STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES

HEALTH SERVICES PROGRAM

LONG TERM CARE

SERVICES MANUAL

STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume .....

September 3, 1979

TO: PROVIDERS OF LONG TERM CARE SERVICES

SUBJECT: REVISED LONG TERM CARE SERVICES MANUAL ADOPTED EFFECTIVE MARCH 29, 1979

We are pleased to forward a completely revised "Chapter II" of the New Jersey Medicaid Program's Long Term Care Services Manual.

This chapter supercedes Chapter II of the "Skilled Nursing Home Services" manual issued on October 22, 1971 and the State of New Jersey Health Services Program Manual of Standards For An Intermediate Care Facility, Level B which was adopted in the New Jersey Register on July 1, 1973, and all Long Term Care Circular Letters up to and including number 101.

"Chapter II" is designed for use by a provider who is billing for long term care services furnished under the Program and has been written in accordance with Federal and State laws, rules, and regulations.

The numerical designation of this chapter has been changed in order to conform with the State of New Jersey, Division of Administrative Procedure requirements for submission into the New Jersey Administrative Code. Under this format Chapter II becomes N.J.A.C. Title 10, Chapter 63, Subchapter 1. Sections of this subchapter have also been renumbered. Scope which was formerly Section 200 becomes Section 1.1 Definitions which were individually numbered under Section 201 are now listed under Section 1.2 . All subsequent sections are similarly numbered. The same format was used in the new billing chapter which you received in July, 1978. All New Jersey Health Services Program manuals/chapters will be similarly renumbered when revised.

Major changes appear in Section 1.16 (i) 1 on page 50. These are;

1. Regulations governing recipient admissions from an acute general hospital, or a Class "A" special hospital now also apply to a Title XIX certified psychiatric hospital.

2. Prior authorization for the admission of an eligible recipient to a long term care facility from a Title XIX certified psychiatric hospital is no longer required.

Please incorporate this new material into your Medicaid binder which should now contain a current Long Term Care Services Manual consisting of;

1. Revised Chapter I dated 12-77
2. Chapter 63, Subchapter 1 dated 9-79
3. Billing Procedures dated 6-78
4. Chapter IV, Medical Day Care Services dated 5-1-77
5. Long Term Care Circular Letters as indicated
   - no. 102 - Pharmaceutical Assistance to the Aged (PAA) Benefits for Patients in Long Term Care Facilities -- File with Chapter I
   - no. 104 - MCNH-30 Certification of Lowest Semi Private Room Rates (LSPRR) -- File with Billing Procedures
   - no. 105 - Medical Day Care Services - new Reimbursement Formula -- File with Chapter IV
   - no. 106 - Directory of Local Medical Assistance Units -- File with Chapter I

no. 107 - Admission Practices	- - File with Chapter I
no. 108 - Change of Telephone Numbers For Individual Medicaid Practitioner (IMP) Number Inquiries	- - File with the IMP Number Directory

The IMP Number Directory may also be maintained in your Medicaid binder.

Please discard:

1. Chapter II of the Skilled Nursing Home Services Manual,
2. Manual of Standards For An Intermediate Care Facility, Level B
3. Long Term Care Circular Letters 1 through 101 inclusive which have been incorporated into the attached revised Chapter II, and 103 which is obsolete.

Any inquiries may be directed to the Chief, Bureau of Procedures Development and Communications, 292-4656.

LONG TERM CARE SERVICES MANUAL

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SUBCHAPTER 1

LONG TERM CARE SERVICES MANUAL

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SUBCHAPTER 1

1.1 Scope

This chapter is concerned with the provision of quality health care services available to eligible recipients of the New Jersey Medicaid Program in a Silled Nursing and/or Intermediate Care Facility.

1.2 Definitions

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

"Consultant pharmacist" means a pharmacist licensed by the New Jersey State Board of Pharmacy, and who meets the following qualifications:

1. Holds a current valid license from the New Jersey State Board of Pharmacy.

2. Has at least one year's experience in the practice of institutional pharmacy. This requirement shall become effective one year from the effective date (7/1/77) of the other requirements herein.

3. Can, upon the request from the Director of the New Jersey Medicaid Program or his designee, produce evidence annually of having successfully completed training and/or educational programs pertaining to the practice of institutional pharmacy, acceptable by Council of Pharmaceutical Continuing Education.

"Intermediate care facility (ICF)" means a free-standing institution or an identifiable part of an institution which is either licensed or approved by the State Department of Health as an ICF and which meets all the State and Federal requirements for participating in the New Jersey Medicaid Program as an ICF.

"Involuntary transfer" means any transfer of a Medicaid patient which is not consented to or was not requested by the patient or by the patient's family or authorized representative.

"Level III, skilled nursing patient" means a person with acute or subacut medical and/or mental dysfunction requiring skilled nursing, psycho-social and restorative care during a 24 hour period. The Level III patient requires continuous 24 hour availability of nursing personnel at the licensed nurse level under the general direction of a registered professional nurse and will require other skilled services on an intensive basis including rehabilitation. The dysfunction may involve one or several physiological systems, may be stabilized or not, with symptoms subsiding or increasing. The patient may be bed fast, chair fast, semi-ambulant or ambulant (with or without assistive devices). Determination of this level of care requires an identification of skills required and evidence that as a practical matter such care can only be provided in a Long Term Care Facility setting.

"Level IV-A, intermediate care patient" means a person with physical and/or mental and/or social dysfunction requiring on a daily basis substantial assistance with personal care needs involving activities of daily living. Nursing care at Level IV-A must be provided 24 hours a day by licensed and non-licensed personnel under the general direction of a registered professional nurse. These patients require continued restorative and psycho-social services which as a practice matter can only be provided in a Long Term Care Facility setting.

"Level IV-B, intermediate care patient" means an ambulant or semi-ambulant person with physical and/or mental dysfunction requiring minimal assistance with personal care needs on a daily basis. The Level IV-B patient requires continuous on-site availability of licensed and non-licensed personnel for each 24 hour period under the general direction of a licensed practical nurse. The patients at this level of care will require continuing restorative, preventive and maintenance care which as a practical matter can only be provided in a Long Term Care Facility setting. The Level IV-B patient is usually fairly self sufficient in activities of daily living with or without self help devices and his needs usually have greater social than medical significance.

"Long Term Care Facility (LTCF)" means a Skilled Nursing Facility (SNF) and/or an Intermediate Care Facility (ICF) which exists as a free-standing institution or an identifiable part of an institution and which meets all the State and Federal requirements for New Jersey Medicaid Program participation as described in Section 1.15 of this manual. LTCF's will be required to provide sufficient professional and non-professional staff to comply with the regulations prescribed by the New Jersey State Department of Health.

"Long Term Care Services for each patient" means an individually planned program of care and rehabilitation as appropriate, in addition to the basic requirements for food and shelter. The plan includes medical, nursing, personal, rehabilitation, recreational and social services. Rehabilitation services and restorative nursing are provided as required by the individual needs of the patient with the degree of skill appropriate to each level of care.

"Medical Director" means a physician licensed under New Jersey State law who is responsible for the direction and coordination of medical care in a LTCF.

"Medical Evaluation Team (MET)" means a team consisting of a Medicaid Regional or Local Medical Consultant, a Medicaid Regional Nurse Supervisor or Regional Staff Nurse, and a Medicaid Social Worker who are assigned to the Local Medical Assistance Unit (LMAU). In addition, a social worker from either the County Welfare Agency (CWA) or the Bureau of Transitional Services (BTS) may be invited to participate as a team member in specific instances.

A MET has the responsibility to review the medical nursing, and social information obtained at the time of the patient's assessment as well as any other supporting data in order to evaluate the need for long term

care, determine the level of care needed, the feasibility of alternate care, the quality of care given and the outcome of service.

"Medical Plan of Care and Treatment" means an individualized patient's written plan of care and treatment, which must be prepared and signed by the attending physician on an indentifiable form in the Medicaid patient's clinical record within 48 hours of admission. At a minimum, the record shall contain the diagnosis, prognosis, rehabilitation potential (if any) for specific levels of function, recommended special therapies, short and long term goals, projected length of stay at present level of care in the LTCF in addition to an alternate plan for discharge to another level of care and/or type of facility or residence if appropriate or indicated.

"Medicaid Medical Review Team (MRT)" means a team consisting of a Medical Consultant, Regional Nurse Supervisor and/or a Regional Staff Nurse and Regional Medicaid Social Worker or Social Worker Supervisor who carries out the Federal requirements for Periodic Medical Review.

"Medical staff" means one or more duly licensed physicians who act as the attending physician(s) to Medicaid eligible patients in a LTCF.

"Mixed Skilled Nursing Facility and Intermediate Care Facility" means a free-standing institution or an identifiable part of an institution which is either licensed or approved by the State Department of Health as a SNF and meets all the State and Federal requirements for participation in the New Jersey Medicaid Program as both a SNF and ICF.

"Multiple occupancy in a LTCF" means the mixing of residents requiring various levels of care, i.e., Skilled Nursing, Intermediate A and Intermediate B care, in either the entire facility or in distinct part of a facility which is certified for that Level of Care.

"Qualified occupational therapist" means one who is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

"Periodic Medical Review (PMR)" means a process of professional review at least once in a twelve month period by the New Jersey Medicaid Program MRT of the adequacy and quality of long term care provided by the LTCF for patients cared for by that facility.

"Qualified physical therapist", for program payment purposes means an individual who is licensed as a physical therapist by the state in which the physical therapist is practicing and who meets one of the following requirements:

1. Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical

Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

2. Prior to January 1, 1966, was admitted to membership by the American Physical Therapy Association, or was admitted to registration by the American Registry of Physical Therapists, or has graduated from a physical therapy curriculum in a 4 year college or university approved by a State Department of Education; or

3. Has two years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary except that such determinations of proficiency will not apply with respect to persons initially licensed by a state as a physical therapist after December 31, 1977, or seeking qualification as a physical therapist after that date; or

4. Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

5. If trained outside the United States, was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, has one year of experience under the supervision of an active member of the American Physical Therapy Association, and has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

"Physician's Services" means those services provided within the scope of practice of his profession as defined by the laws of New Jersey and those services which are performed by or under the direct personal supervision of the physician.

1. "Physician" means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners.

2. "Direct Personal Supervision" means that the services must be rendered in the physician's presence. It is not the intent of the Program to reimburse a physician for history and/or physical examinations performed by interns, residents, other house staff members or physician's assistants.

"Prior authorization" means approval granted by the Division of Medical Assistance and Health Services through the appropriate Local Medical Assistance Unit (LMAU) for payment for LTCF services rendered to a Medicaid eligible patient for a specific time period.

"Rehabilitation and/or restorative nursing care" means skilled nursing care provided by a registered professional nurse, or under the direction of a registered professional nurse qualified by experience in rehabilitation or restorative nursing care. This person acts both independently and as a member of a health care team directed toward rehabilitation and restoration of an individual to his maximum potential for self-care and independence, including skilled services in treatment, maintenance, prevention, teaching, emotional support, social stimulation and controls necessary to meet the established goals for physical, mental, emotional behavioral and social levels of function.

"Rehabilitation Services" means physical therapy, occupational therapy, speech therapy, and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best possible functional level. They do not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form, massage, routine calisthenics or group exercises, assistance in any activity or use of a simple mechanical device not requiring the special skill of a qualified physical therapist. Rehabilitation services in a LTCF must be made available to covered persons as an integral part of a comprehensive medical care program. Such services include not only intermittent or part-time service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

"Skilled Nursing Facility (SNF)" means a free-standing institution or an indentifiable part of an institution which is either licensed or approved by the State Department of Health as a Skilled Nursing Facility and which meets all the State and Federal requirements for participation in the New Jersey Medicaid Program as a Skilled Nursing Facility.

"Social Services" means the identification of social and emotional needs of the patient(s) and the provision of services to meet those needs.

"Speech pathologist" means an individual who is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

"Utilization Control" means a surveillance program established to ensure the quality and timeliness of services provided to Medicaid eligible patients and to safeguard against unnecessary and/or inappropriate utilization of care and services.

"Utilization Review" means a continuous program of review of the need for services to eligible recipients.

1.3 REQUIRED SERVICES (The following services are included in the per diem rate)

(a) Bed and Board

Beds are provided in rooms approved by the New Jersey Department of Health and board is provided to meet basic nutritional needs. Linens for beds and bathroom shall be included.

(b) Laundry

Laundering of personal clothing (excluding dry cleaning).

(c) Special diets

Therapeutic diets as prescribed by the patient's attending physician.

(d) Nursing Services

1. Skilled Nursing Facility Level III

i. The SNF provides 24 hour nursing services in accordance with the minimum standards set forth by the New Jersey Department of Health.

ii. Nursing services are provided in accordance with an individual plan of care designed to ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitation nursing care as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well groomed and protected from accident, injury and infection, and encouraged, assisted, and trained in self care and group activities.

iii. Nursing service personnel are assigned duties consistent with their education and experience and based on the patient load.

2. Intermediate Care Facility Level IV-A

i. The ICF IV-A provides 24 hour nursing services in accordance with the minimum standards set forth by the New Jersey Department of Health.

ii. Nursing services are provided in accordance with an individual plan of care setting forth measurable goals or behaviorally stated objectives and prescribing an integrated program of individually designed activities, experiences, or therapies necessary to achieve such goals or objectives. The overall objective of the plan is to attain and/or maintain the optimal physical, intellectual, social, or vocational functioning of which the patient is presently or potentially capable.

iii. Nursing personnel are assigned duties consistent with their educational and experience and based on the patient load.

3. Intermediare Care Facility Level IV-B

i. The ICF Level IV-B provides 24 hour nursing services in accordance with the minimum standards set forth by the New Jersey Department of Health.

ii. Nursing services are provided in accordance with the patient's health care plan for medications, treatments, diet, and other health related services, notification of physician when changes are appropriate and coordination of the health care plan and services with the social plan of care and discharge plan.

iii. Nursing personnel are assigned duties consistent with their education and experience and based on the patient load.

(e) Restorative nursing services

Restorative nursing is an active program of restorative care, which is an integral part of all nursing service, directed toward assisting each patient to achieve and maintain an optimal level of independence in self-care and to assist him to achieve his maximum possible physical, mental, and social efficiency. Restorative nursing initiated prior to admission or persons transferred to LTCF's from other health care delivery providers should be continued in the SNF and/or ICF. If no restorative care was initiated prior to admission, the registered professional nurse should assess the patient or resident for restorative care needs and initiate a restorative plan of care.

1. Functions of restorative nursing

As a minimum, the functions of restorative nursing shall include:

i. Developing a plan for restorative nursing care services based upon a nursing assessment of patient needs which will be periodically updated to reflect any changes in patients' or patient's needs;

ii. Carrying out specific restorative nursing techniques such as the prevention of physical deformities through positioning, change of position, range of motion exercises, etc., teaching ambulatory techniques of brace and crutch walking etc., the prevention and care of decubitus ulcers, teaching self-care activites including the utilization of self help devices, controlling incontinency by bowel and bladder retraining, assiting with problems of communication, motivation and emotional support with the application of reality orientation, remotivation, and behavior modification techniques.

(f) Non-legend drugs (i.e., drugs which by Federal law do not require a prescription).

(g) Medical supplies

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

(h) Durable medical equipment

Routinely used equipment ordered for Medicaid eligible patients in a participating medical institution i.e., durable medical equipment (e.g., walkers, wheelchairs, bed-rails, crutches, traction apparatus, IPPB machine, electric nebulizers, and electric aspirators) and other therapeutic equipment and supplies essential to furnish the services offered by the facility for the care and treatment of its patients is considered part of the institution's cost, and cannot be billed directly to the program by the supplier. In exceptional situations See Section 1.4(c).

(i) Equipment necessary for administration of oxygen

Equipment for administration of oxygen for patients in a LTCF is a required service. Oxygen itself must conform to United States Pharmacopeial Standards in order to be used as a medicinal gas.

(j) Housekeeping and maintenance services

Housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment are required services.

(k) Patient activities

An ongoing patient activities program shall be established as an adjunct to the treatment program. The program shall be a planned schedule of recreational, social, spiritual, and other purposeful activities designed to meet the needs and interests of all patients, whether ambulatory, chairbound, or bedfast. It shall enable the patients to maintain a sense of usefulness and self respect, and when possible, help to prevent regression. It shall encourage restoration to self-care and resumption of normal activities and stimulate and support the patient's desire to use physical and mental capabilities to the fullest extent.

1. Staff

i. Patient activities staff shall meet the qualifications for the positions of Patient Activities Coordinator and Patient Activities Consultant as defined in the N.J. State Department of Health Manual of Standards for Licensure of Long Term Care Facilities (1.49, 1.50 and 13.5). The facility shall appoint a patient activities coordinator who shall provide patient activity services in the facility at least 10 hours per week for every 15 patients.

ii. Facilities of more than 60 patients shall have a full-time coordinator. Additional patient activity time shall be provided proportionate to the number of patients over 60.

iii. If the coordinator does not meet the qualifications, a patient activities consultant shall be appointed who shall provide at least four hours of consultation in the facility per month until the coordinator meets the requirements, a period not to exceed two years.

iv. The use of volunteers should be encouraged and utilized to supplement full-time staff. Volunteers should be trained and supervised in this performance of their duties by qualified staff.

2. Program

A written schedule of activities shall be established and posted so that patients and staff are aware of daily programs. There shall be a diversity of activities seven days per week, including evenings. Activities should be varied to include passive and active programs, individual and group sessions, totally reflecting the interests and needs of the population of each facility. There shall be input into the planning and carrying out of the programs by a Patient Council which meets regularly with the Coordinator.

3. Space and equipment

i. Sufficient space shall be provided for group activities and for each patient's individual use. Activity areas shall be accessible to all patients.

ii. Community social and recreational facilities shall be utilized to the fullest extent possible. Community groups shall be encouraged to plan and participate in programs in the facility and, conversely, patients also shall be encouraged to participate in programs in the community. Transportation shall be provided to and from destination in the community.

iii. Adequate indoor and outdoor recreational areas shall be provided with sufficient equipment and materials available to support all activities.

4. Patient utilization

i. Patients shall be encouraged but not required to participate in all activities. Outreach efforts to involve patients in activities programs shall be the responsibility of all staff.

ii. The activities coordinator and activities staff shall be aware of each patient's physical and medical limitations and restrictions, so that the activities program can have a positive effect upon the overall treatment plan.

iii. All staff of the facility shall be trained in the value of an activities program for overall effective patient care and shall cooperate with, and participate in, activities provided within the facility.

5. Visiting and religious attendance

Provisions shall be made for relatives and friends of patient to participate in patient life.

(l) Social services

1. Staff

i. The LTCF may elect to either provide social services directly or arrange with an appropriate social agency, usually the county welfare agency, for the provision of social services.

ii. Social Services staff shall meet the qualifications for Social Work Designee and Social Worker as defined in the Health Department Manual of Standards for Licensure of Long Term Care Facilities (1.66, 1.67 and 12.4).

iii. The facility shall appoint a social worker, or a social work designee who receives onsite consultations from a social worker. The social worker or designee shall provide social services in the facility one hour per week for every six patients. Facilities of 210 patients shall have on full-time social worker or designee. Additional social work time shall be provided in the facility proportionate to the numbers of patients over 210 at a ratio of one additional hour per six additional patients.

iv. Social work consultation to the designee shall be at least two hours per week in facilities of 60 or more patients and four hours per month in facilities of 60 or fewer patients.

2. Delineation of roles of social service staff

i. A social work designee/social worker shall be responsible for identifying the social needs of the patients and for providing or arranging for services to meet these needs; gathering and documenting the social record, involving other agencies in providing services where necessary; cooperating with other staff in the facility in clarifying the social aspects of treatment; planning and preparing patient and family for, the arranging for both admission and discharge; the social worker may assist in the development of the social work department and the training of staff in social care areas.

ii. A social worker in the consultant capacity shall be responsible for training the designee to identify needs, provide and document social services. The consultant may also provide inservice training in the area of social care to other facility staff, intervene in difficult case situations, and advise the administrator in the development and organization of the social services department.

3. Program

i. The facility shall have satisfactory arrangements for identifying medically related social and emotional needs of patients and for providing services to meet these needs. Identifying social needs means that each patient's situation is reviewed regularily (at least semi-annually) to determine what problems or gaps exist in interrelationships and activities within the facility and with the family, and to develop a course of action to meet these needs. Contact shall be made frequently with patients, family and staff to assess patient needs.

ii. Social services to be provided shall consist of an initial interview with the patient and family, on-going conuseling with patients and families (individual and/or group), consultation and advice to nursing and other professional staff, the handling of social problems related to interpersonal relationships, behavior difficulties, family situations, information and referral and contact with other agencies, advocacy: assisting patients in asserting and understanding rights, tangible services related to money, clothing, and other personal incidental items, discharge planning and implementation of discharge arrangements.

4. Space

Office space shall be available to insure visual and auditory privacy for social service interviews with patient and family.

1.4 Additional Services

(a) As a condition for qualifying as a LTCF under the New Jersey Medicaid Program, the facility must maintain effective agreements in order to provide additional services which might be required by an individual patient. It is the right of Medicaid eligible patients in an LTCF, in consultation with the attending physician, to exercise free choice with respect to a provider of additional services. If such patient does not choose to exercise such a right, or is unable by virtue of his or her physical or mental condition to do so, a person authorized to act on the patient's behalf may, in consultation with the attending physician, designate a provider. In the absence of such person, the facility may, in consultation with the attending physician, designate a provider.

All additional services listed in this section require the attending physician's signature on the order sheet.

The following must be provided and/or be available to Medicaid eligible patients in an LTCF, but are not part of the per diem rate paid to the LTCF, unless included in the cost study of the LTCF by the Bureau of Audits, Office of Program Integrity Administration of this Division.

(b) Laboratory X-ray including portable and other diagnostic services

1. Laboratory Services: A LTCF must have written agreements with one or more clinical laboratories so that the facility can obtain laboratory services, including emergency services promptly.

   A laboratory must be:

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

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

   iii. Approved for participation as an independent laboratory provider by the New Jersey Medicaid Program.

   If the facility has its own laboratory capabilities under the above provisions, the services may not be billed on a separate fee-for-service basis.

2. X-ray Services: A LTCF must have written agreements with one or more general hospitals or one or more Board certified or Board eligible radiologists so that the facility can obtain radiological services, including emergency services promptly.

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

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

3. Other diagnostic services (e.g., ECG, EEG, etc.). A LTCF must have written agreements with one or more general hosptials or one or more qualified providers so that the facility can obtain such specified services including emergency services promptly.

(c) Special medical equipment

When unusual circumstances require special medical equipment not usually found in a LTCF, such special equipment may be reimbursable with prior authorization from the Local Medical Assistance Unit (LMAU) serving the county where the facility is located. Any equipment so purchased is the property of the patient for whom it was authorized.

(d) Transporation services

When a Medicaid eligible patient requires a service or care not regularly provided by the LTCF, arrangements to obtain these services are to be made by facilities with appropriate agencies or other responsible persons.

1. Transporation provided by LTCF

   If a transporation service is provied by the LTCF to an inpatient of that LTCF, no additional reimbursement is allowed. Reimbursement is included in the per diem rate.

