. 66(1978), Subchapter 1, General Provision, was readopted as R.1984 d.332, effective July 23, 1984. See: 16 N.J.R. 1443(a), 16 N.J.R. 2131(a).

Pursuant to Executive Order No. 66(1978), Subchapter 2, HCPCS Codes, was readopted as R.1984 d.508, effective November 15, 1984. See: 16 N.J.R. 2336(a), 16 N.J.R. 3031(b).

Pursuant to Executive Order No. 66(1978), Chapter 65, Medical Day Care Manual, was readopted as R.1989 d.504, effective August 25, 1989. See: 21 N.J.R. 1794(a), 21 N.J.R. 3005(a).

Chapter 65, Medical Day Care Manual, was repealed and Chapter 65, Medical Day Care Services Manual, was adopted as new rules by R.1991 d.87, effective February 19, 1991, operative March 1, 1991. See: 22 N.J.R. 3327(b), 23 N.J.R. 448(a).

Pursuant to Executive Order No. 66(1978), Chapter 65, Medical Day Care Services Manual, was readopted as R.1996 d.6, effective November 30, 1995. See: 27 N.J.R. 3540(a), 28 N.J.R. 184(b).

Pursuant to Executive Order No. 66(1978), Chapter 65, Medical Day Care Services, was readopted as R.2001 d.5, effective November 30, 2000, and Chapter 65 was recodified as N.J.A.C. 8:86 by R.2001 d.5, effective January 2, 2001. See: Source and Effective Date. See, also, section annotations.

Chapter 86, Medical Day Care Services, was renamed Adult and Pediatric Day Health Services; Subchapter 2, HCPCS Codes, was renamed Billing Codes; Appendices A, B, C, and D were repealed and adopted as new rules; Appendices E, F, and G were repealed; and Appendix H was recodified as Appendix E by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006). See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 8:86-1.1 Purpose and scope
- 8:86-1.2 Definitions
- 8:86-1.3 Program participation and evaluation
- 8:86-1.4 Required services
- 8:86-1.5 Clinical eligibility and prior authorization for adult or pediatric day health services
- 8:86-1.6 Basis of payment
- 8:86-1.7 through 1.9 (Reserved)

SUBCHAPTER 2. BILLING CODES

- 8:86-2.1 Introduction
- 8:86-2.2 Billing Codes

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX D

APPENDIX E

SUBCHAPTER 1. GENERAL PROVISIONS

8:86-1.1 Purpose and scope

(a) The Adult and Pediatric Day Health Services Program is concerned with the fulfillment of the health needs of eligible individuals who could benefit from a health services alternative to total institutionalization. Adult and Pediatric Day Health Services is a program that provides medically necessary services in an ambulatory care setting to individuals who are nonresidents of the facility, and who, due to their physical and/or cognitive impairment, require such services supportive to their community living. Pediatric day health services are available only for technology-dependent and/or medically unstable children who require continuous, rather than part-time or intermittent, care of a licensed practical or registered professional nurse in a developmentally appropriate environment.

(b) In order to be eligible for services through the Adult and Pediatric Day Health Services Program, an individual must have been determined to be eligible for one of the following: community Medicaid, New Jersey Care ... Special Medicaid Programs (including the medically needy segment), NJ FamilyCare-Plan A, fee-for-service, the Community Care Program for the Elderly and Disabled, the Caregiver Assistance Program, the Adult Family Care program, Model Waivers, the AIDS Community Care Alternatives Program, the Traumatic Brain Injury Program, or the ABC Program for medically fragile children. Individuals enrolled in the Home Care Expansion Program or the Jersey Assistance for Community Caregiving Program are likewise eligible for adult and pediatric day health services. In addition to being financially

eligible, an adult or pediatric day health services beneficiary must satisfy the clinical eligibility requirements at N.J.A.C. 8:86-1.5.

Amended by R.1994 d.427, effective August 15, 1994.
See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).
Amended by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).
See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).
Rewrote the section.

8:86-1.2 Definitions

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

“ACCAP” means the AIDS Community Care Alternative Program created pursuant to the Omnibus Budget Reconciliation Act of 1981.

“ADL” or “ADLs” mean, respectively, activity of daily living or activities of daily living.

“Adult or pediatric day health services beneficiary” or “beneficiary” means an individual who is a Medicaid beneficiary, pursuant to N.J.A.C. 10:49, a HCEP participant, pursuant to N.J.A.C. 8:81, or a participant in the JACC, who is eligible for adult or pediatric day health services pursuant to N.J.A.C. 8:86-1.5. An adult beneficiary is at least 18 years of age. A pediatric beneficiary is from birth through five years of age.

“Adult or pediatric day health services facility” means an identifiable part of a nursing facility, or a hospital affiliated facility, or a freestanding ambulatory care facility, or such other facility that is licensed by the Department in accordance with its Standards for Licensure of Adult and Pediatric Day Health Services Facilities, N.J.A.C. 8:43F, and that possesses a valid and current provider agreement from the Department.

“Advanced practice nurse” means an individual so certified by the New Jersey State Board of Nursing in accordance with N.J.S.A. 45:11-23 et seq.

“AFC” means the Adult Family Care program created pursuant to the Omnibus Reconciliation Act of 1981.

“CAP” means the Caregiver Assistance Program, a Medicaid Home and Community Based Program under the Enhanced Community Options Waiver, pursuant to N.J.A.C. 10:60-10.2.

“Department” means the State of New Jersey Department of Health and Senior Services.

“HCEP” means the Home Care Expansion Program established pursuant to N.J.S.A. 30:4E-6.

“HIV adult day health services facility” means an adult day health services facility which provides additional services to

individuals with HIV infection in an identifiable and separate setting and which is licensed pursuant to N.J.A.C. 8:43A.

“JACC” means the Jersey Assistance for Community Caregiving Program, an ElderCare Initiative pursuant to the State of New Jersey Appropriations Act.

“Legally authorized representative” means a person or entity that is legally empowered by law, judicial order, power of attorney, or otherwise to make decisions on behalf of the beneficiary and includes a beneficiary’s spouse or immediate next-of-kin.