2. Ambulance and invalid coach

   Prior authorization from the LMAU is required for transportation by a certified transportation provider except in emergency conditions, i.e., critical illness or injury status for which prompt medical care may be crucial to saving life or limb.

   i. Ambulance service is covered only when the use of any other method of tranportation is medically contraindicated.

   ii. Invalid Coach service may be utilized when covered persons require transportation from place to place for medical purposes and whose use of a lesser form of transportation, i.e., cab, bus, or private vehicle would create a serious risk to life or health.

3. Other transportation not directly reimbursable

   Transportation by taxi, train, bus, and other public conveyances is not directly reimbursable by the New Jersey Medicaid Program. Inquiry should be made to the County Welfare Agency for authorization and payment for such transportation.

(e) Rehabilitation services

Rehabilitation services include physical therapy, occupational therapy, speech therapy services and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best functional level. It does not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill or a qualified physical therapist. Rehabilitation services shall be made available to eligible recipients as an integral part of a comprehensive medical program.

1. When prior authorized, reimbursement to a LTCF may be made for more than one type of therapy service performed on the same day, e.g., physical therapy and speech therapy.

2. Where the same type of therapy is performed more than once on a given day, or the therapy rendered is a different modality within the same type of therapy, reimbursement will be made for one therapy treatment only. All therapy must be provided under direct supervision and in the presence of a qualified therapist or physiatrist.

3. Providers of service

   i. Rehabilitation services shall be provided by qualified therapists employed by or under contract to:

      (1) an approved Home Health Agency; or

      (2) a licensed or accredited general or special hospital; or

      (3) an approved independent outpatient health facility; or

      (4) a LTCF

   ii. Reimbursement for rehabilitation services is made to the LTCF and not to the therapist by this program. Prior authorization is required as outlined in Section 1.4(e)5.

      (1) Outpatient physical therapy and speech therapy services furnished by a Medicare Certified facility to its Medicare eligible inpatients may be billed by the facility to Medicare under part B only when the beneficiary has exhausted his benefits under part A or is otherwise ineligible for part A benefits. When physical therapy or speech therapy services are furnished under arrangements to combination Medicare/ Medicaid patients, these services should be billed to the provider's Part A Intermediary using the form Provider Billing for Medical and Other Health Services SSA-1483 (Exhibit #23).

      (2) Outpatient physical therapy and special thérapy furnished only by a Medicaid LTCF to Medicaid eligible inpatients only may be billed by the facility to the Bureau of Claims and Accounts if prior authorization has been given by the LMAU. The facility must state to the LMAU that it is not a Medicare provider and therefore, no Medicare denial letter is needed.

      (3) Medicaid may reimburse Medicare certified facilities through their Part A Intermediary (Blue Cross or Prudential) for the unsatisfied deductible (Medicare Part B) when physical therapy or speech therapy services are performed for patients eligible for both programs.

4. Billing Medicaid following Medicare decline

   i. If the SSA-1483 (Exhibit #23) claim for physical therapy or speech therapy is declined by Medicare and you wish to bill Medicaid for these services a request for authorization must be made to the LMAU. When submitting such a request for authorization to the LMAU the facility must attach a copy of the Medicare denial letter. Medicaid will not authorize pay-

ment for any therapy claim which was denied by Medicare by reason of "not medically necessary". If authorization is granted by the LMAU the facility shall bill the Bureau of Claims and Accounts in accordance with established procedures, e.g., therapy charges, MCNH-14 (Exhibit #5) plus the form Request for Authorization or Reauthorization for Prescribed Rehabilitation Treatment Program, FD-06 (Exhibit #1).

ii. When submitting requests for prior authorization of physical therapy or speech therapy to the LMAU on behalf of patients not covered by Medicare benefits, the facility must state that the "patient is not a Medicare beneficiary".

5. Medicaid patients not eligible for Medicare benefits

Prior authorization by the Medical Consultant of the LMAU is required for rehabilitation services. Authorization shall be considered only when the request includes a written prescription by a licensed physician who is the patient's attending physician, substantiating the need, type of therapy, objective of treatment, and an estimate of the number of treatment days. Prescriptions must be definitive as to type and scope.

Orders such as "Physical Therapy three times a week" will not be accepted. Prior authorization may be for a period not exceeding 60 days. Subsequent authorizations for periods not exceeding 60 days may be issued by the Medical Consultant of the LMAU when the request is supported by the written prescription of the attending physician, including a statement of the anticipated number of treatments required, and a progress report of the recipient's condition.

6. Procedure regarding the acquisition of prior authorization for prescribed rehabilitation services

i. All LTCFs requesting prior authorization of rehabilitation services for Medicaid eligible patients receiving care in their facilities will use the Form FD-06 (Exhibit #1).

ii. The LTCF will be responsible for the total completion of the "Patient Information" and "Medical Information and Therapy Requested" portions of the form, in triplicate. If the request is for initial authorization of rehabilitation service, it will not be necessary to complete #13 on the form. Please note also that if the form is completed by the therapist rather than the attending physician, the latter's prescription must be attached to the request when it is submitted to the LMAU.

iii. Following Medical Consultant review and disposition, the billing and provider copies of the form will be returned to the LTCF by the LMAU. The billing copy is to be submitted to the Bureau of Claims and Accounts along with the MCNH-14 form, (Exhibit #5) for payment.

7. Therapy charges - billing procedures - Please refer to Section 1.11(h) Therapy Charges for detailed instructions.

(f) Dental services *

It is required that all facilities assist Medicaid eligible patients to obtain dental care through a licensed or consulting dentist who shall provide, or make provision for:

1. Appropriate consulting services

2. In-service education to the facility

3. Policies concerning oral hygiene

4. Routine and emergency services

(g) Podiatry services *

It is required that all facilities assist Medicaid eligible patients to obtain podiatry care through a licensed podiatrist who shall provide, or make provision for:

1. Appropriate consulting services

2. In-service education to the facility

3. Policies concerning foot care

4. Routine and emergency services

(h) Vision care services *

It is required that all facilities assist Medicaid eligible patients to obtain vision care through an ophthalmologist or licensed optometrist who shall provide, or make provision for:

1. Routine and emergency services

(i) Psychological services *

It is required that all facilities assist Medicaid eligible patients to obtain psychological care through a psychiatrist or a licensed psychologist who shall provide, or make provision for:

1. Routine and emergency services

(j) Chiropractic services *

It is required that all facilities assist Medicaid eligible patients to obtain chiropractic care through a licensed chiropractor who shall provide, or make provision for:

1. Routine and emergency services

* When dental, podiatry, vision care, psychological, chiropractic services are ordered as well as any medical or surgical specialty consultation, such services must be prescribed under the attending physician's signature and appear on the order sheet. In view of Patient's Rights (See Section 1.9), if these services were to arise as a result of a patient's request and be consistent with medical necessity, then the attending physician must note knowledge of the request on the order sheet affixing a signature thereto.

Example:
"Optometric consultation by Dr. R. L. Smith at patient's request/ A.B. Turner, M.D.".

1.5 Utilization Control

(a) Utilization control is a surveillance program established to ensure the quality and timeliness of services provided to eligible individuals, and to safeguard against unnecessary and/or inappropriate utilization of care and services. The utilization control program has as its components:

1. Utilization review;

2. Certification and recertification;

3. Patient plan of care;

4. Alternate care and discharge planning;

5. Post-payment review procedures;

6. Periodic medical review;

7. Additional visits to long term care facilities.

(b) Utilization review

Utilization review is a continuous program of review of the need for services to eligible individuals which includes:

1. Certfication of medical necessity

The Medicaid MET must determine necessity for long term care and the level of care in all cases of a Medicaid eligible patient except transfer from a general or special hospital to a LTCF (See Appendix - A, List of Special Hospitals).

2. Assessment - reassessment of care requirements

i. The medical needs of all Medicaid eligible patients referred for long term care will be assessed and conferenced by the MET prior to authorization of long term care.

ii. Initial assessment of all patients admitted to LTCFs from a general or special hospital will be done within 30 days.

iii. Continuation of long term care will be dependent on authorization by the MET at intervals of nor more than three months for Level III, not more than nine months for Level IV-A and not more than 12 months for Level IV-B.

3. Alternate care - discharge planning considerations

i. Alternate care planning is the determination, initially and periodically as to whether or not each Medicaid eligible patient requires initial placement or continued placement in an institutional setting and whether or not their nursing, social and other health care needs can be met through alternative institutional or non-institutional services.

(1) The MET will authorize initial long term care after consideration and rejection of possible means of alternate care. Similarly, the possibility of alternate means of care will be a prime consideration in every reassessment of the level of care required by the patient.

(2) The facility shall maintain continued vigilance and effort to utilize alternate means of care for all long term care patients. The MRT will examine patients records for proof of continued vigilance and effort by the facility to utilize alternate means of care for all long term care patients.

ii. Discharge planning is a coordinated plan promulgated by the LTCF Health Care Team at least seven days after admission and revised thereafter as the patient's condition indicates.

(1) The LTCF Health Care Team consists minimally of the attending physician, the nurse and social worker and should include as well other disciplines such as special therapists and dietician where individually applicable.

(2) The discharge plan will ensure that each patient has an appropriate plan for continuing care at another level at a specified projected time.

iii. Medical Review Team (MRT) responsibilities (See Section 1.5(g).

iv. Long Term Care Facility responsibilities

(1) The initial discharge plan shall be recorded in the Medicaid eligible patient's record within seven days of admission, and shall be reviewed periodically. The initial and periodic reviews shall be entered in the patient's medical record and shall specifically include consideration of possible alternate care.

(2) At the time of discharge or transfer, the facility shall prepare a patient summary (See Patient Information Transfer Form - Exhibit #30) which will accompany the patient to the receiving facility or be available to his attending physician if the discharge is to be to the community. This summary shall include at a minimum the diagnosis, current treatment, relevant medical, nursing and social information and disposition of the patient.

(c) Certficiation and re-certification

A physician must certify in the patient's medical record the need for services in a LTCF. This must occur at the time of admission or, if later, at the time the patient applies for Medicaid. The need for care at the given level must be recertified as follows:

1. Skilled Nursing Facility Level III and Intermediate Care Facility Level IV-A - Every 30 days.

2. Intermediate Care Facility Level IV-B - Every 60 days.

(d) Patient plan of care

The components of a patient plan of care:

1. The medical plan of care

2. The nursing plan of care

3. The social plan of care

4. Special Therapies

Note: The total plan of care shall be written based on the Medical Plan of Care and shall be readily available for use by all concerned with direct patient care. The plan shall be revised whenever indicated by change in the patient's condition and minimally at intervals described in Section 1.8(a)2 iv.

(e) Alternate care - discharge planning

See Section 1.5(b)3.

(f) Post-payment review procedures

The Medicaid Program performs a post-payment review procedure at the Central Office that allows for the development and review of recipient utilization profiles, provider service profiles, and exceptions criteria, and identifies exceptions in order to rectify mis-utilization practices of recipients and providers.

(g) Periodic medical review

1. Procedure

i. Following the nursing reassessment of each Medicaid eligible patient in the facility, a MET conference with a Medical Consultant and a Regional Staff Nurse is held. The patient's medical, nursing and social care services are evaluated in terms of the needs of that patient and a decision is made as to the level of care necessary and the most appropriate of the possible alternate care settings for the delivery of the health services required (See Section 1.5(b)3i). If health care services are no longer required, see Section 1.5(b)3 ii.

(1) The MET evaluates the quality of care which the individual patient has been receiving, according to the criteria for the level at which the patient has been maintaned during the previous authorization period. (MCNH-4(A), 4(B) and 4(C) --- Exhibits #19, 20 and 21).

ii. The LMAU Administrator shall notify the administrator of the facility of the scheduled visit no less than five working days beforehand and shall advise the administrator of those facility personnel whom the MRT expect to be present at the visit.

iii. At the time of the visit for the purpose of PMR, the report for the specified period is reviewed with the facility staff in comparison with the current observations. See MCNH-51 (Exhibit #12).

iv. Following the visit, a post-conference is held by the MRT during which the Periodic Medical Review Form MCNH-50 (Exhibit #11) is completed in writing and forwarded to the facility administrator from the office of the Medical Director.

v. The Form MCNH-50 (Exhibit #11) signed by the MRT becomes a useful guide so that each facility may constantly examine itself to assure continuity of compliance. The Facility (when requested) must submit a plan of correction of deficiencies to the Medical Director of the Division of Medical Assistance and Health Services within 30 days of receipt of the MCNH-50 (Exhibit #11).

(h) Additional visits to Long Term Care Facilities

The New Jersey Medicaid Program reserves the right to make additional on-site visits by the Division staff as required.

1.6 Authorization process - (See Section 1.16 Admission policies)

(a) If a Medicaid recipient has been prior authorized for admission, the LTCF must submit a Notification from Long Term Care Facility of Admission or Termination of a Medicaid Patient, Form MCNH-33 (Exhibit #7) to the LMAU serving the County where the LTCF is located, within two working days of admission.

(b) If a Medicaid recipient did not require prior authorization for admission and was admitted directly from an approved general or special hospital after a 3 day inpatient stay the LTCF must submit an MCNH-33 form (Exhibit #7 along with a copy of the Patient Information Transfer form, Exhibit #30) to the LMAU serving the county where the LTCF is located, within two working days of admission.

(c) If a LTCF fails to notify the LMAU of the admission of a Medicaid eligible recipient by submission of an MCNH-33 (Exhibit #7) and a hospital information transfer form (Exhibit #30) within the 30 days guaranteed authorization period, any time between the 30th day and the date of assessment may not be authorized for payment.

(d) The LTCF will be given written notification of any MET decision changing the patient's authorized level of care by distribution of the form Medical Authorization for Long Term Care MCNH-7 (Exhibit #3).

(e) Prior authorization

1. Whenever the term "prior authorization," "authorization," or "re-authorization" is used in this manual, it shall mean approval granted by the Division of Medical Assistance and Health Services through the appropriate LMAU for payment for LTCF services rendered to an eligible recipient for a specific time period. Payment will be made only for periods when the recipient is Medicaid eligible.

2. Prior authorization must be obtained from the LMAU for Medicaid recipients entering a LTCF from the patient's home or other place of residence, County Mental Institutions, Special Class B, Class C Hospitals, or Veterans Hospital. Medicaid patients admitted from an Acute Care Hospital, Class A Special Hospital or N.J. Title XIX Certified Psychiatric Hospital do not require prior authorization for the first 30 days if the Medicaid patient had been admitted for 3 days immediately preceding the admission to the LTCF.

3. The maximum durations for a single authorization for long term care are as follows:

   i. Level III - 3 months

   ii. Level IV-A - 9 months

   iii. Level IV-B - 12 months

   Note: Although an authorization may be given for a maximum period of time as indicated above the MET may give an authorization for a shorter period of time.

(f) Medical evaluation team

A MET has the responsibility to review the medical, nursing and social information obtained at the time of the patient's assessment, as well as any other supporting data in order to evaluate the need for long term care, determine the level of care needed, the feasibility of alternate care, the quality of care given and the outcome of services. See Sections 1.5(b) and 1.5(g).

(g) Authorization procedure

1. Following notification from a LTCF of admission of a Medicaid eligible patient or the change in patient status from private/ Medicare to Medicaid or a request for assessment by receipt of a form PA-4 (Certification of Need for Patient Care in Facility Other Than Public or Private General Hospital) - (Exhibit #28), from the County Welfare Agency, a referral is made to the Regional Staff Nurse in order to initiate a nursing assessment. If the referral involves a patient residing in the community, a referral is also made to the Medicaid Social Worker for a social assessment.

2. When the assessment of the patient is completed the Local Administrator schedules a conference of the MET.

3. The MET will render a decision either to authorize or deny, in the following fashion:

   i. Authorized long term care

   If the patient was assessed in a community setting (home assessment), written notification utilizing the Letter of Approval for Long Term Care Placement MCNH-58 (Exhibit #16) is sent to the patient/family.

   (1) If placement in a LTCF has already been accomplished, written notification, Form MCNH-34-C1 (Exhibit #8) is sent from the LMAU to the County Welfare Agency. A copy of the Home Assessment MCNH-61 (Exhibit #17) is sent to the LTCF where the patient has been placed.

   (2) An MCNH-7 (Exhibit #3 Medical Authorization for Long Term Care) is completed and copies are distributed to: Bureau of Claims and Accounts, LTCF, direct services agency.

   ii. Deny long term care

   (1) Written notification utilizing the Letter of Denial for Long Term Care following Home Visit MCNH-54 (Exhibit #13) or Letter of Denial of Reassessment MCNH-55 (Exhibit #14) is sent to the Patient/Family/ Sponsor with copies to the attending physician, County Welfare Agency, and LTCF when applicable.

(2) If the Medicaid patient had been currently authorized for long term care or has been newly admitted under an assured Level IV-B 30 day authorization period, an additional 20 day period of authorization from the date the written notice of denial is sent will be permitted in order to permit alternate placement. An MCNH-7 (Exhibit #3) covering this period is prepared and distributed in accordance with Section 1.6(g)3 i.

(3) If, however, extenuating circumstances exist whereby placement cannot be made within the time frame defined in the Medicaid letter of denial, the facility may submit a request for a review of the situation in writing to the Chief, Bureau of Local Adminitration, Division of Medical Assistance and Health Services, P. O. Box 2486, Trenton, N.J. 08625.

(4) The request must be submitted prior to the end of the grace period, sufficiently describing special circumstances which surround the case and the efforts that have been extended to discharge the patient to a lesser level of institutional care before consideration will be given to extend the grace period of authorization.

(h) Reauthorization procedures

1. Within forty-five days before the expiration of an authorized period of LTCF services, a Regional Staff Nurse shall assess the needs of the patient to determine the patient's current health status, continuing need for long term care and/or other appropriate alternatives.

2. The MET will re-evaluate the available data to determine need of continued LTCF placement and the appropriateness of alternatives.

3. If the MET decision is to approve long term care, the MCNH-7 (Exhibit #3) will serve as notification to County Welfare Agencies, Long Term Care Facilities and the Bureau of Claims and Accounts.

(i) Challenges and changes

It is recognized that certain level of care decisions made by the LMAU MET will occasion disagreement from either the LTCF, the attending physician or the patient and/or patient sponsor. The disagreement may involve a challenge to a recent MET decision or a change in the patient's condition during a period of authorization. The procedures to be followed are as follows:

1. Challenge to a recent MET decision concerning a newly authorized Medicaid eligible patient.

   i. A written statement signed by the attending physician must be submitted within 30 days of receipt of the MCNH-7 to the Local Medical Assistance Unit Administrator requesting a reconsideration of the case.

(1) The request for a review must be specific to an individual patient, whether the disagreement is due to further evidence not available in the medical record at the time of assessment or merely a general difference of opinion regarding the interpretation of the level of care criteria. It must identify medical information or evidence which justifies a difference in level of care decision.

ii. The LMAU MET will review the case and render a decision in writing:

(1) to sustain the previous decision, or

(2) to modify the previous decision based on the new medical evidence.

2. Change in a Medicaid patient's condition during a period of authorization.

i. A written statement signed by the attending physician which describes the medical reason for a change in level of care must be submitted to the LMAU. If the status of the patient is acute, the facility should discharge the patient to a hospital.

ii. The LMAU MET will review the case and render a decision:

(1) to sustain the previous decision, or

(2) to modify the previous decision based on the new medical evidence.

(j) Denial of medical authorization

1. Before finalizing a decision to deny authorization for continued care in a LTCF, the Medical Consultant of the LMAU shall discuss with the attending physician the basis of the tentative decision, and recommendations for alternate care or placement.

2. When a denial of a reauthorization is made, the patient/family/sponsor, the County Welfare Agency, the attending physician, the LTCF, and the Bureau of Claims and Accounts shall be officially notified in writing.

(k) Termination of medical authorization

When authorization for long term care has been terminated because of discharge, death, transfer, ineligibility, or change in Health Services Program number, the facility will receive the "Provider Copy" of the Termination of Medical Authorization for Long Term Care (MCNH-8 - Exhibit #4) from the LMAU. Concurrently, a copy of the MCNH-8 is submitted to the Bureau of Claims and Accounts to terminate the

authorization in the computer system. The facility is to retain its copy for the record.

Note: It is the responsibility of the LTCF to notify the appropriate LMAU at least 14 days in advance of a projected discharge of a Medicaid patient into the community (Form MCNH-33 - Exhibit #7).

1.7 Reimbursement by level of care

(a) The facility shall comply with the terms of its Provider Agreement MCNH-38 (Exhibit #10) in maintaining a minimum number of Medicaid patients, and is permitted to mix patients requiring various levels of care; i.e., skilled nursing and intermediate care in either the entire facility or in a distinct part of the facility which is approved for the level of care required. If a facility wishes to exceed its contractual minimum it is encouraged to do so. Reimbursement rates are established by the New Jersey State Department of Health for each level of care. The facility will be paid at the established rate for eligible patients authorized at the various levels.

(b) New Jersey Medicaid skilled nursing facility patients can be placed only in a distinct part(s) of a facility approved for this purpose. Placement of a patient assessed as needing skilled nursing care in a non-approved portion or unit of a SNF, other than in an emergency situation for a short period of time will warrant disapproval of payment for patients so placed.

(c) The MET will exercise its professional judgment in conforming with "The Manual of Standards Intermediate Care Facilities" published by the New Jersey State Department of Health, in determining the appropriate level of patient care, Level III, Level IV-A or Level IV-B (See Section 1.2).

1.8 Medical services and clinical records

(a) Medical services

1. General requirements

i. There shall be a Medical Director, retained by each LTCF, who will be responsible for the coordination and quality of patient care in that facility.

ii. All Medicaid eligible patients admitted to a LTCF are admitted only upon the recommednation of a licensed physician.

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

Note: If a physician who has admitted or referred a patient to a LTCF chooses not to act as the attending physician for such patient; or has failed to make appropriate arrangements for medical care of such patient; or due to his absence for any cause, then it shall be incumbent upon the facility to provide such care on an ongoing basis.

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

2. Standards for physicians in Long Term Care Facilties

i. Medical Director

The LTCF must retain, pursuant to a written agreement, a physician licensed under New Jersey State Law to serve as Medical Director on a part-time or full-time basis as is appropriate for the needs of the patients and the size of the facility. The Medical Director is responsible for the overall coordination of the medical care in the faciltiy to ensure the adequacy and appropriateness of the medical services provided to patients and to monitor the health status of employees.

ii. Duties of Medical Director

The duties of the Medical Director include, among others, the following:

(1) Participation in the development of written policies, rules and regulations which are approved by the governing body.

(2) Delineation of the responsibilities of the attending physician(s).

(3) Acting as liaison between administration and medical staff for improving services and insuring the carrying out of responsibilities of the medical staff.

(4) Surveying the execution of patient care policies which includes the adequacy and appropriateness of the services of health professional and supporting staff. Monitoring the health status of the facility's employees.

(5) Participation in the review of incidents and accidents that occur on the premises to identify hazards to health and safety of employees and patients. The Medical Director is goven appropriate information to help ensure a safe and sanitary environment for patients and personnel.

(6) Ensuring that the medical regimen is incorporated in the patient care plan.

(7) Participation in staff meetings and department committees such as infection control, pharmaceutical services, credentials, patient care, etc.

(8) Participation in in-service training program.

(9) Reviewing written reports of surveys and inspection and makes recommendations to the administrator.

(10) Participation in special projects such as medical evaluation studies.

iii. Initial medical findings and physician's orders. There shall be available to the LTCF, prior to, or at the time of admission, patient information which includes current medical findings, diagnosis, medical care plan, rehabilitation potential and a transfer summary of the course of treatment including laboratory findings in the transferring health facility, if any. There shall be orders from a physician for the immediate care of the patient.