“Licensed practical nurse (LPN)” means an individual who is so licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-27.

“Limited assistance” means physical help in maneuvering of limbs or other non-weight-bearing assistance at least three times during the past three days.

“Medicaid beneficiary” means an individual who participates in the program for medical assistance, including Medicaid Waiver programs, authorized under Title XIX or Title XXI of the Social Security Act and administered jointly by the New Jersey Department of Health and Senior Services and the New Jersey Department of Human Services.

“Medical nutrition therapy” means the assessment of nutritional status and treatment, use of diet therapy, counseling and specialized nutritional supplements.

“Medication administration” means a procedure in which a prescribed medication is given to a beneficiary by an authorized person in accordance with all laws and rules governing such procedures. The complete procedure of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the prescriber’s orders, giving the individual dose to the beneficiary, seeing that the beneficiary takes it, and recording the required information, including the method of administration. After the prescribed medication has been given the RN shall: assess the beneficiary for the development of side effects or interactions and/or for a change in the beneficiary’s ability to maintain the medication regimen (which may include an assessment of the beneficiary’s compliance with the medication regimen, the beneficiary’s knowledge about the dose and medication taken and the side effects and interactions, and swallowing difficulties or short-term memory deficits).

“Pediatric day health services facility” means a facility that provides additional services in order to provide for the needs of technology dependent or medically unstable children and conforms to the rules in this chapter and to the rules at

N.J.A.C. 10:122, Manual of Requirements for Child Care Centers.

“Physician assistant” means an individual so licensed by the New Jersey State Board of Medical Examiners pursuant to N.J.S.A. 45:9-27.10 et seq.

“Registered professional nurse” or “RN” means an individual who is so licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-26.

“Skilled services” means needed skilled services provided daily at the adult day health services facility by an RN or licensed practical nurse and shall include, but are not limited to, oxygen need, ostomy care, daily nurse monitoring (for example, medication administration, pacemaker checks, urinary output, unstable blood glucose, unstable blood pressure with physician/advanced practice nurse intervention), skin treatment of wounds, treatment of stasis ulcers, intravenous or intramuscular injections and nasogastric or gastrostomy tube feedings and medical nutrition therapy.

“Supervision/cueing” means oversight, encouragement, or cueing provided at least three times during the past three days, or supervision provided one or more times plus physical assistance provided no more than two times for a total of at least three episodes of assistance or supervision.

“Wounds” means ulcers, burns, Stage II, III and IV pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites.

Amended by R.1994 d.427, effective August 15, 1994.

See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).

Amended by R.2001 d.5, effective January 2, 2001.

See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).

In “Medical day care center” and “Prior authorization”, amended N.J.A.C. reference.

Amended by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Deleted definitions “Administration—medical day care center,” “Division,” “Medicaid District Office,” “Medical day care center,” “Pediatric medical day care center,” “Prior authorization” and “Volunteer”; added definitions “ACCAP,” “ADL,” “Adult or pediatric day health services beneficiary,” “Adult or pediatric day health services facility,” “Advanced practice nurse,” “AFC,” “CAP,” “Department,” “HCEP,” “HIV adult day health services facility,” “JACC,” “Legally authorized representative,” “Licensed practical nurse (LPN),” “Limited assistance,” “Medicaid beneficiary,” “Medical nutrition therapy,” “Medication administration,” “Pediatric day health services facility,” “Physician assistant,” “Registered professional nurse,” “Skilled services,” “Supervision/cueing” and “Wounds.”

8:86-1.3 Program participation and evaluation

(a) An adult or pediatric day health services facility shall meet the following requirements in order to participate in the New Jersey Medicaid, HCEP, or JACC programs:

1. Licensure and approval by the Department in accordance with the Standards for Licensure of Adult and

Pediatric Day Health Services Facilities of the Department as set forth at N.J.A.C. 8:43F;

2. Completion of the New Jersey Medicaid Provider Application PE-1 (Appendix A, incorporated herein by reference), the Participation Agreement PE-5 (Appendix B, incorporated herein by reference) and a written narrative Statement on the Proposed Adult or Pediatric Day Health Services Facility (Appendix C, incorporated herein by reference) and approval as a Medicaid adult or pediatric day health services provider by the Department. The New Jersey Medicaid Provider Application (PE-1) and the Participation Agreement (PE-5) are also available by contacting Unisys for Medicaid participation at (800) 776-6334 and on the Worldwide Web at www.njmmis.com. Ongoing participation as a provider is contingent upon continued licensure and approval by the Department;

i. Adult day health services facilities providing services to JACC participants shall also be approved as a JACC provider/vendor by the Department.

3. Maintenance of a daily attendance record that includes the printed name and the arrival and departure times of each beneficiary attending on that day, signed by each adult beneficiary in acknowledgement of the beneficiary having been present for the time indicated, and submission to the Department of a monthly roster, using the form posted at www.state.nj.us/health, of all beneficiaries who attended at least one day that month;

i. If an adult beneficiary is unable to sign the daily attendance record, the administrator of the facility or his or her designee shall attest in writing to the accuracy of the indicated arrival and departure times of the beneficiary, and the signed attestation shall be included as part of the daily attendance record maintained by the facility; and

4. Preparation of a complete financial statement and a cost report, annually detailing expenditures of the adult or pediatric day health services facility. Adult or pediatric day health services facility costs shall be segregated from other operational costs. (Department reimbursement rates may be based on cost report information or on a percentage of nursing facility per diem rates.) Cost reports shall be signed by the administrator or an officer of the facility. Cost reports shall include a statement that adult or pediatric day health services costs have been verified as to type and amount. Financial statements shall be signed by a certified public accountant(s) licensed in accordance with N.J.A.C. 13:29. Financial statements shall include a statement that the financial statement has been prepared in accordance with generally accepted accounting principles and that all adult or pediatric day health services costs have been verified as to type and amount.

i. Cost reports and financial statements shall be maintained at the facility and shall be available for

review by, or submission to, the Department upon request.