(1) If the above transfer summary information is not available in writing in the facility upon admission of the patient, it is to be obtained by the facility after admission.

(2) If medical orders for the immediate care of patient are unobtainable at the time of admission, the physician with responsibility for emergency care gives temporary orders.

(3) A current health facility discharge summary containing the above information is acceptable. If the admission is from other than a health facility, orders from a physician are to be obtained for the patient immediately after admission.

iv. Required documenation in patient's plan of care and treatment. The LTCF shall require that the health care of every patient is under the supervision of a New Jersey licensed physician who, based on the evaluation of the patient's immediate and long term needs, prescribes on a designated form a planned regimen of medical care.

(1) Each patient or an individual responsible for him shall designate a personal physician. If either is unable or unwilling to designate a personal physician, the Medical Director/Administrator of the facility shall designate one.

(2) The initial medical evaluation of the patient shall be based on a history and physical examination done within 48 hours of admission and shall be placed on the chart within that time period. An alternate method permits the acceptance of an examination if performed by the attending physician within 5 days prior to admission and if placed on the facility chart within 48 hours of admission. See Procedure Codes - 9010 or 9011 under Appendix B, Procedure Codes - Long Term Care Facility Visits in the New Jersey Medicaid Physician's Manual.

(3) The Medical Plan of Care and Treatment shall be reviewed by the attending physician with documentation by date and signature as often as appropriate to the Medicaid

patient's needs as specified, but documentation with date and signature confirming this must be done at least every 30 days for Levels III and IV-A patients, and every 60 days for Level IV-B patients.

(4) The charge nurse and other appropriate personnel involved in the care of the patient shall assist in planning the total program of care.

(5) Orders concerning medications and treatments are in effect for the specified number of days indicated by the physician but in no case exceed a period of 30 days for Level III and IV-A or 60 days for Level IV-B. Vague and blanket orders are not acceptable and within the above time frame it shall be incumbent upon the physician to review all orders and re-confirm in writing with signature and date.

(6) Telephone orders are accepted only when necessary and only by a licensed nurse (registered professional nurse or licensed practical nurse). Telephone orders are written into the appropriate clinical record by the nurse receiving them and are countersigned by the physician with 48 hours.

Exception: Telephone orders of minor medications given as a single dose do not require counter signing within 48 hours; e.g., antacids, laxatives, etc., but will be countersigned at time of next visit.

(7) EMERGENCIES: In the event of emergency phone orders where the life of the patient may be endangered or his clincal status may be compromised, such orders must be countersigned by the physician within 12 hours from time the order was given.

Exception: If the patient has been transferred out of the facility within the 12 hour period the time limit is waived.

(8) Stop orders are to conform with regulations promulgated by the Formulary Commitee of the facility.

(9) Patients are to be examined by a physician at least once every 30 days for Level III and IV-A and once every 60 days Level IV-B. The physician will record and sign in the clinical record: the date of the visit to and the time spent with the patient, pertinent facts concerning the patient's current status, relevant findings and significant changes, and certification of the need for continued long term care.

(10) There is evidence that the attending physician has made arrangements for the medical care of the patient in his absence.

(11) At the time of discharge or transfer, the facility shall prepare a patient summary which will accompany the patient to the receiving facility or be available to his attending physician if the discharge is to be to the community. This summary shall include at a minimum the diagnosis, current treatment, relevant medical, nursing and social information and disposition of the patient.

v. Availability of physicians for emergency care

The Long Term Care Facility shall have one or more physicians available to furnish necessary medical care in case of emergency, if the physician responsible for the care of the patient is not immediately available. A schedule listing the names and telephone numbers of these physicians and the specific days each is on call is to be posted in each nursing station. There shall be established procedures to be followed in an emergency, which covers immediate care of the patient, persons to be notified, and reports to be prepared.

(b) Clinical records

1. General requirements

i. An individual record must be maintained for each patient covering his medical, nursing, social, and related care in accordance with accepted professional standards. All entries on the patient's clinical record shall be current, dated and signed by appropriate staff member.

ii. That portion of each Medicaid patient's complete clinical record covering the six previous months' entries shall be the minimal portion of the record readily available at the appropriate nurse's station for use of DMAHS professional staff whenever necessary.

2. Maintenance of clinical records
(See Section 1.8(a)2 iv. for records required within 48 hours)

i. The LTCF shall maintain a separate medical record for each patient admitted with all entries kept current, dated and signed by appropriate personnel. The record includes:

(1) An identification sheet which includes patient's name, Medicare Number, Medicaid HSP Number, Social Security Account Number, age, sex, home address, and religion. Also include names, addresses and telephone numbers of referral agency (and hospital from which admitted, if any), personal physician, dentist, and next of kin or other responsible person. Name and address of funeral home is also included if available.

(2) Discharge or transfer summary from prior health facility.

(3) Initial medical evaluation (history, physical, diagnosis).

(4) Signed physician's orders including all medications, treatments, diet and special therapies.

(5) Certfication and Recertification.

(6) Medical Plan of Care and Treatment with periodic review.

(7) Progress notes written at the time of each visit.

(8) Incident reports.

(9) Signed laboratory and X-ray work.

(10) Consultation reports.

(11) Dental, podiatry, vision care, etc. reports.

(12) Nursing records.

(13) Social service records including signed documentation that patient's rights were explained.

(14) Patient activities records.

(15) Therapeutic Leave Record.

3. Deceased patient record

The clinical record of a deceased patient shall be properly completed. It shall include:

i. Written reports of visits made by the physician during the critical stages of illness.

ii. Written documentation of death pronouncement by the physician.

iii. Complete nurse's notes containing all necessary and pertinent information documenting the patient's progress during the illness and apparent demise, notification of physician and next of kin.

iv. Autopsy records where appropriate.

v. Written record of the disposition of the deceased.

4. Retention of records

All clinical records of discharged patients shall be completed promptly and shall be filed and retained in accordance with State law as follows:

i. The medical records or photographic reproduction thereof shall be retained by the licensee of the facility for a period of 10 years following the most recent discharge of the patient.

In addition, a discharge summary sheet shall be retained for a period of 20 years following the most recent discharge of the patient. The discharge summary sheet shall contain the patient's name, address, dates of admission and discharge and a summary of the treatment and medication rendered during the patient's stay. Any x-ray films related to such confinement shall be retained for a period of five years.

ii. The licensee of the facility shall be responsible for the retention and storage of medical records for the required length of time.

iii. In the event the facility transfers ownership or discontinues operations, the current licensee shall continue to be responsible for the retention and storage of medical records for the required length of time.

5. Transfer of records (See Section 1.16)

If the patient is transferred to or from another health care facility, a copy of the patient's clinical record or an abstract thereof, including the current patient care plan, shall accompany the patient.

6. Confidentiality of records

All information contained in the clinical records is treated as confidential and shall be disclosed only to authorized persons.

7. Staff responsibility for records

If the LTCF does not have a full or part time medical records librarian, an employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed, and preserved in accordance with accepted procedures. The designated individual is to be trained by and must receive regular consultation from a medical records librarian who is under written contract with the facility.

1.9 Patient's rights (See Section 1.19(a) 2 Personal Needs Allowance)

(a) In adherence with CFR Title 42:405.1121 (R), 42 CFR 449.12 (a) (1) (ii) (B) and New Jersey P.L. 1976 Chapter 120, each LTCF shall assure that the referenced patients' rights are made available to every patient, his next-of-kin or guardian upon admission and to each individual already in residence as evidenced by their written acknowledgement. Facility staff shall be trained and involved in the implementation of these standards.

(b) Patient entitlements

1. Patients shall: have the right to manage his own financial affairs unless he or his guardian authorizes the administrator to manage such patient's financial affairs. Such authorization shall be in writing and shall be attested by a witness who is unconnected with the LTCF, its operations, staff personnel and administrator.

2. Have the right to wear his own clothing. If clothing is provided to the patient by the facility, it shall be of a proper fit.

3. Have the right to retain and use his personal property in his immediate living quarters, unless the facility can demonstrate that it is unsafe or impractical to do so.

4. Have the right to receive and send unopened correspondence and to have unaccompanied access to a telephone at a reasonable hour, including the right to a private phone at the patient's expense.

5. Have the right to obtain from his physician complete and current information concerning his medical diagnosis, treatment and prognosis in terms and language the patient can reasonably be expected to understand, except when the physician deems it medically inadvisable to give such information to the patient and records the reason for such decision in the patient's medical record. In such a case, the physician shall inform the patient's next-of-kin or guardian. The patient shall be afforded the opportunity to participate in the planning of his total care and medical treatment to the extent that his condition permits and shall have the right to refuse treatment. A patient shall have the right to refuse to participate in experimental research, but if he chooses to participate, his informed written consent must be obtained and he may cancel his participation at any time.

6. Have the right to confidentiality and privacy concerning his medical condition and treatment, except that records concerning said medical condition and treatment may be disclosed to another LTCF or health care facility on transfer, or as required by law or third party contracts. Written consent of the patient shall be obtained for release of information to all other persons and/or agencies.

7. Have the right to unrestricted communication, including personal visitation with any persons of his choice, at any reasonable hour.

8. Have the right to present grievances on behalf of himself or others to the administrator, State governmental agencies or other persons without threat of discharge or reprisal.

9. Have the right to a safe and decent living environment and care rendered with due respect, recognizing the dignity and individuality of the patient.

10. Have the right to refuse to perform services for the LTCF that are not included for therapeutic purposes in his plan of care as recorded in his medical record by his physician.

11. Have the right to reasonable opportunity for interaction with members of the opposite sex. If married, the patient shall enjoy reasonable privacy in visits with his spouse and, if both are patients of the LTCF, they shall be afforded the opportunity, where feasible, to share a room, unless medically inadvisable.

12. Not to be deprived of any constitutional, civil or legal right solely by reason of admission to a LTCF.

13. Have the right to leave the facility during the day if authorization is given by the physician, and noted on the patient's medical record, and may participate in social, religious and community activities at his discretion.

14. Any patient may discharge himself upon written release. When a facility wishes to transfer or discharge a patient on a non-emergency basis, it may do so in accordance with the procedure for Involuntary Transfer of Patients. See Section 1.16.

(c) Facility responsibility

Every LTCF shall have the responsibility for:

1. Maintaining a complete record of all funds, personal property and possessions of a patient, which have been deposited for safekeeping for use by the patient. (See Section 1.9(b)1). This record shall contain a listing of all deposits and withdrawals transacted, and these shall be substantiated by receipts given to the patient or his guardian. Each patient or his guardian shall be provided with a written quarterly statement which shall account for all of the patient's property on deposit. The patient or his guardian shall be allowed daily access, during specific periods established by the facility, and at a reasonable hour to his property on deposit.

2. Providing for the spiritual needs and wants of patients by notifying, at a patient's request, a clergyman of the patient's choice. Arrangements shall be made, at the patient's expense, for attendance at religious services of his choice when requested. No religious beliefs or practices, or any attendance at religious services shall be imposed upon any patient.

3. Admitting only that number of patients for whom it reasonably believes it can safely and adequately provide nursing care. Any admission and individual who has completed an application for admission and who is denied such admission shall be given the reason for such denial in writing.

4. Ensuring that discremination based upon age, race, religion, sex or nationality with respect to participation in recreational activities, meals or other social functions is prohibited.

5. Ensuring that no patient shall be subjected to physical restraints except upon written orders of an attending physician, for a specific type of restraint and a specific period of time, when necessary to protect such patient from injury to himself or others. Restraints shall not be employed for purposes of punishment or the convenience of any staff personnel. The confinement of a patient in a locked or barricaded room shall be prohibited.

6. Ensuring that drugs and other medications shall not be employed for purpose of punishment, for convenience of any staff personnel, or in such quantities so as to interfere with a patient's rehabilitation or his normal living activities.

7. Ensuring that a mentally retarded individual may participate in a behavior modification program involving use of restraints or adverse stimuli, only with the informed consent of his parent or guardian.

8. Ensuring that every patient prior to or at the time of admission and during his stay, shall receive a written statement of the services provided by the facility, including those required to be offered by the facility on an as-needed basis, and of related charges, including any charges for services not covered under Title XVIII and Title XIX of the Social Security Act, as amended, or not covered by the facility basic per diem rate. This statement shall further include the payment, fee, deposit and refund policy of the LTCF.

(d) Complaint procedure

If allegations are made concerning violation(s) of any of the above sections an investigation will be conducted, and if the allegations are substantiated, appropriate State action will be taken in accordance with provisions of P.L. Law 1976 Chapter 120. (See Section 1.18 LONG TERM CARE FACILITY COMPLAINT SYSTEM).

1.10 Pharmaceutical services

(a) Legend/non-legend drugs - Prescribed legend drugs must be supplied to each individual patient by a licensed pharmacy. Unless the facility has a licensed pharmacy, a stock supply of legend drugs in the LTCF is prohibited. Non-legend drugs, such as aspirin, milk of magnesia, etc., may be separately stocked in the drugroom of the LTCF. This will permit the LTCF to maintain a supply of non-legend drugs to be administered as directed by the prescribing physician under the supervision of a Consultant Registered Pharmacist in keeping with established stop order policies. In such instances, the non-legend drugs may be dispensed and labeled from the stock supply at the LTCF by the Consultant Registered Pharmacist. However, it is to be emphasized that the pharmacist is the only person, other than a physician, dentist, or podiatrist legally authorized to perform this activity.

1. The New Jersey Medicaid Program does not reimburse for Methadone when used for drug detoxification or addiction.

(b) Stop orders

"Stop orders" are internal policy regulations of the LTCF and unrelated to the New Jersey Medicaid Program regulations. Thus, such "orders" do not supercede Program regulations concerning the prescribing of drugs and pharmaceutical services as outlined in the N.J. Medicaid Pharmacy Manual.

(c) Quantity of medication

In LTCFs if the quantity of drug or medication is not indicated in writing by the prescriber, the pharmacy provider must dispense an appropriate quantity of medication not to exceed a one month supply.

Note: Since refill instructions are not normally given on medication order sheets in LTCFs where stop order policies exist, an order for continuation of medication shall be deemed a new prescription for the purpose of reimbursement. Refills will not be allowed. A new written prescription and prescription number is required.

Exception: For patients authorized as Intermediate Care Level IV-B, where the required interval between physicians visits may be every 60 days rather than every 30 days, the initial one month supply of medication may be refilled one time only, if authorized on original medication order (i.e., dispense 60 day supply).

(d) Institutional permits

Pharmacies with Institutional Permits shall be reimbursed on a daily per patient capitation fee pro-rated at 75% of the fee for pharmacies with Retail Permits.

(e) Signed physicians orders (See Section 1.8(a)2 iv).

Signed physicians' orders for medications, drugs, tests, diet and treatment administered to eligible patients must be accurately recorded on the patient's chart with review and update as required.

(f) Required consultant pharmacist services (See Section 1.2)

1. Scope of Services

All services required of a Consultant Pharmacist in LTCFs, as stipulated in Federal and State statutes, rules and regulations, including (but not limited to) those listed herein shall be provided.

2. Responsibilities:

In cooperation with the LTCF, the Consultant Pharmacist shall:

i. Assure that all drugs are dispensed, and in cooperation with the Director of Nursing, shall assure all drugs are administered in compliance with all State and Federal laws.

ii. Establish and monitor the implementation of written policies and procedures, through the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), to insure the safe use, storage, integrity, administration, control and accountability of drugs.

iii. Assure the drug records are in order and an account of all controlled substances is maintained and reconciled.

iv. Assure that patient's medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physician's orders and established stop order policies.

v. Assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same patient are monitored for potential adverse reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications and that the physician is advised promptly of any recommended changes.

vi. Review and drug regimen (e.g., dosage form, route of administration, time of administration) of each patient at least monthly, and report any irregularities pertaining to medications to the attending physician, Medical Director or Director of Nursing, as appropriate. Irregularities in the administration of medications shall be reported promptly to the Director of Nursing.

vii. Report in writing at least quarterly to the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a summary of the review of each patient's drug regimen and clinical record and the consultant pharmacist's findings and recommendations.

viii. Assure there is maintained and available upon request from the Medicaid Program, documented records of the disposition, disposal or destruction of unused or discontinued drugs.

ix. Serve as an active member of the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), and Infection Control Committee of the facility.

x. Provide, and document, in-service programs for the complete nursing staff. This training shall include, but not be limited to, registered nurses, licensed practical nurses, and aides and shall be given at least quarterly.

xi. Devote a sufficent number of hours to carry out these responsibilities, maintain a written record of activities, findings and recommendations.

1.11 Medicare/Medicaid

(a) The New Jersey Medicaid Program will reimburse for services provided to combination Medicare/Medicaid recipients for LTC services only after Medicare Services have been fully utilized or when medically necessary services are not covered by the Medicare Program. (Exceptions - See Section 1.11(g)3 i).

(b) Certified Facilities

Only Skilled Nursing Facilities as defined in Section 1.2 certified by the Department of Health, Education and Welfare and the New Jersey Department of Health are eligible to be reimbursed by Medicare for services rendered consistent with all Medicare requirements. These facilities may at the time of certification or at their option apply to the Division of Medical Assistance and Health Services for approval as a participating provider in the New Jersey Medicaid Program.

(c) Medicare (Part A) Coverage of Skilled Nursing Care Benefits

Medicare covers eligible beneficiaries needing post-hospital skilled nursing care when they are placed in Medicare Certified Facilities.

(d) Expiration of Part A Medicare Benefits

When Medicare benfits are terminated or exhausted because of coverage limitations, Medicaid may be billed on behalf of eligible recipients provided that:

1. The services are allowable and provided within the standards and procedures established by the New Jersey Medicaid Program as described in this manual.

2. No payment is received from any other source, including third-party insurance or from the relatives of the recipient or the recipient except as stated below.

   i. Any regular income received by the recipient (e.g., pension, Social Security, etc.) as determined by the County Welfare Agency and reported on form Statement of Income Available for Long Term Care Payment PA-3L (Exhibit #27) shall be used to offset Medicaid per diem payments except for a $25 Personal Needs Allowance (PNA), and any other deductions allowed for maintenance of a home, spouse, or dependents.

   ii. Recipient's Personal Needs Allowance (PNA) monies cannot be required to be used to pay for any medically necessary service received and covered by Medicaid.

   Note: ACCEPTANCE BY A PROVIDER OF PAYMENT TO SUPPLEMENT MEDICAID REIMBURSEMENT CONSTITUTES A VIOLATION OF NEW JERSEY MEDICAID REGULATIONS. ADDITIONALLY, SEPARATE CHARGES FOR CARE AND SERVICES LISTED IN SECTION 1.3 ARE ALSO PROHIBITED.

3. The Certified Facility provides written documentation of a denial of Medicare coverage:

   i. The requirement of documentation applies to billings under Part A Medicare by Certified Facilities regardless of the beneficiary's level of care or placement in a non-certified section within the facility. The Certified Facility must

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 are obtained from the Medicare Fiscal Intermediary affirming denial and consisting of:

(1) Copy of form Inpatient Hospital and Skilled Nursing Facility Admission and Billing SSA-1453 (Exhibit #22) or

(2) Notice of denial of coverage form Notice of Medicare Claim Determination SSA-1954 (Exhibit #25) or form Notice of Medicare Claim Determination SSA-1955 (Exhibit #26), or

(3) The facility statement of non-coverage to be signed by an administrator or officer and accepted only under the Limitation of benefits as described in Section 1.11(d).

(e) Coinsurance (Part A)

1. In each benefit period, Medicare Part A may provide full coverage of the Medicare per diem rate of the Certified Facility for the first 20 days of the beneficiary's stay. On the 21st through the 100th day, the Medicare per diem is reduced by a coinsurance factor.

2. If the patient has available income during the coinsurance period of Medicare eligibility that may be applied to the cost of his or her medical services, that income must be utilized to offset coinsurance charges prior to Medicaid billing. Under no circumstances may the facility receive duplicate payment.

3. Medicare coinsurance may be paid by the New Jersey Medicaid Program in order that the total combined Medicare/Medicaid reimbursement will equal but may never exceed the facility's Medicaid Skilled Nursing Facility rate. In no instance will such Medicaid payment exceed the Medicare coinsurance factor. In some cases, the Medicare rate, after deducting the coinsurance factor, will exceed the Medicaid SNF per diem. Under these circumstances, Medicaid will not pay the coinsurance factor. (See Billing Instructions Chapter III in Section 2.4).

(f) Services covered by Medicare Part A

The following services are covered by Medicare Part A as part of the benefit package for Certified Facilties providing skilled nursing care and may not be billed as additional services during the benefit period to the beneficiary:

1. A Semi-private room (two to four beds in a room)

2. All meals, including special diets

3. Regular nursing services

4. Rehabilitation services, such as physical therapy or speech pathology. When the beneficiary in the Certified Facility has exhausted Part A benefits the facility must apply, for Medicare Part B payments for outpatient physical therapy and speech pathology before billing Medicaid. (Use Form SSA-1483, Exhibit #23).

5. Drugs furnished by the facility during the patient's stay

6. Medical supplies such as splints and canes

7. Use of appliances such as a wheelchair

(g) Application of Part B Medical Insurance Benefits to Medicare-Medicaid patients

The Medicaid Agency pays Part B Medicare insurance premiums for all eligible Medicare-Medicaid patients. Claims for Part B services may be billed to Medicaid only after these Medicare benefits have been exhausted.

1. The following services are covered by Medicare Part B;

i. Physicians' Services

Medicare-Medicaid patients, regardless of level of care or placement in a Certified Facility, are entitled to physicians' services, and services of other practitioner providers covered by Medicare Part B. The following services if given to Medicare-Medicaid patients in LTCFs must be billed to Medicare on a standard Medicare claim forms. The patient's Health Services Program Case Number must be included in item 5 of the Request for Medicare Coverage SSA-1490 (Exhibit #24).

(1) Medical and surgical services by a Doctor of Medicine or Osteopathy.

(2) Certain medical and surgical services by a Doctor of Dental Medicine or a Doctor of Dental Surgery.

(3) Certain services by Podiatrists which they are legally authorized to perform by the state in which they practice.

(4) Other services which are ordinarily furnished in the doctor's office and included in his bill such as diagnostic tests and procedures and medical supplies.

(5) Drugs and biologicals which cannot be self-administered.

ii. Limited services by chiropractors

iii. Outpatient hospital services

iv. Medical services and supplies

v. Home health services

vi. Outpatient physical therapy, speech pathology services and other health care services.

(1) In order to be covered for rehabilitation services under Part B, the beneficiary must be in a Certified Facility.

(2) If such services are denied by Medicare but considered medically necessary in the professional judgment of a Medicaid Medical Consultant, reimbursement for such services is allowed by Medicaid when:

(A) A request by the Certified Facility for authorization in accordance with standard procedures is made to the Medicaid LMAU, and

(B) The request is accompanied by a copy of the Medicare denial letter, and

(C) The LMAU issues an authorization.

Note: If authorization is granted by the LMAU, the SNF shall bill the Bureau of Claims and Accounts in accordance with established procedures, e.g., MCNH-14 (Exhibit #5) plus the authorization form FD-06, (Exhibit #1).