(b) The Department shall conduct an ongoing evaluation of the facility's day care program by on-site visits to the adult or pediatric day health services facility. The Department shall inform the adult or pediatric day health services facility, in writing, of the results of the on-site evaluation.

(c) Department staff may request a plan of correction if the facility is evaluated as providing substandard services and/or inadequate documentation of these services or otherwise violates any applicable regulations. The plan of correction shall address deficiencies noted by Department staff, and shall be submitted to the Department by the facility by the requested date.

1. If a follow-up on-site visit reveals that the plan of correction is not being implemented, the Department shall take enforcement actions in accordance with N.J.A.C. 8:43E, General Licensure Procedures and Enforcement of Licensure Regulations.

(d) Non-compliance with the Department's rules at N.J.A.C. 8:43F or 8:86 may result in sanctions and remedies being imposed as provided in the Medicaid Administration Manual found at N.J.A.C. 10:49, General Licensure Procedures and Enforcement of Licensure Regulations found at N.J.A.C. 8:43E or any other applicable law or regulation.

(e) Providers wishing to contest decisions made by the Department pursuant to this section may request a fair hearing pursuant to the procedures set forth below:

1. If sanctions and remedies have been imposed under the Medicaid Administration Manual, then the adult or pediatric day health services facility must submit a request for a hearing pursuant to the provisions of N.J.A.C. 10:49-10 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

2. If sanctions and remedies have been imposed pursuant to N.J.A.C. 8:43F-2.8, then the adult or pediatric day health services facility must submit a request for a hearing pursuant to the provisions of N.J.A.C. 8:43F-2.9, 8:43E and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

3. The provider may request that the matter be settled in lieu of conducting an administrative hearing concerning the contested action. If the Department and the facility agree on the terms of a settlement, a written agreement specifying the terms thereof shall be executed.

(f) Caregivers of beneficiaries or the beneficiaries themselves may be contacted by Department staff to determine appropriateness of care and satisfaction with services provided.

(g) The maximum daily census in any pediatric medical day care center shall be 27 children.

Amended by R.2001 d.5, effective January 2, 2001.

See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).

In (c)1, amended N.J.A.C. reference.

Amended by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Section was "Program participation"; rewrote the section.

8:86-1.4 Required services

(a) Adult beneficiaries served in an adult day health services facility shall receive a minimum of five hours of services per day, excluding transportation time to and from home, not to exceed five days per week.

1. CAP beneficiaries and JACC participants may receive adult day health services as provided in (a) above and as authorized by the case manager.

(b) A child served in a pediatric day health services facility shall receive a minimum of six hours of services per day, excluding transportation time, not to exceed five days per week. In exceptional circumstances, if six hours is contraindicated because of the medical condition of a child, the attending physician, physician assistant, or advanced practice nurse shall approve less than six hours, but in no case less than three hours attendance, and this shall be documented in the child's medical record and reviewed at least every 60 days.

(c) The facility shall provide transportation for beneficiaries to and from their homes as well as to and from physical therapy, occupational therapy, and speech-language pathology services as needed. No beneficiary's total daily transportation time to and from home shall exceed two hours.

1. The facility shall accommodate the special transportation needs of the beneficiary and medical equipment used by the beneficiary.

Amended by R.1994 d.427, effective August 15, 1994.

See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).

Amended by R.2001 d.5, effective January 2, 2001.

See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).

In (a)3ii(1)(A), (a)4i and (a)4ii(3), amended N.J.A.C. reference.

New Rule by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Former N.J.A.C. 8:86-1.4, Required services, repealed.

8:86-1.5 Clinical eligibility and prior authorization for adult or pediatric day health services

(a) Clinical eligibility for adult day health services shall be contingent upon receipt of prior authorization from the Department on the basis of:

1. The results of an assessment of the individual using an instrument prescribed by the Department and the eligibility criteria specified at (f) below. The prescribed assessment instrument is designed to collect standardized information on a broad range of domains critical to caring for individuals in the community, including items related to cognition; communication/hearing; vision; mood and

behavior; social functioning; informal support services; physical functioning; continence; disease diagnoses; health conditions; preventive health measures; nutrition/hydration; dental status; skin condition; environment/home safety; service utilization; medications; and socio-demographic/background information; and

2. The Department's evaluation and consideration of information received from either the facility RN, the individual and/or the individual's legally authorized representative, personal physician or other healthcare professional who has current and relevant knowledge of the individual, the individual's medical or psychosocial needs and the individual's ADL or cognitive deficits. Such information may be considered by the Department along with the results of the assessment performed in (a)1 above and the eligibility criteria in (f) below as the basis for determining clinical eligibility for adult day health services.

(b) The facility shall retain, as part of each beneficiary's permanent record, the signed acknowledgement of the beneficiary or the beneficiary's legally authorized representative, as appropriate, that a determination of eligibility to receive services is not permanent and that redeterminations will be made on the basis of subsequent assessments.

(c) The eligibility assessment shall be performed by professional staff designated by the Department, including staff at the facility in accordance with (d) below. Such assessments shall be performed prior to initial provision of services to the individual and at least annually and as necessary when the plan of care required by N.J.A.C. 8:43F-5.4 reflects a change in status that may alter the beneficiary's eligibility to receive adult day health services.

(d) The Department, for reasons of administrative convenience, may authorize staff of the facility to perform the eligibility assessment on the Department's behalf. In the event that the facility is explicitly authorized and agrees to perform eligibility assessments, the following conditions shall be met:

1. The assessment shall be performed by an RN, using the assessment instrument prescribed by the Department, prior to initial provision of services to the individual and at least annually and as necessary when the plan of care required by N.J.A.C. 8:43F-5.4 reflects a change in status that may alter the beneficiary's eligibility to receive adult day health services. Documentation of the assessment and evaluation required by this section shall be included in the individual's medical record;

2. The initial assessment shall entail a visit to the individual's home and shall include assessment of at least the following:

i. Living arrangements;

ii. The individual's relationship with his or her family;

iii. The individual's home environment;

iv. The existence of environmental barriers, such as stairs, not negotiable by the individual;

v. Access to transportation, shopping, religious, social, or other resources to meet the needs of the individual; and

vi. Other home care services received, including documentation of the frequency and amount of each service received;

3. Results of each assessment shall be signed by both a registered professional nurse of the facility and the facility administrator and shall be submitted to: Director, Office of Long Term Care Options, PO Box 807, Trenton, NJ 08625-0807; and

4. The facility administrator shall certify whether or not the individual has been determined eligible to receive adult day health services. The Department shall presume the determination of the facility to be accurate, with the understanding that the Department retains ultimate authority with respect to determinations of eligibility and shall conduct audits of facility determinations of eligibility through on-site visits, which may include review of facility records and interviews with beneficiaries. Any facility found to be in default of the provisions set forth in this section, including, but not limited to, certifications which are intentionally misleading or false, shall be subject to remedies which may be imposed by N.J.A.C. 8:43F-2.8, 10:49 or any other applicable provision of law.

5. Departmental authorization for facility staff to perform eligibility assessments shall not preclude the Department from withdrawing such authorization if the facility is found in default as provided in (d)4 above or at such time as the Department, with due notice to the affected facility, decides that the Department will resume performing prior authorization by Department staff.

6. When an individual who was found by the adult day health services facility to be ineligible to receive services believes that the facility's performance of the eligibility assessment prescribed by the Department has resulted in an inequity or erroneous determination, the facility shall submit the completed assessment and documentation identifying the individual's issues, signed by the individual, to the Department for review.

i. A request for review shall be submitted by the facility on behalf of the individual within five business days of notification of ineligibility by the facility to the Long-Term Care Field Office, Department of Health and Senior Services, Division of Aging and Community Services, serving the beneficiary's county of residence.

ii. Appropriate professional staff shall conduct a review of the assessment and supporting documentation. Both the individual and the facility should be prepared to provide such substantiating information as may be required for an informal discussion of the issues.

iii. Department staff shall make a determination to uphold or overturn the facility's assessment and shall notify both the individual and the facility within 15 business days of receipt of the requested documentation.

(e) An individual may be granted an opportunity for a fair hearing if he or she: is not satisfied with either the determination made by professional staff of the Department based on a review of the eligibility assessment performed by the facility, in accordance with (d)6 above, or with a direct determination of ineligibility by professional staff designated by the Department, in accordance with (a)1 above; or if the services provided to the individual in an adult or pediatric day health services facility have been terminated, reduced or suspended.

1. A request for an administrative hearing must be submitted pursuant to the provisions of N.J.A.C. 10:49-10 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

2. A request for an administrative hearing shall be considered timely filed if it is submitted within 20 days:

i. From the date of notification of the Departmental determination based on a review of the facility's assessment;

ii. From the date of notification of the direct determination of ineligibility by professional staff designated by the Department; or

iii. From the date that the individual receives notice that his or her services in an adult or pediatric day health services facility have been terminated, reduced or suspended.

3. At the administrative hearing, the burden is upon the individual to demonstrate eligibility for adult day health services under the eligibility criteria at (f) below. A copy of this rule may be obtained from: Department of Health and Senior Services, Division of Aging and Community Services, Office of Community Support and AAA Administration, PO Box 807, Trenton, NJ 08625-0807.

4. The individual may request that the matter be settled in lieu of conducting an administrative hearing concerning the contested action. If the Department and the individual agree on the terms of a settlement, a written agreement specifying the terms thereof shall be executed.

(f) In order to be eligible for adult day health services, an adult shall have been determined eligible for one of the programs specified at N.J.A.C. 8:86-1.1(b), and shall satisfy the following conditions:

1. The individual has received prior authorization from the Department or its designee adult day health services facility in accordance with (a) and (c) above on the basis of having been assessed as satisfying either of the following criteria:

i. The individual requires:

(1) At least limited assistance in at least two of the following ADLs: bathing/dressing, toilet use, transfer, locomotion, bed mobility, and eating, and the facility will provide all of the assistance for the claimed ADLs on-site in the facility; or

(2) At least one needed skilled service (as defined in N.J.A.C. 8:86-1.2) provided daily by a registered professional nurse or licensed practical nurse, or rehabilitation services provided for a time-limited period in order to attain particular treatment goals identified by the attending physician, physician assistant, or advanced practice nurse. The needed skilled services include, but are not limited to, oxygen need, ostomy care, daily nurse monitoring (for example, medication administration (as defined in N.J.A.C. 8:86-1.2), pacemaker checks, urinary output, unstable blood glucose, unstable blood pressure with physician/advanced practice nurse intervention), skin treatment of wounds (as defined in N.J.A.C. 8:86-1.2), treatment of stasis ulcers, intravenous or intramuscular injections, nasogastric or gastrostomy tube feedings and medical nutrition therapy (as defined in N.J.A.C. 8:86-1.2). Needed skilled services shall be provided on-site in the facility. The rehabilitation services include physical therapy, occupational therapy, and speech-language pathology services. Rehabilitation services may be provided off-site; or

ii. The individual requires either:

(1) Supervision/cueing in at least three of the following ADLs: bathing/dressing, toilet use, transfer, locomotion, bed mobility, and eating, and the facility will provide all of the supervision/cueing for the claimed ADLs on-site in the facility; and exhibits problems with short-term memory and with following multitask sequences, and has some difficulty in daily decision-making in new situations or greater level of impairment, as measured by the assessment instrument prescribed by the Department; or

(2) At least one needed skilled service (as defined in N.J.A.C. 8:86-1.2) provided daily by a registered professional nurse or licensed practical nurse, or rehabilitation services provided for a time-limited period in order to attain particular treatment goals identified by the attending physician, physician assistant, or advanced practice nurse. The needed skilled services include, but are not limited to, oxygen need, ostomy care, daily nurse monitoring (for example, medication administration (as defined in

N.J.A.C. 8:86-1.2), pacemaker checks, urinary output, unstable blood glucose, unstable blood pressure with physician/advanced practice nurse intervention), skin treatment of wounds (as defined in N.J.A.C. 8:86-1.2), treatment of stasis ulcers, intravenous or intramuscular injections, nasogastric or gastrostomy tube feedings and medical nutrition therapy (as defined in N.J.A.C. 8:86-1.2). Needed skilled services shall be provided on-site in the facility. The rehabilitation services include physical therapy, occupational therapy, and speech-language pathology services. Rehabilitation services may be provided off-site.