2. Denial of Part B claims by Medicare

i. When a service under Part B has been denied payment by the Fiscal Intermediary and such service was considered by the attending physician to be medically necessary to the care of the patient, the provider (e.g., physician) should return the claim to the Medicare Intermediary with supporting documentation of medical necessity.

Should this claim again be denied it will automatically be referred to the Medicaid Program for their review and further consideration if the Medicaid H.S.P. # is listed in Item #5.

Example: If a physician makes more than one visit to a patient in a LTCF during a given month, documentation of the medical necessity of subsequent visits after the first one must be included with the claim to Medicare.

3. Coinsurance and deductible payments

i. Coinsurance:

Medicaid does not assume responsibility for payment of coinsurance for certain services under Part B Medical Insurance when the basis of payment is fee for service (e.g., Physicians, Podaitrists, etc.). However, coinsurance is paid for certain other Part B Provider services where the basis for payment is not fee for service (e.g., durable medical equipment), but only in those instances where the Medicare allowable reimbursement is less than the Medicaid established reimbursement for those items.

ii. Deductibles:

Medicaid does assume responsibility for deductible payments for Part B Medical Insurance services if the serivce/item is medically necessary.

(h) Therapy Charges

1. Medicaid may reimburse Medicare Certified SNF's through their Part A Intermediary (Blue Cross or Prudential) for the unsatisfied deductible (Medicare Part B) when physical therapy or speech pathology services are performed for patients eligible for both programs.

2. When the facility is requesting reimbursement for physical therapy and speech pathology services for combination Medicare/Medicaid patients, the SSA-1483 Claim form (Exhibit #23) shall be utilized. Item 10 on the SSA-1483 form (Exhibit #23) must indicate New Jersey Medicaid Program. Item 11 must show the beneficiary's Health Services Program Number (HSP #). No prior authorization from the LMAU is required for such Medicare/Medicaid combination Claims.

Note 1: When a Medicare certified facility requests reimbursement for physical, and/or speech therapy services for a patient which has been denied by Medicare but for which authorization has been obtained from the LMAU they should use the MCNH-14 billing form (Exhibit #5).

Note 2: Reimbursement under any circumstances will not be made unless the authorization form FD-06 (Exhibit #1) has been submitted to the Bureau of Claims and Accounts.

1.12 Out-of-state placement

(a) When payment for out-of-state long term care is required for any reason, payment is limited to emergency situations only.

(b) The out-of-state facility must be licensed as a SNF or ICF by the state and the rate of reimbursement may not exceed that authorized by the Title XIX program in the State in which the facility is located or the reimbursement rate authorized by the New Jersey Health Services Program, whichever is lower, for the level of care required by the patient.

(c) Claims on behalf of persons in out-of-state LTCFs will not be approved until a review of the completed medical record has been made to determine the need for long term care services and to determine appropriateness of moving the person to a LTCF in New Jersey. The complete medical record must be submitted to:

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

1.13 Absence from facility (bed hold)

(a) Absence Due to admission to a hospital

1. No payment will be made to LTCFs for holding a bed for a Medicaid patient who has been discharged from the LTCF and admitted to a hospital (See Section 1.6(k).

2. Admission procedures (See Section 1.16) must be followed when the Medicaid recipient has been readmitted following a period of hospitalization.

(b) Absence Due to Therapeutic Leave

1. The Medicaid Program will reimburse facilities their per diem rate for reserving beds for Medicaid patients who are absent from the facility for a therapeutic home visit up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of unused leave days may be carried over into the next calendar year. It shall be the responsibility of the facility to maintain accurate leave day records on the Medicaid patient's chart for review by the Division.

2. A therapeutic home visit is defined to include visits with relatives and friends and leaves to participate in Medicaid approved therapeutic or rehabilitative programs. Home visits are limited to therapeutic home visits only and does not include hospital visits.

3. The absence of a Medicaid patient from the facility for this purpose must be authorized in writing by the patient's attending physician and included in the patient's plan of care.

4. In those instances where a patient is in more than one LTCF within a calendar year, it will be the responsibility of the new facility to determine the number of therapeutic leave days that have been allowed for payment by the previous facility within the same calendar year. A record of leave days should be a part of the information provided on the Patient Information Transfer Form (Exhibit #30).

5. The facility shall reserve and hold the same room and bed for the Medicaid patient on the therapeutic home visit. Said bed shall not be occupied by another patient during the period of time in which the Medicaid patient is on such leave.

6. Where a patient's condition or situation requires more than 24 therapeutic leave days annually, as determined by the patient's attending physician, prior authorization for the additional leave days must be obtained from the LMAU. The request for prior authorization must be submitted in writing to the LMAU administrator over the signature of the attending physician. A facility will be reimbursed its per diem rate for reserving a bed for a Medicaid patient for any additional days so authorized.

1.14 Records

(a) As a condition for participation in the New Jersey Medicaid Program it is required that LTCFs maintain medical, nursing, social, patient activities and billing records on all long term care Medicaid patients in accordance with accepted professional standards and practices.

(b) Required Clinical Records
(See Section 1.8(b)

(c) Required Nursing Records

1. Nursing Evaluation

i. The initial evaluation of the patient is begun on the day of admission to the LTCF. It is the complete, documented and identifiable appraisal of the patient's current health status and provides a data base for assessment of the existing and potential requirements for care.

ii. The tools utilized shall include a nursing history form, admission form(s), transfer form(s), the medical plan of care, and narrative admission notes by all disciplines involved in therapy.

iii. Other data utilized should include the following - clinical signs and symptoms; patient strength and weaknesses; mental, emotional, behavioral and social aspects; relevant safety requirements; attention to patient comfort and dignity; and plans for alternate care where applicable.

iv. The nursing care plan (i.e., the nursing diagnoses, patient goals, and nursing approaches) shall derive from the evaluation.

v. A re-evaluation of the patient is a documented comparision of the patient's previous and present health status. The content should identify the effectiveness of, and the patient's response to, therapeutic intervention and, whenever possible, the reason for any ineffectiveness in patient response should be included. This procedure should be accomplished through team conferences including all levels and shifts of nursing staff (in so far as possible) in a review of the patient's total record.

vi. Re-evaluations shall be documented in a consistently identifiable manner distinct from other content in the nurses' notes. Re-evaluations shall be completed whenever there is a noticeable change in the patient's condition indicating a need for change in the nursing care plan and minimally according to the level of care. (See Nursing Care Plan 1.14(c)2).

vii. From the information available selected pertinent information will be designated as the basis for continuing or revising the current plan of care.

2. Nursing Care Plan

   i. This is an easily identifiable and accessible record of individualized nursing care to be provided to the Medicaid patient as part of the total patient care plan. It is cognizant of the medical plan of care, includes patient participation and directs the approaches of nursing staff in meeting the patient's needs for nursing care. The plan contains short and long term goals; restorative and/or rehabilitative nursing care including follow-up of special therapies; personal, preventive and maintenance care requirements. The nursing care plan properly instituted by qualified nursing staff will provide the best method of ensuring effective nursing care.

   ii. For Intermediate Care, Levels IV-A and IV-B, the care plan will indicate nursing-social care planning.

   iii. The nursing care plan shall be reviewed regularly and revised as often as necessary according to changes in patient's condition and to attainment of and/or revisions in goals as indicated. Revisions shall be based on appropriate documentation of the re-evaluation procedures. Minimal review and documentation shall be weekly for Level III, bi-weekly for Level IV-A and monthly for Level IV-B.

3. Nurses' Notes

   i. The nurses notes shall be legible, individualized summaries of the patient's current condition and response to the nursing care plan as carried (i.e., to the effectiveness of approaches and progress toward established goals). They will include appropriate attention to preventive, maintenance, restorative and/or rehabilitation nursing interventions performed in relation to physical, mental, emotional, behavioral and social care.

   ii. Specific references shall be made to the patient's reaction to medications and treatments; to special therapies; observations of clinical signs and symptoms; and current physical, mental, emotional, behavioral and social problems.

   iii. Nursing entries shall be made as often as necessary to the Medicaid recipient's condition but minimal requirements by level of care:

      (1) Skilled Nursing Care (Level III)

      Medicaid patients shall have daily summaries for the first five days after admission written by staff of each shift and weekly summaries thereafter, as a minimum.

      (2) Intermediate Care (Level IV-A)

      Medicaid patients shall have daily summaries for the first five days after admission written by staff of each shift and bi-weekly summaries, including nursing-social care, thereafter, as a minimum.

(3) Intermediate Care (Level IV-B)

Medicaid patients shall have daily summaries for the first five days after admission written by each shift and monthly summaries related to nursing-social care, thereafter, as a minimum.

(4) Problem-Oriented Medical Records

When problem-oriented medical records, or a modification of this format, are attempted in lieu of certain other medical, nursing, social and special therapy records, each system will be evaluated by the Medicaid MET as to whether it effectively and consistently includes all aspects of the minimal record requirements as to content, location and identify.

(5) Medication and Treatment Record

For each Medicaid patient, a specific medication and treatment record shall be kept on which all medications, treatments, and special procedures for patient safety ordered by the attending physician are signed for by a qualified member of the nursing staff when administered or when omitted.

(6) Incident Reports

Any incident occurring to a Medicaid eligible patient which has, or could have, physical or emotional adverse effect upon his safety or well-being shall be entered in the nurses' notes and a completed incident report shall be appended to the Medicaid patient's medical record and/or on file in the Administrator's office. This report shall include the date, time and location of the incident with details and circumstances under which it occurred, the action taken and any other relevant information. The incident report shall be signed by the reporting nurse with subsequent comments and countersigned by the attending physician.

(d) Social Service Record

1. Purpose

The purpose of the social record is to provide a concise, permanent account of personal and social information about the patient and family leading to a better understanding of the patient and his needs, and a more appropriate treatment program. Information noted should be germane to the patient's illness and plan of care, and should reflect individualized goals and needs. The record should be organized in such a way as to faciliate communication among those who use it.

2. Confidentiality and accessibility

   i. The social record is a confidential document. It shall be available only to the attending physician, appropriate members of the nursing and other professional staff, and to health and welfare agency personnel who are directly involved in the patient's care.

   ii. The patient's written consent (or that of a responsible person acting on his behalf) must be obtained before social information is transmitted to an outside agency or individual. The consent form must be filed with or on the patient's chart. All personnel having access to the record shall be trained to appreciate its confidential nature.

   iii. The individual social record must be a part of the medical chart. Any information determined prejudicial or damaging to the patient shall be maintained apart from the medical chart, with an entry in the record indicating the availability of the additional material upon approval of the staff person responsible for social care.

   iv. The social history and three years of progress notes (if appropriate) shall be on the medical chart.

3. Content and quality

   i. Social record is a documentation on the patient chart of social history, progress notes, clinical notes and referrals. All notes shall be signed and dated.

   ii. Social history: shall include family background, education, employment, interests, activities, organizational memberships, psycho-social functioning, relationships with family and friends, reason for and feelings about placement, social plan and goals, discharge plan and services to be provided to meet social needs.

   iii. Progress notes: shall summarize changes in patient's condition and feelings. Frequency of family visits shall be noted, as well as patient's and family's attitude toward each other and relationships within facility as they affect patient's medical condition and plan of care. Participation in activities shall be indicated. Changes in goals, service provision and discharge plan shall be identified. All referrals to outside resources must be documented and dated on the record. Follow-up to the referral shall be provided to ensure that social needs are met. Clinical notes of counseling shall also be recorded.

   iv. Frequency of recording

      (1) Social record shall be completed within seven days following admission and updated regularly; at least every six months thereafter. Significant changes in patient's situation shall be recorded. Referrals to outside agencies shall be recorded on the day of the referral.

(2) Updated entries shall be made by the person responsible for providing social care to the patient, i.e., the facility social worker/social work designee, or a social agency staff person functioning under a contractual arrangement with the facility.

(e) Patient activities record

1. Purpose

The purpose of the patient activities record is to enable staff to understand the patient's past interests, hobbies, leisure time, work and religious experiences as they relate to his current social needs within the facility. His current participation in activities must be recorded so that patient's social life can be coordinated with medical and nursing needs.

2. Accessibility

An individual record must be kept on the medical chart. It should include the initial evaluation and two years of progress notes. The activity coordinator may keep a separate calendar of activities and record of general participation.

3. Content

i. The activity record shall include the initial evaluation and progress notes. The initial evaluation and all notes shall be signed and dated. The initial evaluation shall identify patient background information, including patient interests, skills, past employment, hobbies, organizational memberships, religious preferences. These may be obtained from the social history and interviews with the patient and/or family upon admission. Initial goals shall be stated, and a plan formulated to engage patient in an activity program in keeping with his interests and medical condition.

ii. Progress notes shall summarize patient participation in individual and group activities. Patient attitudes with changes in interest, medical condition, goals, plans, and discharge program.

4. Frequency

i. An initial evaluation of patient's needs and interests must be conducted and recorded in the patient's individual record within seven days of the date of admission.

ii. There shall be a quarterly review of patient's activity plan, in cooperation with the patient and a written evaluation of the patient's progress, identification of needs, and establishment of activity goals for the next quarter.

(f) Billing Records

1. Chapter III of this manual identifies the procedures required for the general use of the billing transaction forms and computer generated forms. All appropriate reports should be retained until audited by the Division.

2. The facility must establish and maintain appropriate and accurate records and accounts of all receipts and disbursements of resident funds, which shall be subject to review and fiscal audit by the State of New Jersey as may be required.

3. Six Month Time Limitation on Claims Submitted by Long Term Care Facilities

   i. Claims for LTCF services and/or authorized therapies that are older than six billing months will be rejected.

   ii. The Division will accept all legitimately authorized charges submitted within five months from the last day of the billing month in which services were initially provided.

   iii. For purposes of this time limitation, a claim is the submission of a properly completed transaction form(s) provided by the Division indicating a request for reimbursement for authorized LTCF services and/or authorized therapy services provided to an eligible recipient and which has been submitted to the Bureau of Claims and Accounts within the time limit specified.

   iv. In the event an improperly submitted claim is rejected, a new five month time limitation for resubmission of the rejected claim will begin after the last day of the month in which the claim was rejected.

   v. In exceptional cases where it was beyond the control of the LTCF to claim reimbursement within the six month period, a written request for payment may be submitted with documentation to the Bureau of Claims and Accounts, Division of Medical Assistance and Health Services, 324 East State Street, P. O. Box 2486, Trenton, New Jersey 08625. Retroactive claims will not be approved for payment in those instances where it is judged that the claim could have been submitted or resubmitted within the time limitation as defined above.

1.15 Program participation

(a) A LTCF operated by a public or private agency or organization, either proprietary or non-profit, or a subdivision of such an agency or organization must meet the following qualifications in order to participate in the New Jersey Medicaid Program:

1. Licensure or approval by the New Jersey State Department of Health

2. Certification by the New Jersey State Department of Health that the LTCF meets the federal and state requirements for participation in the New Jersey Medicaid Program.

3. Approval for participation as a LTCF provider by the New Jersey Medicaid Program. This includes as a minimum the approval of a New Jersey Medicaid Provider Application FD-20 (Exhibit #6) and Provider Agreement MCNH-38 (Exhibit #10), as submitted by the provider of the New Jersey Medicaid Program. Continued participation as a New Jersey Medicaid provider is contingent upon re-approval by the New Jersey Medicaid Program.

4. Filing of an acceptable Cost Study for Long Term Care Facility form MCNH-1 (Exhibit #29) with the New Jersey State Department of Health and the Division of Medical Assistance and Health Services. After the initial cost study is filed, continued participation will be subject to acceptable annual filings.

1.16 Admission policies

(a) The agreement for participation in the New Jersey Medicaid Program stipulates that a facility will provide all required services for specific levels of care. Under this agreement, there can be no discriminatory admission policies as to level of care.

(b) Participation in the Medicaid Program will be limited to providers of service who accept, as payment in full, for covered services the amounts paid in accordance with the reimbursement policy. Providers who have an agreement with the Medicaid State agency and who solicit contributions, donations, or gifts directly from Medicaid patients or family members shall be deemed to be in noncompliance with this Federal requirement. Medicaid patients and their families should be fully informed that their right to long term care services is not contingent upon contributions.

(c) A Medicaid eligible recipient may be admitted to a LTCF only upon the recommendation of a physician which includes a written plan of care, and where applicable a plan of rehabilitation. In order for payment to be made, each recipient admitted to a LTCF must have been prior authorized by a Medical Consultant of the LMAU, except as indicated in Section 1.16.

(d) If long term care placement is approved, a copy of the Authorization Form MCNH-7 (Exhibit #3) is sent to the County Welfare Agency, LTCF, and the Division's Bureau of Claims and Accounts.

(e) Payment will not be made by the New Jersey Medicaid Program for long term care services provided to private paying patients who have applied for, and subsequently been declared eligible for Medicaid benefits by a County Welfare Agency or by the Social Security Administration while in a LTCF, unless they have been found in need of, and authorized for, long term care by the Medicaid Medical Consultant. (See Section 1.6).

(f) The County Welfare Agency shall furnish the LMAU, a statement of the recipient's budgetary information, PA-3L (Exhibit #27) using the appropriate format.

(g) The County Welfare Agency, the attending or referring physician, the LTCF when appropriate, and the recipient's family or sponsor shall be promptly notified in writing of the decision to approve or deny long term care placement.

(h) Before decision to deny the request for long term care placement, the Medical Consultant of the LMAU shall discuss with the attending physician the basis of the decision and suggestions for alternate care or placement.

(i) In the event that a LTCF admits a Medicaid eligible recipient from other than a general acute hospital or Special Class A Hospital, or N.J. Title XIX Certified Psychiatric Hospital without prior authorization from the LMAU, the effective "beginning" date of the initial authorization period will be the date of assessment by the Medicaid nurse. Facilities admitting such recipients without prior authorization will not be reimbursed by the New Jersey Medicaid Program for any care rendered before the assessment.

1. Admission from an acute general hospital, Class "A" special hospital, and N.J. Title XIX certified psychiatric hospital

i. When an inpatient is to be discharged from the hospital to a LTCF, the transfer must be to a Medicare participating SNF if Medicare (Title XVIII) benefits are available.

ii. Admission of an eligible recipient from one of these hospitals to a LTCF does not require prior authorization. Reimbursement will be made from the first day of care, provided that the eligible recipient had been duly admitted as a bed-patient in the hospital for three days immediately preceding the transfer. The Medicaid Regional Staff Nurse will visit the LTCF to assess the Medicaid recipient within 30 days of admission. Following assessment, if the patient has been found in need of long term care by the MET, an authorization will be given as to the actual level of care. In the event that the individual does not require long term care and the MET decision is to deny further authorization for long term care the LTCF will be reimbursed at the Level IV-B payment rate from the date of admission up to the date of discharge, if the discharge occurs not later than 20 days from the date of the MCNH-55 (Exhibit #14) denial letter.

iii. When an inpatient is to be discharged from the hospital and continuing medical care is required, a legible abstract or summary (See Exhibit #30) must be prepared by either the attending physician or the hospital and signed by the attending physician, covering the Medicaid recipient's care in the hospital with recommendation for further medical care, and transferred with the patient to the LTCF.

iv. The LTCF must submit a Notification of the Admission of the Medicaid Eligible recipient, MCNH-33 Form, (Exhibit #7) along with a copy of the hospital transfer form (Exhibit #30) or its equivalent PA-4 Form (Exhibit #28) to the LMAU serving the county where the LTCF is located, within two working days of admission.

2. Admission from a Class "B" special hospital

   i. Admission of a Medicaid eligible recipient from an approved Class B Special Hospital to a LTCF requires prior authorization by a Medicaid Medical Consultant.

   ii. A Medical Consultant in reviewing a request for continued authorization in the Class B Special Hospital, may determine that the patient requires long term care and no longer needs care in a special rehabilitation hospital. In such case he may authorize a level of care for a maximum of 30 days by completing an MCNH-7 (Exhibit #3). The Medicaid Regional Staff Nurse will visit the LTCF to "Reassess" the Medicaid patient within these 30 days.

   When a Class B Special Hospital inpatient is to be discharged from the hospital and continuing medical care is required, a legible abstract or summary must be prepared either by the attending physician or by the hospital and signed by the attending physician, covering the patient's care, and transferred with the patient to the LTCF.

   iii. The admitting LTCF must submit a notification of the admission of the Medicaid eligible recipient, form MCNH-33 (Exhibit #7), along with a copy of the hospital transfer form (Exhibit #30) to the LMAU serving the county where the LTCF is located, within two working days of admission.

3. Admission from a Class "C" special hospital

   i. Admission of a Medicaid eligible recipient to a LTCF from an approved Class C Special Hospital requires prior authorization by a Medicaid Medical Consultant of the Division.

   ii. When an inpatient is to be discharged from the hospital and continuing medical care is required, a hospital transfer form (Exhibit #30) must be prepared either by the attending physician or by the hospital and signed by the attending physician, covering the patient's care in the hospital with recommendations for further medical care, and must be transferred with the patient to the LTCF.

   iii. The admitting LTCF must submit a notification of the admission of the Medicaid eligible recipient, form MCNH-33, (Exhibit #7) along with a copy of the hospital transfer form, to the LMAU serving the county where the LTCF is located, within two working days of admission.

4. Admission from a recipient's home and all other places of residence

   i. Admission of an eligible Medicaid recipient from home and all other places of residence to a LTCF requires prior authorization by a Medicaid Medical Consultant of the Division. The following procedures are completed before authorization can be approved:

(1) Upon the receipt of a PA-4 (Exhibit #28) from the County Welfare Agency, a Regional Staff Nurse and Medicaid Social Worker visit the Medicaid eligible recipient and make assessments of the level of medical nursing and social care required by the individual, in addition to evaluating alternatives to Long Term Care. See MCNH-4 (Exhibit #2).

(2) A MET (Medical Consultant, Regional Staff Nurse and/or Regional Nurse Supervisor, Medicaid Social Worker) reviews the medical-social information and other supporting data to evaluate need and determine appropriateness of placement in a LTCF.

(3) If long term care placement is approved, the Medicaid Social Worker assists the recipient/family to make an appropriate placement. Either the patient or the Medicaid Social Worker will have in his possession an approval letter. See Letter of Approval for Long Term Care Placement MCNH-58 (Exhibit #16) and MCNH-35 (Exhibit #9).

ii. The LTCF must submit a notification of the admission of the Medicaid eligible recipient form MCNH-33, (Exhibit #7) to the LMAU serving the county where the LTCF is located, within two working days of the admission.

iii. Following notification of placement, a copy of the Home Assessment (MCNH-61 Exhibit #17) and the Home Assessment Transfer (MCNH-76 Exhibit #18) will be sent to the LTCF and the County Welfare Agency by the LMAU.

5. Transfer of a patient from one long term care facility to another during a current authorization period

i. Admission of an eligible Medicaid patient from another LTCF requires prior authorization by a Medicaid Medical Consultant of the Division.

ii. Transfer requested by Medicaid patient

(1) Such requests are to be submitted in writing to the LMAU by the Medicaid patient and/or family or sponsor. In order to maintain the patient's freedom of choice, consideration will be given to authorization of the transfer when there is no medical contraindication.

(2) Upon receipt of a request for transfer, a Regional Staff Nurse and Medicaid Social Worker shall assess the Medicaid patient when indicated, to determine the current health status and appropriateness of the transfer, and his acceptance of this transfer.

(3) The MET will evaluate the information and if approved, will authorize the transfer. The Medicaid Social Worker will work with the Medicaid patient/family to arrange an appropriate transfer.

Either the Medicaid recipient or the Medicaid Social Worker will have an approval letter in his possession at the time of transfer. See Letter of Approval for Long Term Care Transfer (MCNH-57 Exhibit #15).

(4) The receiving LTCF must submit a notification of the admission of the Medicaid eligible recipient form MCNH-33 (Exhibit #7) to the LMAU serving the county where the LTCF is located, within two working days of admission.

iii. Involuntary transfer initiated by the facility

Effective March 1, 1977, the Division implemented the following procedural guidelines which affect the involuntary transfer of the Medicaid patients from a LTCF.

(1) Purpose

The Division recognizes that there may be problems in relocating infirmed aged persons from a LTCF. The purpose of these regulations is to specify the circumstances in which the involuntary transfer of a Medicaid patient in a LTCF is authorized and to establish conditions and procedures designed to minimize the risks, trauma and discomfort which may accompany the involuntary transfer of a Medicaid patient from a LTCF.

These regulations shall be interpreted consistent with the federal requirement that care and service under the Medicaid program be provided in a manner consistent with the best interests of the patient.

(2) Applicability

These regulations shall apply to the involuntary transfer of a Medicaid patient at the request of a LTCF but not to the Division's utilization review process, except as indicated in item (3) of this section.

An involuntary transfer is any transfer of a Medicaid patient which was not consented to or requested by the patient or by the patient's family or authorized representative.

Medicaid patient includes (a) a Medicaid patient residing in a LTCF which has a Medicaid provider agreement in effect, including patients over the minimum number stipulated in the agreement, and (b) a patient who had entered the facility as a non-Medicaid patient and becomes a Medicaid patient or is awaiting resolution of Medicaid eligibility, except for a patient who enters the facility under a

signed admission agreement for private payment and then converts to Medicaid within six months from the date of admission.

These regulations shall not apply to the internal relocation of a Medicaid patient within a facility.

(3) Grounds for involuntary transfer:

A Medicaid patient may be transferred involuntarily only for the following reasons:

The transfer is required by medical necessity.

The transfer is necessary to protect the physical welfare or safety of the patient or other patients.

The transfer is required because of non-payment for the patient's stay in the facility, or

The transfer is required by the New Jersey State Department of Health pursuant to licensure action or to the facility's suspension or termination as a Medicaid provider by the Division.

A Medicaid patient shall only be involuntarily transferred when adequate alternative facilities acceptable to the Division are available.

(4) Criteria for determination

In any determination as to whether a transfer is authorized by these regulations, the burden of proof by a preponderance of the evidence shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled.

Where a transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

The effect of relocation trauma on the patient.

The proximity of the proposed facility to the present facility and to the family and friends of the patient.

The availability of necessary medical and social Federal and State regulations.

(5) Procedure for involuntary transfer

The facility shall submit to the Division a written notice with documentation of its intention to and reason for the involuntary transfer of a Medicaid patient from the facility

If the Division's MET determines that an involuntary transfer is warranted, the patient and/or the patient's authorized representative, shall be given 30-days prior written notice by the Division that a transfer is proposed by the facility and will take effect upon completion of the relocation program specified in item (6) of this section, unless the patient requests a hearing within 30 days of the date of the written notice, in which case the transfer is stayed pending the decision following the hearing, except in instances that an acute situation or emergency exists.

The written notice to the patient and/or authorized representative will advise of the right to a hearing.

The Division will endeavor to comply with the hearing time requirements in State and Federal regulations, unless an adjournment is requested by the appellant.

The hearings will be conducted at a time and place convenient to the patient. Notification shall be sent to all parties concerned.

All hearings shall be conducted in accordance with the Fair Hearing procedures adopted by the Division.

(6) Relocation procedure

In the event the relocation of a patient is a final Division determination, the Division shall afford relocation counselling for all prospective transferees in order to reduce as much as possible the impact of transfer trauma.

The staff of the transferring and receiving LTCFs shall assist in the transfer process, although responsibility and authority for the coordination and transfer rests with the Division and shall include:

Medical evaluation review by Division medical, nursing and social service staff.

Initial patient, family or authorized representative counselling.

Involvement of the patient, family or authorized representative in the placement process with recognition of a patient's right to freedom of choice.

Patient preparation and site visit for all able to do so within the capability of the transferring agent.

Unless the patient otherwise requests, the patient shall be accompanied on the transfer day by a family member, authorized representative or attendant.

Follow-up counselling at the new location.

There shall be no administrative hearing on a claim of failure to implement the requirements of this section for relocation counselling.

(7) No owner, administrator or employee of a LTCF shall attempt to have patients seek relocation by harrassment or threats. Such action on behalf of the facility may be cause for the curtailment of future admission of Medicaid patients to the facility or for termination of the Medicaid Provider Agreement with the facility.

(8) Any complaints regarding the handling of patients relative to their transfer shall be referred to the Division for investigation and corrective action.

6. Change from private status to Medicaid eligible status of a long term care patient

i. The LTCF must submit an MCNH-33 notification form (Exhibit #7) directly to the LMAU in all known instances of private patients making application for Medicaid eligibility, as explained in the instructions section of the form.

ii. Payment will not be made by the New Jersey Medicaid Program for long term care services provided to private paying patients who have applied for, and subsequently been declared eligible for Medicaid benefits by a County Welfare Agency or Social Security Administration while in the LTCF, unless said patient has been found in need of, and authorized for, long term care by the Medicaid Medical Consultant following assessment by the MET.

iii. If the authorization is approved, the case is referred to the Local Administrator to be retained until verification of financial eligibility is established. When established, beginning date of authorization will reflect the <u>date of eligibility</u>.

iv. If the authorization is to be denied, the Medical Consultant first attempts to confer with the patient's attending physician by telephone. Written notification of denial MCNH-54 (Exhibit #13) will be sent by the LMAU to the Medicaid patient's family or sponsor with LMAU copies to the attending physician, County Welfare Agency and LTCF.

1.17 Non-covered services

(a) In addition to the general exclusions listed in Chapter I, non-covered services in LTCFs include but are not limited to the following:

1. Care of non-medical nature

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

   Services of a private duty nurse.

3. Private attendant services

   Services of a private attendant.

4. Services and supplies not related to care of patient

   Services and supplies not directly related to the care of the patient (e.g., guest meals and accommodations, television, telephone, personal items, etc.).

5. Fee-for-service

   Practitioner or therapy services furnished on a fee-for-service basis by an owner, partner, administrator, stockholder, or others having a direct or indirect financial interest in the LTCF.

1.18 Long term care facility complaint system

(a) A system has been established by the Division to receive, document and investigate complaints from multiple sources and to take appropriate corrective action as required. It is the Division's policy that the source of the complaint be held confidential unless permission to do otherwise is obtained from the complainant.

(b) In addition to investigation by the Division, when complaints against a facility indicate the facility's failure to correct previously reported survey deficiencies or to comply with established licensure and Medicare/Medicaid certification standards, such complaint reports will be forwarded to the New Jersey State Department of Health for review and action. Any violations will be referred to the office of the Attorney General for review and action, as required.

1.19 Utilization of available income of long term care patients against cost of care/recovery and application of income/personal needs allowance/voluntary contributions

(a) Medicaid patients must use their available income as determined by the County Welfare Agency (CWA) to offset the cost of care in LTCFs.

1. Recovery and application of income paid on behalf of a Medicaid eligible person in a long term care facility

   i. After provision for personal needs allowance (PNA) ($25.00 per month) has been met and after provision for other allocations, maintenance of spouse and/or dependent's/home have been satisfied as indicated on the form Statement of Income Available for Long Term Care Facility Payment PA-3L (Exhibit #27), patient's income must be applied to the cost of medical or remedial care.

ii. The amount which must be collected by the LTCF from the patient, patient's family or Representative Payee, if any, will be established in the process of determining eligibility and identified by form PA-3L (Exhibit #27) issued by the CWA.

iii. Since SSI recipients receive only a $25.00 per month S.S.I. payment (after they have been in the facility for an entire calendar month) no PA-3L (Exhibit #27) will be issued, as this entire amount shall be applied to PNA.

iv. LTCF's should notify the CWA immediately whenever there is a change/difference in any source of income as well as when any assets or resources come to the attention of the LTCF.

2. Personal needs allowance (PNA)

i. Accumulation of personal needs allowance (PNA)

(1) All Medicaid eligible patients residing in LTCFs are permitted to accumulate a sum of money from their PNA, which when combined with any other resources retained by or for the person, does not exceed a maximum of $1500.

(2) If the facility is aware that the PNA is in excess of the resource limit of $1500, the patient should be advised of his right to spend the excess monies for personal needs. It is requested that the LTCF advise the patient and/or authorized representative that the patient may be terminated from Medicaid coverage, unless the amount in excess of $1500 is expended.

(3) The patient, however, may choose to reduce excess PNA by applying some of the accumulated PNA toward the cost of his care. Checks payable to the "Treasurer, State of New Jersey", can be directed to the Chief, Bureau of Claims and Accounts, Division of Medical Assistance and Health Services, P. O. Box 2486, Trenton, New Jersey 08625.

ii. Guidelines for the proper use of personal needs allowance

(1) The PNA, currently $25.00 a month, is intended to meet the personal needs of patients residing in LTCFs. These funds are to be spent as the patient wishes, with the hope that the patient will be encouraged to maintain an interest in life, and a sense of personal dignity.

(2) Patients have the unquestionable right to manage their own PNA, but may prefer to have the LTCF manage the monies on their behalf. Facilities assuming this responsibility are to adhere to the following examples of acceptable expenditures for individual needs, to ensure the proper utilization of the patient's personal monies. These examples are of a general nature and are not all inclusive, as it is an impossible task to identify every conceivable personal use item that might apply to payment from the PNA. However, it must be clearly understood that PNA is

not to be used to obtain services or items which are subject to payment through the per diem reimbursement system, or for other medically indicated special items and services covered by either the New Jersey Medicaid Program or State licensure requirements.

(A) Small purchases: deodorant, cosmetic, electric shavers, hair spray, lotions, powders, special soaps, shampoo, hair or clothes brushes, tobacco, candies, and ice cream, etc.

(B) Personal items: articles of clothing, jewelry, watches, accessories, haircuts, beauty parlor, newspapers, and magazines, etc.

(C) Contacts with the community: home visiting, luggage for a home visit, trips to special events or places of interest, long distance telephone calls, personal stationery, postage stamps, gifts for the family, etc.

(D) Personalization of living area: a patient may wish to make his living area more "home like", with a colorful bedspread, rug, pictures, personally-owned chair, chest, etc., of a type not furnished by the facility.

(E) Recreation and hobbies: games, photographic materials, aquariums, plants, radios, recorders, television set, etc.

Note: Every effort should be extended by the LTCF in allowing the patients and/or authorized representative reasonable access to the PNA and assuring the funds are used solely in accordance with the personal needs and wishes of the patient. Items shall be considered as personal property and properly labeled and recorded as such, so that the patient may take them when discharged or transferred to another living arrangement. In most instances, good judgment will dictate the appropriate use of PNA; however, should there be a need for clarification in an individual case, the matter may be referred to the Administrator of the LMAU serving the LTCF.

iii. Uniform accounting system for personal needs allowance

Although LTCFs are not obligated to accept fiduciary responsibilities for Medicaid patients' PNA, they provide the most accessible means for patients to have use of their personal money. In order to ensure fiscal accountability for these funds, a uniform accounting system is required of all LTCFs assuming this fiduciary responsibility. The Division monitors this area through both the PMR and the auditing processes which include the following:

(1) The facility must have a written statement signed by the patient and/or authorized representative indicating that the patient's choice is for the facility to handle his PNA.

(2) The facility must develop written policies and procedures for the handling and disposition of the PNA and this shall be given to the patient and/or authorized representative.

(3) A general ledger control account must be established to record the total amount of PNA held in escrow by the facility.

(4) A subsidiary ledger must be established whereby each patient's deposits and disbursements would be recorded and the total of the patients' balances must be reconciled to the general ledger control account each month.

(5) A regular checking or savings account must be opened by the facility to segregate the PNA from the operating funds of the facility.

(6) When recording the patients' incomes in a cash receipts journal, the PNA must be segregated from the available income applied to the cost of the patients' care. The PNA may be deposited periodically during the month, directly into the regular checking or savings account restricted for PNA. The general ledger control account (Escrow Account) must reflect a credit posting to reflect the total PNA received during the month and each patient's subsidiary ledger account must also be posted to record the deposits to the appropriate patient's accounts.

(7) To facilitate patients' access to their PNA, a portion of the total cash held must be transferred periodically from the segregated checking/savings account to the facility's checking account. These amounts could then be transferred to a petty cash fund as necessary to make disbursements by cash. The amounts transferred to checking accounts and petty cash funds would depend on each facility's experience.

(8) In compliance with Federal and State regulations the facility is required to submit for the patient's and/or authorized representative's review, a written account at least quarterly of any financial transactions made on behalf of the patient.

(A) Families who request the patients' PNAs must either accept a check or sign a petty cash voucher for cash. Insofar as possible, a family member must have authorization in writing from a patient for a specific amount before funds are disbursed from the PNA.

(9) When drawing checks or cash to make disbursements from the patient PNA account, an original invoice or a signed receipt from the patient or authorized representative, stipulating the use of funds, must be retained by the facility and referenced to the patient's account.

(10) When the facility draws checks on behalf of patients or reimburses the petty cash fund, disbursements of PNAs must be segregated from the operating expenses of the facility. At the end of each month, the general ledger account (Escrow Account) must be charged for the total PNAs disbursed and each patient's subsidiary ledger account must reflect the monthly disbursements on his behalf.

(11) When a savings account is maintained, the interest accumulated is the property of the patient and cannot be used for the general welfare of all patients in the facility unless specific authorization from the patient is obtained for this purpose. When interest is credited to the account, this interest should also be recorded to the general ledger control account and subsidiary ledger.

(12) Upon discharge or transfer to another LTCF, the facility shall provide the patient with a final accounting statement and a check in the amount of his close-out balance within seven working days of the transfer. However, patients being transferred to another LTCF shall have the option of authorizing the facility in writing to transfer any balances to a patient account at the new facility. The transfer of a PNA account from one facility to another must be documented in writing with a copy given to the patient and/or authorized representative. Any patient being discharged or transferred has a right to any personal property owned by him, e.g., television, radio, etc.

(13) Upon the death of a patient, notification must be given to the CWA before the disposition of any PNA, since there may exist a burial claim or prior lien for public assistance granted. Personal property belongs to the estate of the deceased, not to the facility.

Questions regarding this uniform accounting system should be referred to the Chief, Bureau of Audits, Division of Medical Assistance and Health Services.

3. Voluntary contributions

The New Jersey Medicaid Program encourages families or any other concerned individual(s) to make voluntary contributions to the State of New Jersey on behalf of Medicaid patients. Inquiries should be directed to the Bureau of Claims and Accounts.

1.20 Unannounced off-hour Medicaid visits

(a) The New Jersey Medicaid program conducts unannounced off-hour visits to LTCFs which participate as providers of skilled nursing and/or intermediate care services for reimbursement under the Medicaid program.

(b) The purpose of the off-hour visit is to assure that Medicaid patients are receiving appropriate quality health care services commensurate with their individual requirements. Routine patient assessments and periodic medical reviews are not conducted during the off-hour visits.

(c) Facilities are selected on an essentially random basis. The off-hour visit program is conducted by Medicaid personnel, including physicians, nurses and social workers.

(d) Following the off-hour visit, a report of the findings will be forwarded to the facility from the Division.

LONG TERM CARE SERVICES MANUAL

FORM EXHIBITS

The following are attached top sheets only of the individual forms listed below:

Exhibit Number	Form Number	Title of Form	Obtained From and/or Issued By
1	FD-06	Request for Authorization or Reauthorization for Prescribed Rehabilitation Treatment Program	Prudential Ins. Co. of America
2	MCNH-4	Assessment and Reassessment Data Sheet Form	Division of Medical Assist. and Health Serv.
3	MCNH-7	Medical Authorization for Long Term Care	" " "
4	MCNH-8	Termination of Medical Authorization for Long Term Care	" " "
5	MCNH-14	Therapy Charges	" " "
6	FD-20	Medicaid Provider Application	Prudential Ins. Co. of America
7	MCNH-33	Notification from Long Term Care Facility of Admission or Termination of a Medicaid Patient	Division of Medical Assist. and Health Serv.
8	MCNH-34	Letter of Authorization Local Medical Assistance Unit to County Welfare Agency	" " "
9	MCNH-35	Letter of Authorization Local Medical Assistance Unit to Bureau of Transitional Services	" " "
10	MCNH-38	1979-1980 Agreement	" " "
11	MCNH-50	Periodic Medical Review Team Report	" " "
12	MCNH-51	Facility Summary Form	" " "
13	MCNH-54	Letter of Denial for Long Term Care Following Home Visit	" " "
14	MCNH-55	Letter of Denial Following Assessment	" " "
15	MCNH-57	Letter of Approval for Long Term Care Transfer	" " "
16	MCNH-58	Letter of Approval for Long Term Care Placement	" " "
17	MCNH-61	Home Assessment	" " "
18	MCNH-76	Home Assessment Transfer	" " "
19	MCNH-4(C)	Level III Patient Summary Form	" " "
20	MCNH-4(A)	Level IV-A Patient Summary Form	" " "
21	MCNH-4(B)	Level IV-B Patient Summary Form	" " "
22	SSA-1453(6)	Inpatient Hospital and Skilled Nursing Facility Admission and Billing	Prudential Ins. Company of America
23	HCFA-1483	Provider Billing for Medical and Other Health Services	" " "
24	HCFA-1490	Request for Medicare Payment	" " "
25	SSA-1954	Notice of Medicare Claim Determination	" " "
26	HCFA-1955	Notice of Medicare Claim Determination	" " "
27	PA-3L	Statement of Income Available for Long Term Care Facility Payment	Division of Public Welfare
28	PA-4	Certification of Need for Patient Care in Facility Other Than Public or Private Genl. Hosp.	" "
29	MCNH-1	Cost Study for Long Term Care Facility	N.J. Dept. Health
30	Unnumbered	Patient Information Transfer Form	Respective Acute General Hospital or Special Class A Hospital

Appendix A - List of Special Hospitals
Appendix B - Physicians Fee Schedule
Procedure Codes - Home/Nursing Home Visits

Exhibit #1

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REQUEST FOR AUTHORIZATION OR REAUTHORIZATION FOR PRESCRIBED REHABILITATION TREATMENT PROGRAM

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____ PATIENT'S FULL ADDRESS _____

HEALTH SERVICES PROGRAM CASE NO. _____ PERSON NO. _____ AGE _____ M or F SEX _____

PROVIDER IDENTIFICATION (NAME & ADDRESS)

SOCIAL SECURITY OR EMPLOYER I.D. NO.

TELEPHONE NO.

MEDICAL INFORMATION AND THERAPY REQUESTED

1. TYPE OF THERAPY REQUESTED: ( ) PHYSICAL ( ) OCCUPATIONAL ( ) SPEECH
2. HAS PATIENT PREVIOUSLY RECEIVED THERAPY FOR PRESENT ILLNESS? ( ) YES ( ) NO IF YES WHEN _____
3. PERTINENT DIAGNOSES (BOTH MEDICAL & THOSE REQUIRING REHAB. SERVICES) _____
4. DATE OF ONSET OF MEDICAL DX. _____ OF REHAB. DX. _____ 5. PROGNOSIS _____
6. PROSTHETIC OR ORTHOTIC DEVICE IN USE? ( ) YES ( ) NO _____
7. WAS PATIENT ABLE TO AMBULATE PRIOR TO ONSET OF PRESENT ILLNESS? ( ) YES ( ) NO
8. PRESENT FUNCTIONAL STATUS OR DEGREE OF INCAPACITY (CHECK APPROPRIATE SECTION)
   ( ) BEDRIDDEN ( ) CHAIRFAST ( ) AMBULATES WITH ASSISTANCE ( ) INDEPENDENT AMBULATION ( ) ABLE TO SUPPLY PERSONAL NEEDS
9. DOES PATIENT'S MENTAL OR PHYSICAL STATUS PERMIT SUGGESTED THERAPY? ( ) YES ( ) NO
10. DESCRIBE SPECIFIC TREATMENT AND MODALITIES RECOMMENDED _____
11. FREQUENCY OF TREATMENT: _____ TIMES PER WEEK; _____ NUMBER OF WEEKS;
    STARTING DATE _____ ENDING DATE _____ TOTAL NUMBER OF TREATMENTS _____
12. ULTIMATE GOAL OF TREATMENT _____
13. REAUTHORIZATION REQUEST (COMPLETE THIS SECTION ONLY IF THIS IS A REQUEST FOR CONTINUATION OF PREVIOUSLY AUTHORIZED THERAPY)
    TO REQUEST REAUTHORIZATION DESCRIBE BELOW THE MEDICAL REASONS FOR REQUESTING ADDITIONAL REHABILITATION SERVICES _____

PRESCRIBER SIGNATURE (TO BE COMPLETED FOR INITIAL AND REAUTHORIZATION REQUEST)

ATTENDING PHYSICIAN OR THERAPIST* SIGNATURE (DATE)

*IF THERAPIST COMPLETES THIS FORM THE ATTENDING PHYSICIAN'S RX MUST BE ATTACHED

FOR DIVISION USE ONLY

AUTHORIZATION INFORMATION:

( ) AUTHORIZATION GRANTED ( ) AUTHORIZATION DENIED, LETTER ATTACHED

PHYSICAL, OCCUPATIONAL, SPEECH THERAPY IS AUTHORIZED _____ TIMES PER WEEK
CIRCLE ONE

FROM _____ TO _____ FOR A TOTAL OF _____ TREATMENTS

AUTHORIZED BY: SIGNATURE TITLE DATE

FD-06 ED 4-78

CONTRACTOR'S COPY

Medicaid 34860

Exhibit #2

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

1. ASSESSMENT OF APPLICANT FOR SNF OR ICF CARE
2. INFORMATION FOR MEDICAL REVIEW AND UTILIZATION REVIEW
3. REASSESSMENT FOR CONTINUED SNF OR ICF CARE

---

01 _____ APPLICANT'S NAME (LAST, FIRST, MIDDLE)

_____ HOME ADDRESS

02 _____ H.S.P. CASE NO. PERSON NO.