(g) If the individual satisfies (g)1 through 3 below, then such individual shall be ineligible to receive adult day health services.

1. If admission of the individual to adult day health services would result in the individual receiving duplicative or substantially identical services as those provided by any other Medicaid funded service that the individual has chosen, then the individual shall not be eligible for adult day health services. Ambulatory care settings include, but are not limited to, the home, personal care attendant services, a physician's office, a hospital outpatient department, a partial care/partial hospitalization program, and an adult day training program.

2. Residents of a residential health care facility shall be ineligible for adult day health services.

3. An adult who requires and who is receiving care 24 hours per day on an inpatient basis in a hospital or nursing home shall be ineligible for adult day health services.

(h) In order to be eligible for services in an HIV adult day health services facility, an individual shall be at least 18 years of age with HIV infection, eligible for adult day health services in accordance with N.J.A.C. 8:86-1.1(b), and require outpatient drug abuse treatment.

(i) In order to be eligible for pediatric day health services, a child shall be from birth through five years of age, shall be a Medicaid beneficiary, and shall satisfy the following:

1. The child shall require continuous nursing services available only in a pediatric day health services facility and shall meet either of the following criteria:

i. Be technology dependent, requiring life-sustaining equipment or interventions, including a tracheotomy, ventilator, central venous pressure (CVP) line, hyper-alimentation gastrostomy tube or a nasogastric tube; or

ii. Be medically unstable requiring ongoing treatment administered by a licensed registered professional nurse (RN) or licensed practical nurse (LPN), such as nebulizer treatments, administration of oxygen, apnea/cardiac monitoring, or intermittent urinary catheterization, to maintain health or requiring ongoing

monitoring and assessment by an RN because of such care needs as seizure disorders or cardiac conditions.

(j) The Department may, at its discretion, require prior authorization of eligible Medicaid beneficiaries by professional staff designated by the Department prior to the provision of services in a new or existing pediatric day health services facility. When applied, prior authorization shall be based upon the eligibility criteria specified at (i) above. The facility administrator shall verify, in writing, that the Medicaid-eligible individual has valid financial coverage to receive services available at the pediatric day health services facility pursuant to N.J.A.C. 8:86-1.6(g).

Amended by R.1994 d.427, effective August 15, 1994.

See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).

Amended by R.2001 d.5, effective January 2, 2001.

See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).

New Rule by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Former N.J.A.C. 8:86-1.5, Staff, repealed.

8:86-1.6 Basis of payment

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

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

2. It is only in the role of attending physician that the medical consultant may bill the New Jersey Medicaid Program on the Health Insurance Claim Form, CMS-1500,

for services provided to a Medicaid beneficiary. The medical consultant shall not bill the New Jersey Medicaid Program separately for any service performed for any Medicaid beneficiary in an adult or pediatric day health services facility while serving solely in his or her capacity as medical consultant.

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

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

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

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

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

(g) The facility administrator shall verify that the beneficiary has valid financial coverage as of the time that services are provided by reviewing a valid Medicaid identification card or calling the Recipient Eligibility Verification System pursuant to N.J.A.C. 10:49-2.11.

1. For Medicaid beneficiaries and HCEP participants, coverage shall be verified through the Recipient Eligibility Verification System and by inspection of the Medicaid eligibility identification card.

2. For CAP beneficiaries, coverage shall be verified through the Recipient Eligibility Verification System and by inspection of a valid Individual Service Agreement.

3. For JACC participants, coverage shall be verified through inspection of a valid Individual Service Agreement.

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

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

Amended by R.1994 d.427, effective August 15, 1994.

See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).

Amended by R.1996 d.6, effective January 2, 1996.

See: 27 N.J.R. 3540(a), 28 N.J.R. 184(b).

Amended by R.2001 d.5, effective January 2, 2001.

See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).

In (a), amended N.J.A.C. reference in the introductory paragraph.

Recodified from N.J.A.C. 8:86-1.8 by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Former N.J.A.C. 8:86-1.6, Recipient review, evaluation and identification, repealed.

8:86-1.7 (Reserved)

Amended by R.1994 d.427, effective August 15, 1994.

See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).

Repealed by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Former N.J.A.C. 8:86-1.7, Records, repealed.

8:86-1.8 (Reserved)

Recodified to N.J.A.C. 8:86-1.6 by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Section was "Basis of payment."

8:86-1.9 (Reserved)

Repealed by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Section was "Disaster plan."

SUBCHAPTER 2. BILLING CODES

8:86-2.1 Introduction

(a) The New Jersey Medicaid Program adopted the Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this subchapter are relevant to certain Medicaid and HCEP adult or pediatric day health services. A separate billing code is used by the fiscal agent for the JACC program.

(b) These codes shall be used when requesting reimbursement for certain adult or pediatric day health services.

Amended by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).

See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).

Rewrote the section.

8:86-2.2 Billing Codes

(a) HCPCS Codes for adult or pediatric day health services are as follows:

HCPCS Code	Description
Z0300	Initial visit, speech-language pathology services
Z0310	Initial comprehensive speech-language pathology evaluation
Z0270	Initial visit, physical therapy
92507	Speech-language pathology services
97799	Physical therapy
W9002	Adult day health services visit
Z1860	Adult day health services visit for the AIDS Community Care Alternatives Program (ACCAP)
Z1863	Pediatric day health services visit for technology dependent children
Z1864	Pediatric day health services visit for medically unstable children

(b) The billing code for services provided to JACC participants is as follows:

J9002 Adult day health services visit for JACC participants.

(c) Fees for adult or pediatric day health services facilities are pre-approved by the Department, based on the reimbursement methodology described in N.J.A.C. 8:86-1.6, with each center's fees established in accordance with the setting in which the medical day care program is operated.

Amended by R.2001 d.5, effective January 2, 2001.
 See: 32 N.J.R. 3053(a), 33 N.J.R. 55(a).
 In (b), amended N.J.A.C. reference.
 Amended by R.2005 d.390, effective December 19, 2005 (operative February 1, 2006).
 See: 36 N.J.R. 5262(a), 37 N.J.R. 385(b), 4968(a).
 Section was "HCPCS Codes"; in (a), substituted "adult or pediatric day health" for "medical day care"; added (b); rewrote former (b) and recodified as (c).

APPENDIX A

New Jersey Department of Health and Senior Services
Office of Provider Enrollment
PO Box 367
Trenton, NJ 08625-0367

PROVIDER APPLICATION

1. Legal Name of Provider		2. Type of Business of Facility									
3. Business Name, if Different from Above		4. Federal Employer ID Number / SSN									
5. Street Address of Service Location Only		6. County									
7. City	State	Zip Code	8. Length of Time at Address								
9. Billing Address (for payments)											
10. Mailing Address (for correspondence)											
11. Name of Nursing Home Administrator, Chief Executive Officer or Other Responsible Official											
12a. Nursing Home Administrator License No.	12b. Effective Date		13. Telephone Number								
14. Indicate the legal status of your organization: <input type="checkbox"/> Profit <input type="checkbox"/> Private <input type="checkbox"/> Municipal <input type="checkbox"/> Charity <input type="checkbox"/> County <input type="checkbox"/> Non-Profit <input type="checkbox"/> Public <input type="checkbox"/> State <input type="checkbox"/> School Nurse <input type="checkbox"/> Other, Specify:											
15. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program:											
16. Do you operate from more than one location? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all other subsidiary or affiliated organizations below: <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: center;">Name</th> <th style="text-align: center;">Service Address</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> </tr> </tbody> </table> (Attach additional sheets if necessary.)				Name	Service Address	1. _____	_____	2. _____	_____	3. _____	_____
Name	Service Address										
1. _____	_____										
2. _____	_____										
3. _____	_____										
17. Are you a member of a chain organization? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate name: _____											
18. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health and Senior Services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate.											
19. Does your business or facility require a license/permit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate type and number: _____ Attach a copy of the license/permit.											
20. Do you require certification, accreditation or approval? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Attach a copy of the certification, accreditation or approval. For example, New Jersey Department of Health and Senior Services (clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services).											

PROVIDER APPLICATION, Continued

Legal Name of Provider	Federal Employer ID Number / SSN
<p>21. Approved by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, indicate Medicare Provider Number: _____</p> <p>Attach a copy of your Medicare approval.</p>	
<p>22. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).</p>	
<p>23. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, explain.</p>	
<p>24. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, explain.</p>	
<p>25. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, explain.</p>	

PROVIDER APPLICATION, Continued

Legal Name of Provider	Federal Employer ID Number / SSN																																																
<p>26. Do any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the other individuals named in response to Question 11 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid Program of any other state or jurisdiction?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list provider name and nature of relationship.</p>																																																	
<p>27. Do you charge for goods and/or services?</p> <p><input type="checkbox"/> To All <input type="checkbox"/> To None <input type="checkbox"/> To Certain Groups Only</p> <p>If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule.</p>																																																	
<p>28. List days and hours of operation.</p>																																																	
<p>29. List the Name(s), Social Security Number(s), Date(s) of Birth, License/Permit Number(s) and Title(s) or Degree(s) for all professional staff in the organization. Include physicians, dentists, psychologists, pharmacists, registered nurses, licensed practical nurses, registered physical therapists, optometrists, etc. [NOTE: Not required for health care providers certified for Medicaid and/or Medicare participation by the New Jersey Department of Health and Senior Services and/or the Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA).]</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;"></th> <th style="width:20%;">Name</th> <th style="width:20%;">Title/Degree (MD, DO, Ph.D, CPO, etc.)</th> <th style="width:10%;">SSN</th> <th style="width:10%;">Date of Birth</th> <th style="width:10%;">License Permit No.</th> </tr> </thead> <tbody> <tr><td>1.</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>2.</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>3.</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>4.</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>5.</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>6.</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>7.</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p style="text-align: center; font-size: small;">(Attach additional sheets if necessary.)</p>			Name	Title/Degree (MD, DO, Ph.D, CPO, etc.)	SSN	Date of Birth	License Permit No.	1.	_____	_____	_____	_____	_____	2.	_____	_____	_____	_____	_____	3.	_____	_____	_____	_____	_____	4.	_____	_____	_____	_____	_____	5.	_____	_____	_____	_____	_____	6.	_____	_____	_____	_____	_____	7.	_____	_____	_____	_____	_____
	Name	Title/Degree (MD, DO, Ph.D, CPO, etc.)	SSN	Date of Birth	License Permit No.																																												
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7.	_____	_____	_____	_____	_____																																												
<p style="text-align: center;">CERTIFICATION</p> <p><i>For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey Medicaid (Title XIX) Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me on this application are willfully false, I am subject to punishment, including but not limited to suspension, debarment or disqualification from the New Jersey Medicaid Program in accordance with N.J.A.C. 10:49-1.17(d)22. I agree to notify the New Jersey Department of Health and Senior Services, Office of Provider Enrollment, at least quarterly, of all future additions to any of those named in Questions 23 - 26, for whom the response to those same questions would be affirmative.</i></p>																																																	
Name of Provider Representative	Title																																																
Signature	Date																																																
FOR STATE USE ONLY																																																	
<input type="checkbox"/> Approve	<input type="checkbox"/> Disapprove	<input type="checkbox"/> Other																																															
Provider Type(s)	Initial _____	Date _____																																															
_____	Category of Service	Specialty																																															
_____	_____	_____																																															