03 _____ DATE OF BIRTH

04 _____ NAME OF FACILITY (CURRENT)

05 _____ DATE OF ADMISSION

_____ ADDRESS

SNF ( ) ICF ( ) MEDICAL ICF ( ) NON-MEDICAL

_____ NAME OF FACILITY (CURRENT)

_____ DATE OF ADMISSION

_____ ADDRESS

SNF ( ) ICF ( ) MEDICAL ICF ( ) NON-MEDICAL

_____ NAME OF FACILITY (CURRENT)

_____ DATE OF ADMISSION

_____ ADDRESS

SNF ( ) ICF ( ) MEDICAL ICF ( ) NON-MEDICAL

06 INITIALLY ADMITTED FROM

( ) HOME

( ) FACILITY OR OTHER _____ NAME AND ADDRESS

( ) ANOTHER STATE, IF YES, WAS HE / SHE RECEIVING MEDICAID BENEFITS FROM THAT STATE? _____ YES _____ NO

IF YES, DESCRIBE CIRCUMSTANCES _____

_____

07 _____ ATTENDING PHYSICIAN, TITLE _____ ADDRESS _____ DATE NOTED

_____ ATTENDING PHYSICIAN, TITLE _____ ADDRESS _____ DATE NOTED

_____ ATTENDING PHYSICIAN, TITLE _____ ADDRESS _____ DATE NOTED

08 DATE OF ASSESSMENT _____ _____ _____

ASSESSMENT NO. _____ _____ _____

PURPOSE OF ASSESSMENT

09 ( ) PREADMISSION LEVEL OF CARE DETERMINATION
10 ( ) ADMISSION LEVEL OF CARE DETERMINATION
11 ( ) REQUEST FOR CHANGE IN LEVEL OF CARE
12 ( ) PERIODIC REVIEW FOR LEVEL OF CARE

Exhibit #3
Date Completed_____

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

MEDICAL AUTHORIZATION FOR LONG TERM CARE

1. Provider Number

_ _ _ _

2. Health Services Program Case Number

_ _ _ _ | _ _ _ _ _ _ _ | _ _

☐ SSI Eligible, No PA-3L is required

3. Patient's Name & S.S.A. Number _ _ _ _ _ _ _ _ _ _ _
S.S.A. #

Last Name _____ First Name _____

4. Effective Date of Medical Authorization

_ _ | _ _ | _ _
Month Day Year

5. Authorization for (check one)
☐ Admission/Readmission
☐ Change in Level of Care

6. Provider Name

_____

7. Authorized Level of Care (check one)
(0) ☐ SNF
(7) ☐ ICF(A)
(8) ☐ ICF(B)

8.

_____
Signature of Medical Consultant

_____
(Name - Typed or Printed)

_____
(Local Medical Assistance Unit)

INSTRUCTIONS

(A) For all cases this form is to be initiated, completed, and distributed by the Local Medical Assistance Unit.

(B) Distribution:
Yellow – Bureau of Claims and Accounts
Green – Provider
Blue – Local Medical Assistance Unit
Pink – County Welfare Agency

THIS MEDICAL AUTHORIZATION IS ONLY VALID IF THE PATIENT HAS BEEN DETERMINED TO BE FINANCIALLY ELIGIBLE FOR MEDICAID DURING THE AUTHORIZED PERIOD.

MCNH-7 (Rev. 4/78)

BUREAU OF CLAIMS AND ACCOUNTS

Exhibit #4

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TERMINATION OF MEDICAL AUTHORIZATION FOR LONG TERM CARE

1. Provider Number

_ _ _ _

2. Provider Name

_____

3. Health Services Program Case Number

_ _ _ _ | _ _ _ _ _ _ | _ _

4. Patient's Name & S.S.A. Number _ _ _ _ _ _ _ _ _

S.S.A. #

_____ _____
Last Name First Name

5. Effective Date of Termination

_ _ | _ _ | _ _
Mo. Day Yr.

6. Reason for Termination (check one)

(1) ☐ Discharge to Hospital
(2) ☐ Discharge, Other
(3) ☐ Death
(4) ☐ Transfer to Another Long Term Care Facility

_____
(Name of Facility)

_____
(County of Location)

(5) ☐ No Longer Eligible for Medicaid
(6) ☐ Denial of Medical Authorization
(7) ☐ Change in HSP Case Number
(8) ☐ Other

7.

_____
Signature of Local Administrator

_____
(Name - Printed or Typed)

_____
(Local Medical Assistance Unit)

INSTRUCTIONS

(A) For all cases this form is to be initiated, completed, and distributed by the Local Medical Assistance Unit.

(B) Distribution:

Blue – Bureau of Claims and Accounts

Green – County Welfare Agency

Yellow – Local Medical Assistance Unit

Pink – Provider

MCNH-8 (Rev. 4/78)

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Bureau of Claims and Accounts

Page ______ Of ______

Exhibit #5

(1) BATCH NO. (DO NOT USE) ______ 1-6

(2) TRANSACTION CODE 1 6 7-8

(4) MONTH AND YEAR ______ 21-24

(5) PROVIDER NO. ______ 25-29

THERAPY CHARGES

Nurs. Home. ______

Address ______

______

Date ______

(3) PATIENT NUMBER	(6)	(7) PATIENT'S LAST NAME	(8) CHG. CODE	(9) CHARGE	TREATMENT (10) TYPE	TREATMENT (11) NO.	(12) LAST TREAT. DATE MO. YR.	*
9 - 20	30	31 - 42	43-44	45 - 49	50	51-52	53 - 56	80
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				
	1		0 1	.				

Exhibit 6

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08625

MEDICAID PROVIDER APPLICATION

1. _____ 2. _____
Legal and/or Trade Name of Organization — Type of Business or Facility

3. _____
Address — Street — City — County — State — Zip Code

4. _____ 5. _____ 6. _____
SSA and/or Employer ID Number — Telephone Number — Length of Time at Above Address

7. _____ 8. _____
Billing Address, If Different — Name of Administrator, Chief Executive Officer, Director or Other Official

9. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program

_____

_____

10. Do you operate from more than one location? [ ] Yes [ ] No If yes, list all other subsidiary or affiliated organization below: (Name and address)

1. _____ _____
2. _____ _____
3. _____ _____

Please attach additional sheet if necessary.

11. Please indicate your preference to receive central or local reimbursement:

[ ] Reimbursement to each Satellite Location
[ ] Reimbursement to Central Location

Billing through a central location is allowable and left to the provider's discretion. However, if the provider chooses to bill centrally, pre-addressed claims MUST be utilized since they reflect the proper address and provider number for that location.

12. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? [ ] Yes [ ] No If yes, have you applied for the Certificate? Attach copy of Certification of Need. If no, explain why you don't require a Certificate.

13. If your business or facility requires a license(s), list type of license(s), license number(s) effective date of license(s), and attach a non-returnable copy.

14. CERTIFICATION, ACCREDITATION OR APPROVAL - - Specify type and attach copy. For Example JCAH (Hospitals); New Jersey Department of Health (Clinics); Office of Community Services (Mental Health Clinics); State Board of Dentistry (Dental Clinics); State Board of Pharmacy (Providers offering Pharmaceutical Services); American Board for Certification in Orthotics and Prosthetics (Prosthetist and/or Orthotist) See also question 15.

15. Approved by Medicare? [ ] Yes [ ] No If yes, attach copy of your approval, if applicable. If no, have you applied for Medicare approval? [ ] Yes [ ] No attach documentation.

16. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid (Title XIX) Program? If yes, list type of service(s) provided and current status. If you were approved at one time and no longer participate, explain the reason(s).

17. Indicate legal status of your organization: Profit Corporation [ ], Non-Profit Corporation [ ], Partnership [ ], Sole Proprietor [ ], Government [ ], Other [ ]. If other please specify:

18. Do you or does your organization have any legal or professional relationships with any other health care organization(s) or facility(ies)? [ ] Yes [ ] No If yes, list all such relationships below:

19. Does any member of your organization have a ten percent or greater financial interest in any other organization or practice of an individual providing services under the New Jersey Medicaid Program? If yes, list name of individual and/or organization.

20. Do you charge for goods and/or services? TO ALL [ ], TO NONE [ ], TO CERTAIN GROUPS ONLY [ ]. If you charge to all or only certain groups, please explain your arrangements and attach copy of your fee schedule.

21. List days and hours of operation.

22. List the Names, SSA Number, License Number and Degree(s) for all Professional Staff in the Organization. Include Physicians, Dentists, Psychologists, Registered Physical Therapists, Optometrists, etc. If more space is needed attach additional sheets.

Name	SSA NO.	License No.	Degree, e.g., MD, DO, DDS RPT, PhD, CPO, OD, etc.

23. 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.

24. _____ Signature of Provider _____ Title _____ Date

FOR DIVISION USE ONLY

[ ] Approve [ ] Disapprove [ ] Other _____ Initial _____ Date

[ ] Approve [ ] Disapprove [ ] Other _____ Initial _____ Date

Exhibit #7

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NOTIFICATION FROM LONG TERM CARE FACILITY OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT

Please complete this form in accordance with the instructions on the reverse side.

I. IDENTIFICATION INFORMATION (Complete all items)

TO: _____ LMAU

DATE: _____

FROM: _____
Long Term Care Facility

_____
Provider Number

PATIENT'S NAME:

_____
(Last) (First) (Middle)

_____
Health Services Program Case # Person #

_____
Social Security Account #

II. ADMISSION INFORMATION

DATE OF ADMISSION: _____

IS THIS A READMISSION? ☐ YES ☐ NO

Patient was admitted from: (Check one, and insert the name of the place)

☐ _____
Acute Care Hospital

☐ _____
Patient's Own Home

Date patient was admitted to above: _____

☐ _____
Special Hospital

☐ _____
Other (Explain)

Date patient was admitted to above: _____

☐ _____
Other Long Term Care Facility

☐ Prior Authorization for Admission

Date patient was admitted to above: _____

By the _____
Local Medical Assistance Unit

III. TERMINATIONS

☐ Discharge order by attending physician Date: _____

☐ Discharge Date: _____ Discharged to: _____
(Name of Place)

☐ Death Date: _____

☐ Transfer to another long term care facility _____
(Name of Facility) (Date)

This Form Completed By

_____
Signature

_____
Title

MC-NH-33 C1 6/75

INSTRUCTIONS FOR COMPLETION OF FORM MC-NH-33

I.
1. This form is to be forwarded to the Medicaid LMAU (Local Medical Assistance Unit) serving the county wherein the long term care facility is located.

2. The form, when completed, is to be submitted within two (2) working days of the admission of a Medicaid eligible patient.

3. If the form is used to notify of an admission, Section III of the form is to be disregarded.

II.
1. If the Medicaid eligible patient has been admitted from an acute care hospital, the "Hospital Transfer Form" or equivalent must be attached to this notification form when submitted to the LMAU.

2. Be sure to insert the name of the place from where the patient was admitted and insert date the patient was admitted to that facility.

3. If the patient has been admitted from his/her residence or other than an acute care hospital in another county and the admission has been prior authorized by an LMAU, be sure to insert the name of the LMAU in the space provided.

4. If a private patient in the facility has applied for Medicaid benefits, the facility should so indicate by filling in the "other" space and forward to the LMAU.

III.
1. Upon discharge, death or transfer, the long term care facility will complete Sections I and III of the form and forward within two (2) working days to the LMAU serving the county wherein the facility is located.

2. The long term care facility is to notify the LMAU directly upon discharge order by the attending physician in order that arrangements be made for an alternate plan of care.

3. If the form is used to notify the LMAU of a termination, Section II of the form is to be disregarded.

This form can be reordered by writing to:

The New Jersey Medicaid Program
Attention: Bureau of Claims and Accounts
P.O. Box 2486
Trenton, New Jersey 08625

Exhibit #8

State of New Jersey

DEPARTMENT OF HUMAN SERVICES

LOCAL AREA OFFICE

_____

_____

TELEPHONE

Area Code _____

_____

DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADDRESS REPLY TO:
POST OFFICE BOX

_____

_____

RE: _____
Name

_____
HSP Number

Dear

This is to advise that the above named individual has been assessed, conferenced, and authorized for _____ care. Placement was made as of _____ in
(Date)

_____
Name of Facility

_____
Address of Long Term Care Facility

Enclosed for your information is a copy of the Home Assessment form which was completed by our social worker prior to the placement. We hope that this information will be helpful to you in your continued service to the patient.

Very truly yours,

_____
Local Administrator

_____
County Local Medical Assistance Unit

MCNH-34-C1 Rev 12/74

Exhibit #9

LOCAL AREA OFFICE

TELEPHONE
Area Code

ADDRESS REPLY TO:
POST OFFICE BOX

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

RE:

Dear

This is to advise that the above-named individual who is presently receiving care at _____ has been assessed, conferenced, and authorized for _____ placement.

In order to complete the necessary authorization, this office will require the following information:

1. _____
   * HSP Case Number and Person Number

2. _____
   Date of Placement

3. _____
   Name of Long Term Care Facility

Please complete the above information and return this form to us as soon as possible. This approval for care will become void if placement is not made within 60 days of this letter.

Your cooperation is most appreciated.

Very truly yours,

_____
Local Administrator

_____
County Local Medical Assistance Unit

* This should reflect the HSP Number assigned by the CWB subsequent to discharge from the institution, and not the institutional I.D. Number.

MC-NH-35 2/73

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

For Division Use Only

_____ Twelve Month Agreement
_____ Six Month Agreement
_____ Other _____
_____ Medicare-Medicaid
_____ Medicaid Only

Levels of Care

_____ Skilled Nursing
_____ ICF-Level A
_____ ICF-Level B

1979-1980 AGREEMENT
SKILLED NURSING AND/OR INTERMEDIATE CARE FACILITY
PARTICIPATION IN THE HEALTH SERVICES PROGRAM

(Name of Facility) _____

(Address) _____

(State License No.)_____ Medicaid Provider No.: SNF _____
ICF-A _____
ICF-B _____

This Contract, made and entered into by and between the Department of Human Services through the Division of Medical Assistance and Health Services, hereinafter designated as the Department, and the above-named facility, a provider of services, whose address is as stated above, hereinafter designated as the Facility, Witnesseth:

WHEREAS, various persons eligible for benefits under the New Jersey Health Services Program (Medicaid) are in need of medical care in the form of Skilled Nursing care, or Intermediate Nursing care, as more specifically set forth in Program regulations and guidelines; and,

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,

WHEREAS, pursuant to N.J.S.A. 30:4D-1 et seq., the Department is responsible for the administration 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,

WHEREAS, to participate in the New Jersey Medicaid Program, a Skilled Nursing Facility and/or Intermediate Care Facility must: (1) be licensed under the laws of New Jersey; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a licensed nursing facility administrator who holds a current license; (4) meet on a continuing basis Federal and State standards for participation in Title XIX; (5) accept the terms and conditions of participation set out herein.

NOW, THEREFORE, in consideration of the mutual promises herein contained, it is agreed by and between the parties hereto as follows:

A. FACILITY AGREES:

1. That it will render all services which have been recognized as an element of cost as set forth in the cost survey report submitted;

2. That it will accept the payment approved under the Medicaid Program, based on the level of care required by the eligible individual, as payment in full and will not make any additional charges to the patient or others on his behalf for Medicaid covered services;

3. That it will promptly initiate and terminate billing procedures when individuals covered under this program enter or leave the facility or are assessed at a different level of care, pursuant to applicable regulations;

4. That it will limit billing procedures under this Program to those eligible and authorized recipients that have been placed in the Medicaid certified section of the Facility;

5. That it will bill the Department for reserving beds for Medicaid patients on therapeutic home leave in accordance with State and Federal regulations;

6. 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 but not limited to the following:

   a. Medical records as required by Section 1902(e)(28) of Title XIX of the Social Security Act, and any amendments thereto;

Exhibit #11

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

PERIODIC MEDICAL REVIEW FORM

WEIGHTED SCORE BY CATEGORY AND LEVEL OF CARE

Name of Facility _____ Address _____

On _____, a Periodic Medical Review on-site visit was conducted at this facility covering patient assessments made between _____ and _____. Maximum point scores are identified in each category and sub-category for each level of care. A summary of the results follows:

LEVEL OF CARE

CATEGORY	NUMBER OF PATIENTS III	IV-A	IV-B	COMMENTS
I. Clinical Evaluation of Recipient				
II. Medical Care Information & Quality Evaluation	370	370	254	
A. Summaries from Hospitals	(12)	(12)	(12)	
B. Physicians Evaluations	(78)	(78)	(52)	
C. MCP	(31)	(31)	(21)	
D. Rehab Goals	(31)	(31)	(20)	
E. Medical Orders	(72)	(72)	(51)	
F. Progress Notes	(52)	(52)	(34)	
G. Physicians Visits	(10)	(10)	(10)	
H. MCP Carried Out	(31)	(31)	(20)	
I. Rehab Goals Met	(31)	(31)	(20)	
J. Status of Major Impairment	(22)	(22)	(14)	
III. Nursing Documentation & Nursing Care	605	412	197	
A. Nursing Documentation	(206)	(136)	(68)	
1. Continuity of Care	(11)	(7)	(4)	
2. Nursing Evaluation	(53)	(35)	(17)	
3. Nursing Care Plan	(110)	(73)	(36)	
4. Nurse's Notes	(32)	(21)	(11)	
B. Nursing Care Administered	(399)	(276)	(129)	
1. Personal Needs	(107)	(72)	(36)	
2. Skin Care	(64)	(43)	(21)	
3. Patient Safety	(21)	(14)	(7)	
4. Restorative Nursing Care	(207)	(147)	(65)	

LEVEL OF CARE

CATEGORY	III	IV-A	IV-B	COMMENTS
IV. Other Services Evaluation	88	58	29	
A. Other Services	(44)	(29)	(14)	
B. Individual Nutritional Program	(44)	(29)	(15)	
V. Social Care Evaluation	122	366	748	
A. Social Services	(26)	(78)	(156)	
1. Frequency	(8)	(24)	(48)	
2. Type	(10)	(30)	(60)	
3. Social Interaction Needs	(8)	(24)	(48)	
B. Social Services Records	(28)	(84)	(180)	
1. Content	(10)	(30)	(60)	
2. Quality	(10)	(30)	(60)	
3. Frequency	(4)	(12)	(30)	
4. Accessibility	(4)	(12)	(30)	
C. Patient Activities	(26)	(78)	(160)	
1. Individual	(10)	(30)	(58)	
2. Group	(10)	(30)	(58)	
3. Accessibility	(6)	(18)	(44)	
D. Patient Activities Record	(22)	(66)	(132)	
1. Content	(12)	(36)	(72)	
2. Frequency	(5)	(15)	(30)	
3. Accessibility	(5)	(15)	(30)	
E. Patient Rights	(20)	(60)	(120)	
1. Patient Awareness	(5)	(15)	(30)	
2. Living Space/Clothing	(5)	(15)	(30)	
3. Spending Money	(5)	(15)	(30)	
4. Movement & Communication	(5)	(15)	(30)	
VI. General Outcome of Services	65	44	22	
A. Functional Status - Physical	(23)	(15)	(7)	
B. Functional Status - Mental	(21)	(15)	(7)	
C. Functional Status - Psycho-Social	(21)	(14)	(8)	

Name of facility	Provider No.
Address	
City	Telephone No.

State of New Jersey
Division of Medical Assistance and Health Services

FACILITY SUMMARY FORM

Level _____

Date _____ to _____

Page_____of _____

Enter weighted score for each item as indicated on each Patient Summary Form
*Before PMR visit, enter *Average on last sheet*

PATIENT'S NAME Last First	II A	B	C	D	E	F	G	H	I	J	III A 1	2	3	4	B 1	2	3	4	IV A	B	V A 1	2	3	B 1	2	3	4	C 1	2	3	D 1	2	3	E 1	2	3	4	VI A	B	C	VII A
TOTAL																																								
* AVERAGE																																								

MCNH - 51 (Rev. 3/79)

Exhibit #12

Exhibit #13

State of New Jersey

DEPARTMENT OF HUMAN SERVICES

LOCAL AREA OFFICE

DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADDRESS REPLY TO:
POST OFFICE BOX

TELEPHONE
Area Code ———

Date:

Dear

The Medical Review Team of_____ Local Medical Assistance Unit has recently reviewed your medical and social history.

Evidence available to the Team does not substantiate a need for nursing facility care as defined by the New Jersey Health Services Program and set forth in New Jersey Administrative Code (N.J.A.C.) 10:65-1.1, Appendix A.

If you or your family wish to exercise your right to appeal this decision you (or someone authorized to act on your behalf) may submit a request for a fair hearing in accordance with N.J.A.C. 10:49-5.3 to:

Division of Medical Assistance and Health Services
Fair Hearing Section
P.O. Box 2486
Trenton, New Jersey 08625

Such requests must be submitted in writing within 20 days from the date of this letter.

Sincerely yours,

_____Medical Consultant

_____Local Medical Assistance Unit

MCNH-54 (Rev. 4/76)

Exhibit #14

State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON. NEW JERSEY 08625
TELEPHONE
AREA CODE 609

ADDRESS REPLY TO.
POST OFFICE BOX 2486
TRENTON. NEW JERSEY 08625

Date:

Dear

The Medical Review Team of_____Local Medical Assistance Unit has recently reviewed your medical and social history.

Evidence available to the Team does not substantiate a need for continued nursing facility services as defined by the New Jersey Health Services Program and set forth in New Jersey Administrative Code (N.J.A.C.) 10:65-1.1, Appendix A.

If you or your family wish to exercise your right to appeal this decision you (or someone authorized to act on your behalf) may submit a request for a fair hearing in accordance with N.J.A.C. 10:49-5.3 to:

Division of Medical Assistance and Health Services
Fair Hearing Section
P.O. Box 2486
Trenton, New Jersey 08625

Such requests must be submitted in writing within 20 days from the date of this letter. In the absence of such a request, the New Jersey Medicaid Program will continue to pay the facility until your discharge, but not beyond 20 days from the date of this letter.

Sincerely yours,

_____Medical Consultant

_____Local Medical Assistance Unit

Exhibit #15

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

LOCAL AREA OFFICE

TELEPHONE
Area Code

ADDRESS REPLY TO:
POST OFFICE BOX

H.S.P. #

Dear

Your request for transfer to another nursing home has been reviewed by our Medical Team. Approval of the transfer has been granted.

Our social worker is available to help in locating an appropriate facility, or with other arrangements relating to the transfer. Please feel free to contact this office with any questions you may have.

This letter should be shown to the facility you select, so their admissions office is aware of the transfer authorization.

Very truly yours,

Local Administrator

County Local Medical Assistance Unit

MCNH-57 1/75

Exhibit #16

State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

LOCAL AREA OFFICE

TELEPHONE

AREA CODE

ADDRESS REPLY TO:

POST OFFICE BOX

H.S.P. #

Dear

Your application for nursing home care has been reviewed by our Medical Team, comprised of a physician, nurse, and social worker. You have been approved for _____ care. This approval is granted with the full understanding that it is within your rights under Medicaid freedom of choice provisions to accept or refuse this service.

Arrangements may be made for your admission to a facility of your choice. Our social worker is available to help in locating an appropriate home, or with other arrangements relating to your admission. If you are able to effect placement on your own, please notify this office.

This letter should be shown to the facility you select, so that their admissions office is aware of the approval for nursing home care.

This approval for care is valid for a period of 60 days from the date of this letter. If you have difficulty in locating or selecting a home and the 60 day period is exceeded, please advise us accordingly.

Please feel free to contact this office with any questions you may have.