APPENDIX B

New Jersey Department of Health and Senior Services

**New Jersey Medicaid Program
Title XIX (Medicaid)**

**PARTICIPATION AGREEMENT
BETWEEN**

**NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
AND**

(Medical Day Care Program - Adults)

Name and Address of Facility	State License Number
	Medicaid Provider Number
<p>This contract, made and entered into by and between the Department of Health and Senior Services, hereinafter designated as the Department, and the above-named Facility, a provider of services, hereinafter designated as the Facility, Witnesseth:</p> <p>WHEREAS, various persons eligible for benefits under the New Jersey Medicaid Program are in need of medical day care, as more specifically set forth in Program regulations and guidelines; and</p> <p>WHEREAS, Section 1902(a)(27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or institution providing services under the State Plan for Medical Assistance (Title XIX); and</p> <p>WHEREAS, pursuant to N.J.S.A. 30:4D-1 et seq., and the Reorganization Plan 001-1996, the Department administers this segment of the Medicaid Program and is authorized thereunder to take all necessary steps for the proper and efficient administration of the New Jersey Medicaid Program; and</p> <p>WHEREAS, to participate in the New Jersey Medicaid Program, a Medical Day Care Facility must:</p> <ol style="list-style-type: none"> (1) be licensed under the laws of New Jersey as a non-residential Adult Day Health Care Center by the Department; (2) be currently meeting, on a continuing basis, standards for licensure; (3) be administered by a qualified health professional; (4) meet on a continuing basis Federal and State standards for participation and, more specifically, Medical Day Care standards in Title XIX of the Social Security Act; and (5) accept the terms and conditions of participation set out herein. <p>NOW, THEREFORE, it is agreed, by both parties, as follows:</p> <p>A. FACILITY AGREES:</p> <ol style="list-style-type: none"> 1. That it will render all services which are required for participation in the Medical Day Care program for adults, including at a minimum: medical services, nursing services, social services, transportation, personal care services, dietary services, therapeutic activities, pharmaceutical and rehabilitation services. 2. That it will accept the Medical Day Care rate approved under the Medicaid Program as payment in full and will not make any additional charges to the participant or others on his behalf for Medicaid-covered services, except for authorized physical therapy and speech-language therapy which are not included in the per diem reimbursement and must be billed separately. Medical Day Care Centers for adults will be reimbursed in accordance with methods and procedures set forth in State regulations. 3. That it will promptly initiate and terminate billing procedures pursuant to applicable regulations, when individuals covered under this Program enter or leave the Facility or are assessed at a different level of care. 	

MEDICAL DAY CARE PROGRAM PARTICIPATION AGREEMENT, Continued

Name and Address of Facility	Medicaid Provider Number
<ol style="list-style-type: none"> 4. That it will limit billing procedures under this Program to those authorized participants and for those days on which Medical Day Care services have been received. 5. That it will make available to the appropriate State and/or Federal personnel or their agents, at all reasonable times and places in New Jersey, all necessary records including: <ol style="list-style-type: none"> a. Medical records as required by Section 1902(s)(27) from the Social Security Act of Title XIX and any amendments thereto; b. Records of all treatment, drugs, and services for which vendor payments are to be made under the Title XIX programs, including the authority for and the date of administration of such treatments, drugs, or services; c. Documentation in each participant's records which will enable the Department to verify that each charge is due and proper prior to payment; d. Financial records of the Facility, including data necessary to determine appropriate reimbursement rates; and e. All other records as may be found necessary by the Department to be in compliance with Federal or State law, rule, or regulations promulgated by the United States Department of Health and Human Services or by the Department. 6. That it will comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106; 7. That the maximum number of daily participants will be in accordance with the Department's regulations and licensure standards. 8. That it will cooperate fully in permitting and assisting representatives of the Department to make assessments and evaluations of services needed by and provided to participants in general, and of individual participants who are recipients of the Medical Day Care services. 9. That it will secure and arrange for other health services as may be available for Medicaid patients pursuant to program regulations. 10. That it will comply with State and Federal Medicaid laws, and rules and regulations promulgated pursuant thereto. 11. That it will cooperate fully in permitting and assisting representatives of the Department in determining continuing conformity with the Federal and State standards applicable to non-residential Medical Day Care Facilities. 12. That it will notify the Provider Enrollment unit, within five working days, subsequent to any change in status of its license to operate as issued by the Department. 13. That it will notify the Department within five (5) working days, subsequent to any professional staff changes. 14. That it will notify the Medical Day Care participants, in writing, thirty (30) days prior to the Facility's termination as a Medicaid provider. 15. That the Facility may terminate its participation in the Medicaid Program upon a minimum of sixty (60) days written notice to the Department. 	

MEDICAL DAY CARE PROGRAM PARTICIPATION AGREEMENT, Continued

Name and Address of Facility	Medicaid Provider Number
<p>16. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242(c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or knowing a false statement of fact used in determining the right to a benefit, or in converting a benefit, from this program, to the use of any persons other than one for whom it was intended).</p> <p>17. That breach or violation of any one of the above provisions shall make this entire agreement subject to immediate cancellation at the Department's discretion, in keeping with the procedures adopted by the Department in accordance with the New Jersey Administrative Procedures Act.</p> <p>18. That it will immediately provide the Department with written notice of any change in ownership and/or operation of the Facility, including changes in leases, officers and directors, stock ownership or sale of the Facility, when:</p> <p><u>Corporate (Profit)</u></p> <p>a. There is acquisition of or transfer of ownership through purchase, contract, donation, gift, stock option, etc., of 25% or more of a corporation's outstanding stock (preferred or common).</p> <p>b. There is acquisition of the physical or intangible assets of the Facility by a newly formed or existing corporation.</p> <p><u>Partnership</u></p> <p>a. There is acquisition of or transfer of ownership of 10% or more of the existing partnership's total capital interest.</p> <p>b. There is acquisition of the physical or intangible assets of the Facility by a newly formed or existing partnership.</p> <p><u>Proprietorship</u></p> <p>a. There is purchase of the physical or intangible assets of the Facility.</p> <p><u>Corporation (Non-Profit)</u></p> <p>a. There is a change in the officer, trustee, directors or board members of the Facility.</p> <p>B. DEPARTMENT AGREES:</p> <p>1. That it will pay for authorized services provided by the Facility in keeping with the availability of State appropriations, on the basis of care required by the eligible individual as determined by the Department acting under the applicable regulations, but in no event will payment be made for any individual determined not to require Medical Day Care services.</p> <p>2. That it will reimburse the Medical Day Care Center through the appropriate fiscal agent in accordance with methods and procedures set forth in State regulations.</p> <p>3. That it will make such payments, in accordance with applicable laws and regulations, as promptly as is feasible after a proper claim is submitted and approved.</p> <p>4. That it will give the Facility, (subject to Section A, Paragraph 17 herein), thirty (30) days notice of any impending changes in status as a participating Medical Day Care Facility; the Department may terminate this Agreement without cause following ninety (90) days advance, written notice to the Provider.</p>	