Very truly yours,

_____

Local Administrator

_____

County Local Medical Assistance Unit

MCNH-58(Rev. 10/78)

STATE OF NEW JERSEY

Exhibit #17

DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

HOME ASSESSMENT

1. Name _____ D.O.B. _____ _____ M____ F____ HSP#_____
   Age
2. Present Address _____ Phone_____
3. Marital Status ____M ____ S ____ W ____ D ____ Sep. Date Relationship Terminated_____
4. Spouse's Name _____ Address _____

   _____

5. Other Relatives & Interested Persons (* people most involved)

Name	Relation to Patient	Address	Phone

6. Education _____ Primary Occupation_____Date last employed_____
7. Recreational Interests _____ T.V. _____ Radio _____ Reading _____ Smoking

   Other _____
8. Communications Barrier _____
9. Special Religious Needs _____
10. Income: Social Security _____ S.S.I. _____ Other _____
11. Financial Management

12. Present Living Arrangements

13. Community Agency Involvement

    a) County Welfare Board Service Worker _____

    b) Other Agencies _____

14. Person(s) & Date(s) Interviewed: _____

    _____

15. Medicaid Social Worker _____ LMAU _____

MCNH-61 1/76
(Formerly FD-93)

Exhibit #18

HOME ASSESSMENT TRANSFER FORM

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

HSP#: _____ MARITAL STATUS: _____

PA-4 DIAGNOSIS: _____

1. Activities of Daily Living:
   Assessment Code: I. Independent
   S. Supervise
   A. Assisted
   U. Unable
   R. Reluctant

   a. Feeding _____
   b. Bathing: Face & Hands _____
   Total _____
   c. Dressing:
   Upper Extremities _____
   Total _____
   d. Ambulation:
   Walker-Cane _____
   Wheelchair _____
   Bed to Commode _____
   Chair _____
   Bedfast _____
   Total _____
   e. Elimination:
   Bedpan _____
   Urinal _____
   Toilet _____
   Other _____

2. Continence:

	Yes	No	Comments
Bladder	___	___	_____
Bowel	___	___	_____
Catheters	___	___	_____
Colostomy	___	___	_____

3. Communication:

	Yes	No	Comments
Difficulty with			
Hearing	___	___	_____
Speech	___	___	_____
Vision	___	___	_____

4. Mental Status: _____
   _____

5. Behavior: _____
   _____

6. Current Nursing Needs (NN)
   Restorative Nursing (RN)

   a. Help with bath _____
   b. Skin Care _____
   c. Irrigations _____
   d. Dressings _____
   e. Bladder & Bowel _____
   f. Special Diet _____
   g. Positioning _____
   h. Ambulation _____
   i. Therapies _____
   j. Behavior Modification _____
   k. Applicances _____
   l. Medications _____
   m. Other _____

7. Comments: _____
   _____
   _____

Approved Level of Care: _____

Date: _____ RSN's Signature: _____

LMAU: _____

MCNH-76 6/77

Exhibit #19

LEVEL III PATIENT SUMMARY FORM

NAME _____ HSI' # _____ DATE _____

INSTRUCTIONS: *It is imperative to use the "Guide for Weighted Values". Each specific component has been given a weighted value in relation to its importance to the whole, and broken down by category, sub-category, and level of care required by the patient and provided by the facility. Using a No. 2 lead pencil, mark the box(es) containing the appropriate points of value most descriptive of each item. Total the figures for each sub-category and enter the total in the line opposite. The total number of possible points for all items is 1260.*

I. Clinical Evaluation of Recipient - No Point Score

II. Medical Care Information & Quality Evaluation

A. Summary from Hospital — 1: 1 | 2a: 2 | b: 2 | c: 1 | d: 2 | e: 1 | f: 1 | g: 2 | or 3: 12 | or 4: 0 = _____ (12)

B. Physician Evaluation — 1: 10 | 2: 10 | 3: 10 | 4: 10 | 5: 20 | 6: 6 | 7: 7 | 8: 2 | 9: 2 | 10: 1 | or 11: 0 = _____ (78)

C. MCP — 1: 4 | 2: 3 | 3: 4 | 4: 3 | 5: 4 | 6: 4 | 7: 3 | 8: 3 | 9: 3 | or 10: 0 = _____ (31)

D. Rehab Goals — 1: 5 | 2: 5 | 3: — | 4: 21 | or 5: 0 = _____ (31)

E. Medical Orders — 1: 12 | 2: 12 | 3: 12 | 4: 12 | 5: 12 | 6: 12 | or 7: 0 = _____ (72)

F. Progress Notes — 1: 10 | 2: 12 | 3: 12 | 4: 10 | 5: 8 | or 6: 0 = _____ (52)

G. Physician Visits — 1: 10 | or 2: 0 = _____ (10)

H. MCP Carried Out — 1: 10 | 2: 21 | or 3: 21 | or 4: 0 = _____ (31)

I. Rehab Goals Met — 1: 31 | or 2: 31 | or 3: 0 = _____ (31)

J. Status of Major Impairment — 1: 6 | or 2: 6 | or 3: 22 | or 4: 22 | or 5: 0 = _____ (22)

III. Nursing Documentation & Nursing Care

A. Nursing Documentation

1. Continuity of Care — a: 11 | or b: 0 = _____ (11)

2. Nursing Evaluation — a: 8 | b: 9 | c: 9 | d: 9 | e: 9 | f: 9 | or g: 0 = _____ (53)

3. NCP — a: 5 | b: 11 | c: 19 | d: 11 | e: 11 | f: 32 | g: 11 | h: 5 | i: 5 | or j: 0 = _____ (110)

4. Nurse's Notes — a: 10 | b: 11 | c: 11 | or d: 0 = _____ (32)

B. Nursing Care Administered

1. Personal Needs — a: 23 | b: 21 | c: 21 | d: 21 | e: 21 | or f: 0 = _____ (107)

2. Skin Care — a: 64 | or b: 19 | c: 15 | d: 15 | e: 15 | or f: 0 = _____ (64)

3. Patient Safety — a: 2 | b: 11 | c: 4 | d: 4 | or e: 0 = _____ (21)

4. Restorative Nursing Care — a: 8 | b: 8 | c1: 25 | c2: 25 | c3: 25 | c4: 25 | c5: 25 | d: 8 | e: 8 | f: 8 | g: 10 | h: 24 | i: 8 | or j: 0 = _____ (207)

IV. Other Services Evaluation

A. Other Services — 1: 11 | or 2: 22 | or 3: 44 | or 4: 0 = _____ (44)

B. Individual Nutritional Program — 1: 11 | or 2: 22 | or 3: 44 | or 4: 0 = _____ (44)

V. Social Care Evaluation

A. Social Services

1. Frequency — a 3 | b 5 or c 0 = _____ (8)

2. Type — a 1 | b 3 or c 10 or d 0 = _____ (10)

3. Social Interaction Needs — a 3 | b 5 or c 0 = _____ (8)

B. Social Services Records

1. Content — a 2 | b 2 | c 4 | d 2 or e 0 = _____ (10)

2. Quality — a 2 | b 3 | c 2 | d 3 or e 0 = _____ (10)

3. Frequency — a 2 | b 2 or c 0 = _____ (4)

4. Accessibility — a 2 or b 4 or c 0 = _____ (4)

C. Patient Activities

1. Individual — a 2 | b 2 or c 10 or d 0 = _____ (10)

2. Group — a 2 | b 2 | c 2 | d 4 or e 0 = _____ (10)

3. Accessibility — a 6 or b 0 = _____ (6)

D. Patient Activities Records

1. Content — a 1 | b 2 | c 3 | d 3 | e 3 or f 0 = _____ (12)

2. Frequency — a 2 | b 3 or c 0 = _____ (5)

3. Accessibility — a 2 or b 5 or c 0 = _____ (5)

E. Patient Rights

1. Patient Awareness — a 2 | b 3 or c 0 = _____ (5)

2. Living Space / Clothing — a 1 | b 2 | c 2 or d 0 or e 0 = _____ (5)

3. Spending Money — a 2 | b 3 or c 0 = _____ (5)

4. Movement & Communication — a 3 | b 2 or c 0 = _____ (5)

VI. General Outcome of Services

A. Functional Status-Physical — 1 6 or 2 6 or 3 23 or 4 23 or 5 0 = _____ (23)

B. Functional Status-Mental — 1 6 or 2 6 or 3 21 or 4 21 or 5 21 or 6 0 = _____ (21)

C. Functional Status-Psycho-Social — 1 6 or 2 6 or 3 21 or 4 21 or 5 21 or 6 0 = _____ (21)

VII. Timely Certification/Recertification

A. Certification/Recertification — 1 10 or 2 0 = _____ (10)

Patient is appropriately placed (team judgement) YES _____ NO _____

If above is NO, has alternate care been considered and/or planned by facility? YES _____ NO _____

MET RECOMMENDATIONS:

Date _____ *Level* _____ *for* _____ *Months*

atures (team) _____ _____ _____

- 4 (C) Rev. 4/79

Exhibit #20

LEVEL IV-A PATIENT SUMMARY FORM

NAME _____ HSP # _____ DATE _____

INSTRUCTIONS: *It is imperative to use the "Guide for Weighted Values". Each specific component has been given a weighted value in relation to its importance to the whole, and broken down by category, sub-category, and level of care required by the patient and provided by the facility. Using a No. 2 lead pencil, mark the box(es) containing the appropriate points of value most descriptive of each item. Total the figures for each sub-category and enter the total in the line opposite. The total number of possible points for all items is 1260.*

I. Clinical Evaluation of Recipient - No Point Score

II. Medical Care Information & Quality Evaluation

A. Summary from Hospital — 1: 1 | 2a: 2 | b: 2 | c: 1 | d: 2 | e: 1 | f: 1 | g: 2 or 3: 12 or 4: 0 — = _____ (12)

B. Physician Evaluation — 1: 10 | 2: 10 | 3: 10 | 4: 10 | 5: 20 | 6: 6 | 7: 7 | 8: 2 | 9: 2 | 10: 1 or 11: 0 — = _____ (78)

C. MCP — 1: 4 | 2: 3 | 3: 4 | 4: 3 | 5: 4 | 6: 4 | 7: 3 | 8: 3 | 9: 3 or 10: 0 — = _____ (31)

D. Rehab Goals — 1: 5 | 2: 5 | 3: — | 4: 21 or 5: 0 — = _____ (31)

E. Medical Orders — 1: 12 | 2: 12 | 3: 12 | 4: 12 | 5: 12 | 6: 12 or 7: 0 — = _____ (72)

F. Progress Notes — 1: 10 | 2: 12 | 3: 12 | 4: 10 | 5: 8 or 6: 0 — = _____ (52)

G. Physician Visits — 1: 10 or 2: 0 — = _____ (10)

H. MCP Carried Out — 1: 10 | 2: 21 or 3: 21 or 4: 0 — = _____ (31)

I. Rehab Goals Met — 1: 31 or 2: 31 or 3: 0 — = _____ (31)

J. Status of Major Impairment — 1: 6 or 2: 6 or 3: 22 or 4: 22 or 5: 0 — = _____ (22)

III. Nursing Documentation & Nursing Care

A. Nursing Documentation

1. Continuity of Care — a: 7 or b: 0 — = _____ (7)

2. Nursing Evaluation — a: 5 | b: 6 | c: 6 | d: 6 | e: 6 | f: 6 or g: 0 — = _____ (35)

3. NCP — a: 3 | b: 7 | c: 13 | d: 7 | e: 7 | f: 23 | g: 7 | h: 3 | i: 3 or j: 0 — = _____ (73)

4. Nurse's Notes — a: 7 | b: 7 | c: 7 or d: 0 — = _____ (21)

B. Nursing Care Administered

1. Personal Needs — a: 16 | b: 14 | c: 14 | d: 14 | e: 14 or f: 0 — = _____ (72)

2. Skin Care — a: 43 or b: 13 | c: 10 | d: 10 | e: 10 or f: 0 — = _____ (43)

3. Patient Safety — a: 2 | b: 8 | c: 2 | d: 2 or d: 0 — = _____ (14)

4. Restorative Nursing Care — a: 6 | b: 6 | c1: 18 | 2: 18 | 3: 18 | 4: 18 | 5: 18 | d: 5 | e: 6 | f: 6 | g: 7 | h: 16 | i: 5 or j: 0 — = _____ (147)

IV. Other Services Evaluation

A. Other Services — 1: 7 or 2: 15 or 3: 29 or 4: 0 — = _____ (29)

B. Individual Nutritional Program — 1: 7 or 2: 15 or 3: 29 or 4: 0 — = _____ (29)

V. Social Care Evaluation

A. Social Services

1. Frequency — a 9 | b 15 or c 0 — = _____ (24)

2. Type — a 3 | b 9 or c 30 or d 0 — = _____ (30)

3. Social Interaction Needs — a 9 | b 15 or c 0 — = _____ (24)

B. Social Services Records

1. Content — a 6 | b 6 | c 12 | d 6 or e 0 — = _____ (30)

2. Quality — a 6 | b 9 | c 6 | d 9 or e 0 — = _____ (30)

3. Frequency — a 6 | b 6 or c 0 — = _____ (12)

4. Accessibility — a 6 or b 12 or c 0 — = _____ (12)

C. Patient Activities

1. Individual — a 6 | b 6 or c 30 or d 0 — = _____ (30)

2. Group — a 6 | b 6 | c 6 | d 12 or e 0 — = _____ (30)

3. Accessibility — a 18 or b 0 — = _____ (18)

D. Patient Activities Records

1. Content — a 3 | b 6 | c 9 | d 9 | e 9 or f 0 — = _____ (36)

2. Frequency — a 6 | b 9 or c 0 — = _____ (15)

3. Accessibility — a 6 or b 15 or c 0 — = _____ (15)

E. Patient Rights

1. Patient Awareness — a 6 | b 9 or c 0 — = _____ (15)

2. Living Space / Clothing — a 3 | b 6 | c 6 or d 0 or e 0 — = _____ (15)

3. Spending Money — a 6 | b 9 or c 0 — = _____ (15)

4. Movement & Communication — a 9 | b 6 or c 0 — = _____ (15)

VI. General Outcome of Services

A. Functional Status-Physical — 1 4 or 2 4 or 3 15 or 4 15 or 5 0 — = _____ (15)

B. Functional Status-Mental — 1 4 or 2 4 or 3 15 or 4 15 or 5 15 or 6 0 — = _____ (15)

C. Functional Status-Psycho-Social — 1 4 or 2 4 or 3 14 or 4 14 or 5 14 or 6 0 — = _____ (14)

VII. Timely Certification/Recertification

A. Certification/Recertification — 1 10 or 2 0 — = _____ (10)

Patient is appropriately placed (team judgement) YES _____ NO _____

If above is NO, has alternate care been considered and/or planned by facility? YES _____ NO _____

MET RECOMMENDATIONS:

Date _____ *Level* _____ *for* _____ *Months*

Signatures (team) _____ _____ _____

Exhibit #21

LEVEL IV-B PATIENT SUMMARY FORM

NAME _____ HSP # ____ _____ DATE _____

INSTRUCTIONS: **It is imperative to use the "Guide for Weighted Values".** *Each specific component has been given a weighted value in relation to its importance to the whole, and broken down by category, sub-category, and level of care required by the patient and provided by the facility. Using a No. 2 lead pencil, mark the box(es) containing the appropriate points of value most descriptive of each item. Total the figures for each sub-category and enter the total in the line opposite. The total number of possible points for all items is 1260.*

I. Clinical Evaluation of Recipient - No Point Score

II. Medical Care Information & Quality Evaluation

A. Summary from Hospital — 1: 1 | 2a: 2 | b: 2 | c: 1 | d: 1 | e: 2 | f: 2 | g: 1 or 3: 12 or 4: 0 = _____(12)

B. Physician Evaluation — 1: 7 | 2: 7 | 3: 7 | 4: 7 | 5: 14 | 6: 3 | 7: 4 | 8: 1 | 9: 1 | 10: 1 or 11: 0 = _____(52)

C. MCP — 1: 3 | 2: 2 | 3: 3 | 4: 2 | 5: 3 | 6: 3 | 7: 1 | 8: 2 | 9: 2 or 10: 0 = _____(21)

D. Rehab Goals — 1: 3 | 2: 3 | 3: — | 4: 14 or 5: 0 = _____(20)

E. Medical Orders — 1: 9 | 2: 9 | 3: 9 | 4: 8 | 5: 8 | 6: 8 or 7: 0 = _____(51)

F. Progress Notes — 1: 7 | 2: 8 | 3: 8 | 4: 6 | 5: 5 or 6: 0 = _____(34)

G. Physician Visits — 1: 10 or 2: 0 = _____(10)

H. MCP Carried Out — 1: 6 | 2: 14 or 3: 14 or 4: 0 = _____(20)

I. Rehab Goals Met — 1: 20 or 2: 20 or 3: 0 = _____(20)

J. Status of Major Impairment — 1: 4 or 2: 4 or 3: 14 or 4: 14 or 5: 0 = _____(14)

III. Nursing Documentation & Nursing Care

A. Nursing Documentation

1. Continuity of Care — a: 4 or b: 0 = _____(4)

2. Nursing Evaluation — a: 2 | b: 3 | c: 3 | d: 3 | e: 3 | f: 3 or g: 0 = _____(17)

3. NCP — a: 1 | b: 4 | c: 6 | d: 4 | e: 4 | f: 10 | g: 4 | h: 1 | i: 2 or j: 0 = _____(36)

4. Nurse's Notes — a: 3 | b: 4 | c: 4 or d: 0 = _____(11)

B. Nursing Care Administered

1. Personal Needs — a: 8 | b: 7 | c: 7 | d: 7 | e: 7 or f: 0 = _____(36)

2. Skin Care — a: 21 or b: 6 | c: 5 | d: 5 | e: 5 or f: 0 = _____(21)

3. Patient Safety — a: 2 | b: 3 | c: 1 | d: 1 or e: 0 = _____(7)

4. Restorative Nursing Care — a: 3 | b: 3 | c1: 10 | 2: 7 | 3: 7 | 4: 7 | 5: 7 | d: 3 | e: 3 | f: 3 | g: 3 | h: 6 | i: 3 or j: 0 = _____(65)

IV. Other Services Evaluation

A. Other Services — 1: 4 or 2: 7 or 3: 14 or 4: 0 = _____(14)

B. Individual Nutritional Program — 1: 4 or 2: 7 or 3: 15 or 4: 0 = _____(15)

V. Social Care Evaluation

A. Social Services

1. Frequency	a 18 | b 30 or c 0		= _____ (48)
2. Type	a 6 | b 18 or c 60 or d 0		= _____ (60)
3. Social Interaction Needs	a 18 | b 30 or c 0		= _____ (48)
B. Social Services Records			
1. Content	a 12 | b 12 | c 24 | d 12 or e 0		= _____ (60)
2. Quality	a 12 | b 18 | c 12 | d 18 or e 0		= _____ (60)
3. Frequency	a 15 | b 15 or c 0		= _____ (30)
4. Accessibility	a 15 or b 30 or c 0		= _____ (30)
C. Patient Activities			
1. Individual	a 11 | b 11 or c 58 or d 0		= _____ (58)
2. Group	a 10 | b 12 | c 12 | d 24 or e 0		= _____ (58)
3. Accessibility	a 44 or b 0		= _____ (44)
D. Patient Activities Records			
1. Content	a 6 | b 12 | c 18 | d 18 | e 18 or f 0		= _____ (72)
2. Frequency	a 12 | b 18 or c 0		= _____ (30)
3. Accessibility	a 12 or b 30 or c 0		= _____ (30)
E. Patient Rights			
1. Patient Awareness	a 12 | b 18 or c 0		= _____ (30)
2. Living Space / Clothing	a 6 | b 12 | c 12 or d 0 or e 0		= _____ (30)
3. Spending Money	a 12 | b 18 or c 0		= _____ (30)
4. Movement & Communication	a 18 | b 12 or c 0		= _____ (30)
VI. General Outcome of Services			
A. Functional Status-Physical	1 2 or 2 2 or 3 7 or 4 7 or 5 0		= _____ (7)
B. Functional Status-Mental	1 2 or 2 2 or 3 7 or 4 7 or 5 7 or 6 0		= _____ (7)
C. Functional Status-Psycho-Social	1 2 or 2 2 or 3 8 or 4 8 or 5 8 or 6 0		= _____ (8)
VII. Timely Certification/Recertification			
A. Certification/Recertification	1 10 or 2 0		= _____ (10)

Patient is appropriately placed (team judgement) YES _____ NO _____

If above is NO, has alternate care been considered and/or planned by facility? YES _____ NO _____

MET RECOMMENDATIONS:

Date _____ *Level* _____ *for* _____ *Months*

Signatures (team) _____ _____ _____

Exhibit #22

INPATIENT HOSPITAL AND SKILLED NURSING FACILITY ADMISSION AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

FORM APPROVED
OMB NO. 066-R-0014

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name	First name	MI	2. Sex ☐ M ☐ F	3. Health insurance claim number

4. Patient's address (Street number, City, State, ZIP Code)	5. Date of birth	6. Medical record number

7. Date of this admission	8. Provider name and address (City and State)	9. Provider number	10. Attending physician

11. Dates of qualifying stay FROM THRU	12. Qualifying and other prior stay information

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 13 and 14.

13. Insuring organization and / or State agency name and address	14. Policy and / or medical assistance number

15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

☐ Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date

16. Admitting diagnoses (If employment related, also give name and address of employer)	Do not use this space	17. Discharge or current diagnoses (a) Primary (b) Secondary	Do not use this space
18. Surgical procedures (Show date of each)			

19. STATEMENT OF SERVICES RENDERED	Blood pints furnished	Pints replaced	Not replaced	Charge per pint	Total Charges	Non-covered Chg's.
A.						
Accommodation			Days	Rate		
B. 1-Bed						
C. 2-3-4 Bed						
D. 5 or more Beds						
FOR HOSPITAL ONLY E. Intensive care						
F. Coronary care						
G.						
H. Operating room						
I. Anesthesia						
J. Outpatient services						
K. Blood administration						
L. Pharmacy						
M. Radiology						
N. Laboratory						
O. Medical, surgical and central supplies						
P. Physical therapy						
Q. Occupational therapy						
R. Speech pathology						
S. Inhalation therapy						
T. Other (Describe)						
U. TOTALS						
V. Inpatient deductible						
W. Blood deductible pts. @						
X. Coinsurance days ( ) ( )						
Y. TOTAL DEDUCTIONS						

20. Statement covers period FROM	THRU

21. Date guarantee of payment began	22. Date UR notice received

23. Date active care ended	24. Date benefits exhausted

25. Patient status

A. Date discharged	B. Date of death	C. ☐ Still patient

26. Lifetime reserve days used	27. Non-covered days	28. Covered days

30. Remarks:

PIP
(a) ☐

31. Reimbursement amount $

FOR INTERMEDIARY USE

32. Verified non-covered stays From	Thru	33. Non-pmt. code	34. Days used

35. Approved by	Date approved

29. I certify that the required physician's certification and recertifications are on file.

Signature of provider representative	Date received

HCFA-1453 (6) (10-74) (Formerly SSA-1453 (6))

INFORMATIONAL COPY

Department of Health, Education, and Welfare
Health Care Financing Administration

Exhibit #23

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
OMB No.
066-R-0017

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name	First name	MI	2. Health insurance claim number

3. Patient's address (*Street number, City, State, ZIP Code*)	4. Date of birth	5. Sex
	___ ___ | ___ ___ | ___ ___	☐ M ☐ F

6. Provider name and address (*City and State*)	7. Provider number	9. Type of service
	8. Medical record number	A. ☐ Inpatient C. ☐ Other (*Specify*) B. ☐ Outpatient

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 10 and 11.

10. Insuring organization and/or State agency name and address	11. Policy and/or medical assistance number

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

☐ Contained in provider's record	Signature (*Patient or authorized representative*) (*Signature by mark must be witnessed*)	Date

13. Nature of illness or injury	☐ Check here if illness or injury was connected with employment	Do not use this space

14. Surgical procedures	

Statement of services	Covered Charges		16. Statement Covers Period	First service	Last service
A. Clinic visit ( )				___ ___ | ___ ___ | ___ ___	___ ___ | ___ ___ | ___ ___
B. Emergency room ( )			17. Blood Information	A. Pints furnished	B. Pints replaced
C. Laboratory					
D. Radiology					
E. Pharmacy					
F. Blood					
G. Ambulance					
H. Physical therapy					
I. Other (*Specify*)					
J. TOTAL					

Not Replaced			
C. Pints	D. Charge per pint	E. Patient paid for deductible	

18. Professional component (hospital inpatients)		19. Other professional component
A. Pathology	B. Radiology	

20. Date benefits exhausted or HH plan terminated	21. Patient paid (Excluding 17E)
___ ___ | ___ ___ | ___ ___	

22. I certify that the required physician's certification is on file.	23. Date received
	___ ___ | ___ ___ | ___ ___

FOR INTERMEDIARY USE ONLY

24. Verified Patient Liability		
A. Blood deductible	B. Cash deductible	C. Coinsurance

25. Payment Distribution		26. Date approved
Provider	Patient	___ ___ | ___ ___ | ___ ___

Remarks:

Exhibit #24

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back — **Type or Print Information**)

Form Approved OMB No. 066-R-0012

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

Copy from YOUR OWN HEALTH INSURANCE CARD *(See example on back)* ➡

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number *(Include all letters)*

☐ Male ☐ Female

3 Patient's complete mailing address (including Apt. no.) City, State, ZIP Code

Telephone Number

4 Describe the illness or injury for which you received treatment *(Always fill in this item if your doctor does not complete Part II below)*

Was your illness or injury connected with your employment?

☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below

Name and address of organization or agency

Policy or Identification Number

Note: If you **Do Not** want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient *(See instructions on reverse where patient is unable to sign)*

SIGN HERE ➡

Date signed

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (if lab service, indicate if automated) — Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges (if related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*

Telephone No.

9 Total charges $

Physician or supplier code

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

☐ I accept assignment *(See reverse)* ☐ I do not accept assignment.

13 Name and address of person or facility where services were furnished *(Complete if outside your own office or patient's residence).*

14 Signature of physician or supplier (I certify that the statements under Physicians' Notes on the reverse apply to this bill and are made a part hereof.)

Date Signed

O—Doctor's Office IL—Independent Laboratory H—Patient's Home *(If portable X-ray services, identify the supplier)* IH—Inpatient Hospital SNF—Skilled Nursing Facility OH—Outpatient Hospital OL—Other Locations NH—Nursing Home

HOW TO FILL OUT YOUR MEDICARE FORM

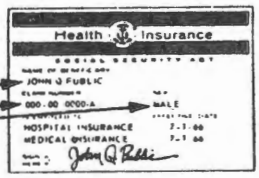
There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay the doctor directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge for covered services; you are responsible for the deductible, coinsurance, and non-covered services. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance.

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from the doctor, you may submit it rather than have the doctor complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, **the patient's name and number**, dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from any social security office.

Notice: It is important to keep a record of your claim in case you ever want to inquire about it. Before you send it in, write down the date you mailed it, the services you received, the date and charge for each, and the name of the doctor or supplier who performed the services. Have this information available when you inquire about a claim.

SOME THINGS TO NOTE IN FILLING OUT PART I
(Your doctor will fill out Part II.)



1 & **2** Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.

3 Enter your mailing address and telephone number, if any.

4 Describe your illness or injury. Be sure to check one of the two boxes.

5 If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

6 Be sure to sign your name. If you cannot write your name, sign by mark (X), and have the signature witnessed. The witness's signature and address must also be shown in item 6.
If you are filing the claim for a Medicare beneficiary, in item 6 enter the patient's name and write "By," sign your name and enter your address in this space, show your relationship to the patient, and explain why the patient cannot sign. (If the patient has died, the survivor should contact any social security office for information on what to do.)

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim 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 Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workmen's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

IMPORTANT NOTES FOR PHYSICIANS AND SUPPLIERS

Item 12: In assigned cases, the physician agrees to accept the charge determination of the Medicare carrier 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 carrier, if this is less than the charge submitted. If the physician or supplier does not want Part II information released to the organization named in item 5, the physician or supplier should write "No further release" in item 7C following the description of services.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare 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 employee, 2) there was a covered physician's service rendered of which the other services are an integral, although incidental part, 3) they must be of kinds commonly furnished in physicians' offices, and 4) the services of nonphysicians must be included on the physicians' bills.

Notice: Anyone 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.

Exhibit #25

Notice of Medicare Claim Determination

INTERMEDIARY NUMBER, NAME AND ADDRESS

DATE

YOUR HEALTH INSURANCE CLAIM NUMBER

☐ HOSPITAL INSURANCE ☐ MEDICAL INSURANCE

DATE OF ADMISSION OR FIRST VISIT _____

TYPE OF SERVICE PROVIDED	SERVICES PROVIDED BY	NOTICE COVERS PERIOD	
	PROVIDER NUMBER _____	FROM	THROUGH
☐ HOSPITAL ☐ SKILLED NURSING FACILITY ☐ HOME HEALTH AGENCY ☐ OTHER _____			

This concerns the services you received from the facility shown above. Medicare cannot pay for the above services for the following reason:

If you have any questions about this notice, you should first get a detailed explanation from your social security office. If you still believe the determination is not correct, you may make a request for reconsideration for Hospital insurance (or a review for Medical insurance). But you must file your request within 60 days from the date of receipt of this notice. You may make the request through your social security office.

Exhibit #26

Notice of Medicare Claim Determination

Intermediary Number, Name and Address

Date

Your Health Insurance Claim No.

Services Provided By: *(Name and Address)*

Provider Number

Type of Service Provided	Date of Admission or First Visit	NOTICE COVERS PERIOD	
		FROM	THROUGH
☐ Hospital ☐ Skilled Nursing Facility	Insurance		
☐ Home Health Agency ☐ Other _____	☐ Hospital ☐ Medical		

This concerns the services you received from the facility shown above. Medicare cannot pay for part of these services for the following reason:

Important: See other side for an explanation of your appeal rights and other information.▶

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Exhibit #27

STATEMENT OF INCOME AVAILABLE FOR LONG TERM CARE FACILITY PAYMENT

Please Print or Type

PATIENT NAME _____ _____
Last First M.I. County Welfare Agency

HEALTH SERVICES PROGRAM CASE NUMBER _ _ _ _ _ _ _ _ _ _ _ PERSON NUMBER _ _

_____ _____
Name of Long-Term Care Facility Facility Address

INSTRUCTIONS: THIS FORM IS TO BE PREPARED FOR ALL CASES, IN EITHER OF THE SITUATIONS LISTED BELOW. CHECK THE APPROPRIATE BOX.

☐ (A) WHEN A CLIENT ENTERS A MEDICAID PARTICIPATING LONG TERM CARE FACILITY.
☐ (B) WHEN A CHANGE OCCURS IN THE AMOUNT OF INCOME AVAILABLE FOR PAYMENT TO A MEDICAID FACILITY.

DISTRIBUTION: A COPY FOR COUNTY WELFARE AGENCY; THE COPIES FOR BUREAU OF CLAIMS AND ACCOUNTS, LONG TERM CARE FACILITY, RECIPIENT, AND LMAU ARE TO BE SENT TO THE LMAU WHICH HAS AUTHORIZED LONG TERM CARE.

IS CLIENT ENROLLED IN SMI PART B MEDICARE BUY-IN GROUP? ( ) YES ( ) NO

SOURCE OF INCOME	HEALTH INSURANCE CLAIM NUMBER, IF APPLICABLE	GROSS MONTHLY BENEFIT
SOCIAL SECURITY BENEFITS _ _ _ _ _ _ _ _ _ SOCIAL SECURITY NUMBER	_ _ _ _ _ _ _ _ _ _ _ _ SUFFIX NET SOCIAL SECURITY BENEFIT PLUS SMI DEDUCTION OF $ _____ EQUALS GROSS BENEFITS	
RAILROAD RETIREMENT		
VETERAN'S ADMINISTRATION		
OTHER (IDENTIFY)		

PRINT OR TYPE NAME AND ADDRESS OF ANY INDIVIDUAL RECEIVING ANY OF THE ABOVE INCOME ON BEHALF OF THE CLIENT, e.g., REPRESENTATIVE PAYEE, GUARDIAN, ETC.

Name and Address:

Name and Address:

A. TOTAL INCOME .....

EXEMPT INCOME	MONTHLY AMOUNT
PERSONAL NEEDS ALLOWANCE	$ 25.00
MAINTENANCE OF SPOUSE (MAA AND MA)	
MAINTENANCE OF SPOUSE AND/OR DEPENDENT CHILDREN (MA ONLY)	
MAINTENANCE OF A HOME (MA ONLY)	
OTHER (IDENTIFY): _____	

B. TOTAL EXEMPT INCOME .....

C. BASIC INCOME AVAILABLE FOR LONG TERM FACILITY CARE (A MINUS B) .....

D. MONTH IN WHICH BASIC INCOME WILL BE AVAILABLE FOR PAYMENT TO FACILITY _____
Month Year

E. ADJUSTED BASIC INCOME OF $ _____, ONLY FOR MONTH(S) OF _____
FOR THE PURPOSE OF (e.g., IDENTIFY SMI PREMIUM DEDUCTION PRIOR TO BUY-IN ACCRETION): _____

NOTE: Income Available for Long Term Facility Care Must be Submitted to the LTC Facility Each Month on a Regular Basis.

_____ _____ _____ _____
I. M. WORKER'S SIGNATURE DATE SUPERVISOR'S SIGNATURE DATE

FORM PA-3L (Rev. 6/78) COUNTY WELFARE AGENCY

Exhibit #28

FORM PA-4
(REV. 4/78)

CERTIFICATION OF NEED FOR PATIENT CARE IN FACILITY OTHER THAN PUBLIC OR PRIVATE GENERAL HOSPITAL

To be completed by Public Assistance Agency _____
(Identify Agency)

Case Name _____ County Registration No. _____

Home Address _____
(Street) *(Municipality)* *(County)*

Health Services Program Case No. _____ *(10 Digits)* Person No. _____ *(2 Digits)* Date of Eligibility _____

Birth Date (or age) _____ Sex: M F *(Circle correct letter)* Veteran: Yes No *(Circle correct word)* Medicare No. _____ *(If applicable)*

Describe Current Living Arrangement _____

If in an Institution, Name _____ Admission Date _____

CERTIFICATION OF PHYSICIAN

This is to certify that the above named individual requires patient care for the chronically ill because:

1. *Diagnosis* (complete) _____

2. *Medication and/or treatment* _____

3. *Other therapy contemplated* _____

4. *Functional capacity of the patient:*

	Independent	Needs Assistance	Potential for Independence	Comments
a. Bathing and personal hygiene				
b. Dressing				
c. Eating				
d. Toiletry				
e. Communication				
f. Ambulation				
g. Nursing care				

5. *Instructional needs*
   - a. ( ) Teaching for independence in activities of daily living.
   - b. ( ) Self-administration of drugs and medications.
   - c. ( ) Diet and nutrition.
   - d. ( ) Self care for special condition; e.g. colostomy, etc.
   - e. ( ) Understanding medical condition.
   - f. ( ) Prevention, care and treatment or complications.
   - g. ( ) Counseling; emotional and motivational support.

6. *Emotional, behavior or social problems (explain):* _____

7. *Characteristics of major disability:* ( ) Static or stable ( ) Progressive ( ) Improving

8. *Is patient now receiving any medication or treatment?* ( ) Yes ( ) No (If "Yes," give details.) _____

9. *Is surgery or other therapy contemplated?* ( ) Yes ( ) No (If "Yes," give details.) _____

10. *Is care in nursing home or public medical institution NOW necessary?* ( ) Yes ( ) No

11. *If "Yes," in question 10, is future discharge contemplated?* ( ) Yes ( ) No

12. *Could patient be adequately cared for now in a facility providing a lower level of care than that provided by a skilled nursing home?* ( ) Yes ( ) No

13. *Could this patient be adequately cared for NOW in boarding home?* ( ) Yes ( ) No
    His own home? ( ) Yes ( ) No *Other facility?* (Describe) _____

14. *I further certify that, in my opinion, this patient does not require treatment for:*
    ( ) *A mental disease, defect or impairment in an institution for the mentally ill or mentally deficient.*

_____, M.D. Date _____

Exhibit #29

New Jersey State Department of Human Services

COST STUDY FOR LONG TERM CARE FACILITY

HES-11
Dec. 77

SCHEDULE 1

Provider Number	Name of Facility	Tel. No. - Area Code

Our latest natural 12 month reporting period was _____ 19___ to _____ 19___. No. Months _____

GENERAL ADMINISTRATIVE INFORMATION
(Check all blocks applicable)

A. TYPE OF FACILITY

1. ☐ Hospital
2. ☐ Long Term Care Facility:
   - ☐ Skilled
   - ☐ ICF A
   - ☐ ICF B
3. ☐ Nursing Unit in Home for Aged
4. ☐ Residential Unit
5. ☐ Public Medical Institution
6. ☐ Other - Specify: _____

B. TYPE OF OWNERSHIP

1. ☐ Proprietary
2. ☐ Voluntary
3. ☐ Governmental
4. ☐ Other - Specify: _____

	Building	Land
Owned by Operator	5. ☐	8. ☐
Leased from Related Organization	6. ☐	9. ☐
Leased from Unrelated Organization	7. ☐	10. ☐

Name of Licensee Corporation Owning Facility _____

Name of Organization Operating Facility _____

Was there a change in ownership during reporting period? ☐ Yes ☐ No

If yes, explain: _____

These documents have been prepared by the Department of Human Services in conjunction with the Department of Health.

WHITE COPY to accom, any patient.
YELLOW COPY for institution's file.

REPRESENTATIVE SAMPLE

Exhibit #30

PATIENT INFORMATION TRANSFER FORM

HOSPITAL AND NURSING HOME

This form has been adopted by the Boards of Trustees of the New Jersey Hospital Association and the New Jersey Nursing Home Association

NAME ....
Last First Middle

ADDRESS .....

.....

Social Security No..... S M W D

Health Insurance Claim No.....

Birth Date..... Sex..... Religion.....

Relative or Sponsor .....
Relationship

Address .....

Home Phone..... Business Phone.....

TRANSFERRED FROM:

.....

.....
Address

Date Admitted..... Date Discharged.....

TRANSFERRED TO:

.....

.....
Address

Date Admitted.....

Physician in Charge at Time of Transfer ..... M. D.

Address ..... Phone No.....

Will this physician care for patient after transfer? .....

PRIMARY DIAGNOSIS: .....

Other Diagnoses:.....

Does patient know diagnosis? .....

IMPORTANT MEDICAL INFORMATION

DISABILITIES
- ☐ Amputation
- ☐ Paralysis
- ☐ Contracture
- ☐ Decub. Ulcer

INCONTINENCE
- ☐ Bladder
- ☐ Bowel
- ☐ Saliva

IMPAIRMENTS
- ☐ Mentality
- ☐ Speech
- ☐ Hearing
- ☐ Vision
- ☐ Sensation

ACTIVITY TOLERANCE LIMITATIONS
- ☐ None
- ☐ Moderate
- ☐ Severe

BEHAVIOR
- ☐ Alcoholic
- ☐ Senile
- ☐ Belligerant
- ☐ Withdrawn
- ☐ Suspicious
- ☐ Noisy

MENTAL STATUS
- ☐ Alert
- ☐ Confused
- ☐ Forgetful

Catheter in place at time of transfer? ....Yes ....No

Allergies: .....

Chest X-ray	date.....	result.....
C.B.C.	date.....	result.....
Serology	date.....	result.....
Urinalysis	date.....	result.....

Other .....

.....

DIET, DRUGS, AND OTHER THERAPY At Time of Discharge

SOCIAL INFORMATION (Adjustment to disability, emotional support from family, motivation for self care, socializing ability, financial plan, family health problem, etc.)

COMMUNICATION ABILITY

	Yes	No
Can speak	☐	☐
Can write	☐	☐
Understands speaking	☐	☐
Understands writing	☐	☐
Understands gestures	☐	☐
Understands English	☐	☐

If no, state language spoken:

.....

ACTIVE CARE AT TIME OF DISCHARGE

BED

Positioned in good body alignment and changed position every ..... hours.

Avoided ..... position.

Prone positioned ..... times/day as tolerated.

DE RAILS?

.....Yes .....No

SIT IN CHAIR

..... hours ..... times/day.

WEIGHT BEARING

Full..... Partial..... None.....

on ..... leg.

LOCOMOTION

Walk ..... times/day.

EXERCISES

Range of motion ..... times/day

to .....

by patient .....

nurse .....

family .....

Stand .....

minutes .....

times/day .....

PATIENT'S AUTHORIZATION: I hereby grant permission to release the above information.

..... Signature of Patient or Sponsor

Signature of Physician or Nurse ..... Date .....

LONG TERM CARE SERVICES MANUAL

APPENDIX A

LIST OF SPECIAL HOSPITALS

ATLANTIC COUNTY
Betty Bacharach
Rehabilitation Center - Class B
Jim Leeds Road
Pomona, 08240

Children's Seashore House - Class B
4100 Atlantic Avenue
Atlantic City, 08401

BURLINGTON COUNTY
Deborah Hospital - Class A
Trenton Road
Browns Mills, 08015

CAMDEN COUNTY
Camden County General Hospital
Geriatric Rehab. Unit - Class B*
and Class C**
P. O. Blackwood
Lakeland, 08012
* Floors 2 & 3
** Floors 4, 5 & 6

ESSEX COUNTY
Kessler Institute for Rahab. - Class B
1199 Pleasant Valley Way
West Orange, 07052

New Jersey Rehab. Center - Class B
(formerly Kim Institute)
240 Central Avenue
East Orange, 07018

United Hospitals Orthopedic Center
for Crippled Children and Adults - Class A
98 Park Avenue
Newark, 07104

HUDSON COUNTY
Jewish Hospital & Rehabilitation
Center - Class B * and Class C
198 Stevens Avenue
Jersey City, 07305
* Bldg. #5, New Wing

MIDDLESEX COUNTY
Robert Wood Johnson Rehabilitation
Hospital - Class B
James Street
Edison, 08817

Roosevelt Hospital - Class B
P.O. Box 151
Metuchen, 08840

Roosevelt Hospital Annex

MOORIS COUNTY
Alan Welkind Neurological Hospital -
Class B
Pleasant Hill Road
Chester, 07930

OCEAN COUNTY
Garden State Rehab. Hosp. - Class B
and Garden State Conval. Center - Class C
14 Hospital Drive
Toms River, 08753

SOMERSET COUNTY
Matheny School - Class C
Main Street
Peapack, 07977

UNION COUNTY
John E. Runnells Hospital of Union
County - Class B* and Class C
Bonnie Burn Road
Berkeley Heights, 07922
* Rehab. Unit

Children's Specialized Hospital - Class B
New Providence Road
Westfield - Mountainside, 07091

PROCEDURE CODES - HOME/NURSING HOME VISITS

MEDICINE

		Medicaid Dollar Value	
		Spec.	Non-Spec.
	HOME/NURSING HOME VISITS INCLUDING SHELTERED BOARDING HOMES		
9010	INITIAL HOME OR NURSING HOME VISIT, new patient to include each of the following: 1. A complete history of the present illness and related systemic review including recording of negative findings 2. A complete past medical history 3. A complete family history 4. A physical examination pertaining to, but not limited to the history of the present illness including recording of negative findings 5. A working diagnosis and treatment plan Minimum average time thirty (30) minutes. No more than one initial home visit is reimbursable per year for the same recipient by the same physician. Procedure code 9010 will be disallowed if procedure codes 9000, 9001, 9008, 9011, 9020, 9026, 9029, 9030 or 9580 have been performed during the prior 12 months by this same physician.	21.	16.
9011	INITIAL HOME VISIT, COMPREHENSIVE, New patient to include each of the following: 1. A comprehensive history of the present illness 2. A complete past medical history 3. A complete family and social/personal history 4. A detailed systemic review including recording of negative findings 5. A comprehensive total system physical examination permitting deferment or omission of one system and including recording of negative findings 6. A complete diagnosis and treatment plan including confirmatory and differential diagnostic procedures recommended Minimum average time is sixty (60) minutes. No more than one comprehensive, initial home visit is reimbursable per year for the same recipient by the same physician. Procedure code 9011 will be disallowed if procedure codes 9000, 9001, 9010, 9020, 9026, 9029, 9008, 9030 or 9580 has been performed during the prior 12 months by this same physician. A copy of the examination must be included with the MC-8 claim form.	26.	21.

APPENDIX B

(PHYSICIANS FEE SCHEDULE)

PROCEDURE CODES - HOME/NURSING HOME VISITS

MEDICINE

		Medicaid Dollar Value		
		Spec.	Non-Spec	
0002	FOLLOW-UP HOME VISIT involving routine care and treatment by the physician and including significant progress notes on office record which describe patient's progress with positive findings and treatment changes recorded. Minimum average time is fifteen (15) minutes.	11.55 10.50 10.50	9.45 8.40 8.40	Area I " " I
9012	FOLLOW-UP HOME VISIT involving routine care and treatment by the physician and including significant progress notes on office record which describe patient's progress with positive findings and treatment changes recorded. Minimum average time is fifteen (15) minutes.	NA		
9083	FOLLOW-UP SKILLED NURSING FACILITY VISIT use when the claim indicates the visit was to see only one patient. This is a single visit involving routine care and treatment by the physician and including significant progress notes on SNF records which describe patient's progress with positive findings and treatment changes recorded. Minimum average time if 15 minutes.	NA		
9084	GANG SKILLED NURSING FACILITY VISIT to be used for SNF visits unless claim indicates otherwise.	NA		
9085	"SPECIAL" OR "ACUTE" SKILLED NURSING FACILITY VISIT to be used only when the claim specifies the visit was due to a "Special" or "Acute" situation.	NA		
0004	FOLLOW-UP NURSING HOME VISIT involving routine care and treatment including those procedures ordinarily performed during an office visit by the physician and including significant progress notes or nursing home records which describe patient's progress with positive findings and treatment changes recorded. Minimum of average time is fifteen (15) minutes.	12.60 11.55 10.50	10.00 9.45 9.45	Area I " " I
9013	FOLLOW-UP NURSING HOME VISIT use when the claim indicates the visit was to see only one patient. This is a single visit involving routine care and treatment by the physician and including significant progress notes on nursing home records which describe patient's progress with positive findings and treatment changes recorded. Minimum average time is 15 minutes.	NA		
9014	BRIEF FOLLOW-UP NURSING HOME VISIT involving routine care and treatment including those procedures ordinarily performed during an office visit by the physician and including significant progress notes on nursing home records which describe patient's progress with positive findings and treatment changes recorded. Minimum average time is ten (10) minutes.	8.00	6.00	

APPENDIX B

(PHYSICIANS FEE SCHEDULE)

PROCEDURE CODES - HOME/NURSING HOME VISITS

MEDICINE		Medicaid Dollar Value	
		Spec.	Non-Spec.
9015	GANG NURSING HOME VISIT to be used for Nursing Home visit unless claim indicates otherwise.	NA	
9016	FOLLOW-UP NURSING HOME VISIT PROLONGED involving 30 or more minutes of physician's personal time in patient contact including documentation on record as well as adequate significant progress note on the chart.	16.	14.
9017	"SPECIAL" OR "ACUTE" NURSING HOME VISIT to be used only when the claim specifies the visit was due to a "Special" or "Acute" situation.	NA	
9018	HOME VISIT each additional member of the same household with documentation of significant findings on the office record.	5.	5.