MEDICAL DAY CARE PROGRAM PARTICIPATION AGREEMENT, Continued

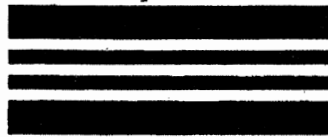
Name and Address of Facility	Medicaid Provider Number
<p>5. That it will notify the Facility of any change in Title XIX rules and regulations as it relates to the Facility's program, and will work with the individual Facility to provide the best care available within the limitations of the law and available money.</p> <p>C. DEPARTMENT AND FACILITY MUTUALLY AGREE:</p> <p>1. That, in the event the Federal and/or State laws should be amended or judicially interpreted so as to render the fulfillment of this agreement, on the part of either party, not feasible or impossible, or if the parties to this agreement should be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the Title XIX Program as a result of amendments or judicial interpretations, then, and in that event, both the Facility and the Department shall be discharged from future obligations created under the terms of this agreement, except for equitable settlement of the respective accrued interests up to the date of termination.</p> <p>2. That, in the event a participating Facility is sold, the Department shall make no division of the reimbursable proceeds for services rendered to Medicaid recipients between buyer and seller, but rather will reimburse the provider of record as of the billing month for all services rendered. Said Provider shall make the necessary adjustments.</p> <p>3. This agreement shall be effective on _____ and will continue unless terminated or amended prior thereto:</p> <p style="margin-left: 20px;">a. by mutual consent of the parties,</p> <p style="margin-left: 20px;">b. for cause under applicable clauses herein, or</p> <p style="margin-left: 20px;">c. because of Federal and/or State government withdrawal from Program participation.</p> <p>4. To be completed by the Facility and the Department:</p> <div style="margin-left: 100px; margin-top: 20px;"> <p>_____</p> <p style="text-align: center;">[Name of Authorized Representative of Facility (Print)]</p> <p>_____</p> <p style="text-align: center;">(Title)</p> </div> <div style="margin-left: 100px; margin-top: 20px;"> <p>_____</p> <p style="text-align: center;">(Date)</p> </div> <div style="margin-left: 100px; margin-top: 20px;"> <p>_____</p> <p style="text-align: center;">(Signature of Authorized Representative of Facility)</p> </div> <div style="margin-left: 100px; margin-top: 20px;"> <p>_____</p> <p style="text-align: center;">[Name of Authorized Representative of NJDHSS (Print)]</p> <p>_____</p> <p style="text-align: center;">(Title)</p> </div> <div style="margin-left: 100px; margin-top: 20px;"> <p>_____</p> <p style="text-align: center;">(Date)</p> </div> <div style="margin-left: 100px; margin-top: 20px;"> <p>_____</p> <p style="text-align: center;">(Signature of Authorized Representative of NJDHSS)</p> </div>	

APPENDIX C**OUTLINE FOR WRITTEN NARRATIVE STATEMENT ON****PROPOSED ADULT OR PEDIATRIC DAY HEALTH SERVICES FACILITY**

1. Describe the philosophy, goals and objectives for providing medical and ancillary health services to a non-resident population in an ambulatory care setting supportive to their community living.
2. Describe the physical facilities to be used for the proposed Adult or Pediatric Day Health Services Facility (diagram acceptable).
3. Describe the proposed Adult or Pediatric Day Health Services Facility, including hours of operation; services to be provided, in-house and/or arrangement and staff who will be implementing the program.
4. Provide staff position descriptions and state qualifications of personnel selected for each position.
5. State total number of participants who will be served by the Adult or Pediatric Day Health Services Facility and give anticipated daily population.
6. Submit a projection of costs to be incurred by the Adult or Pediatric Day Health Services Facility. State the period of projection and provide the basis of cost allocation if applicable.
7. Will the Adult or Pediatric Day Health Services Facility be funded by other than Title XIX; i.e., Title XX and Title III?
8. Is the proposed Adult or Pediatric Day Health Services Facility a new facility or an expansion of an existing facility?
9. Additional comments relevant to the application for Adult or Pediatric Day Health Services Facility under the New Jersey Medicaid Program.

APPENDIX D

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)			
CITY		STATE			CITY		STATE		
ZIP CODE		TELEPHONE (Include Area Code)			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			SEX M <input type="checkbox"/> F <input type="checkbox"/>			
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.			
14. DATE OF CURRENT: MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			\$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)			22. MEDICAID RESUBMISSION CODE			ORIGINAL REF. NO.			
24. DATE(S) OF SERVICE			PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			DIAGNOSIS CODE			
25. FEDERAL TAX I.D. NUMBER			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back)			
28. TOTAL CHARGE			29. AMOUNT PAID			30. BALANCE DUE			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12/80), FORM RRB-1500, APPROVED OMB-1215-0065 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

APPENDIX E

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation
PO Box 4801
Trenton, NJ 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, NJ 08625-0049

Amended by R.1994 d.427, effective August 15, 1994.
See: 26 N.J.R. 1427(a), 26 N.J.R. 3474(a).