CHAPTER 63

LONG–TERM CARE SERVICES

Authority

N.J.S.A. 30:4D–6a(4)(a) and b(14); 30:4D–6.7 and 6.8; 30:4D–7, 7a, b and c; 30:4D–12; Section 1919 of the Social Security Act; 42 U.S.C. § 1396r; 42 C.F.R. 483; and P.L. 1985, c.303.

Source and Effective Date

R.1999 d.364, effective September 24, 1999.
See: 31 N.J.R. 1759(a), 31 N.J.R. 3116(a).

Executive Order No. 66(1978) Expiration Date

Chapter 63, Long–Term Care Services, expires on September 24, 2004.

Chapter Historical Note

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

Chapter 63, Skilled Nursing Home Services Manual, was repealed and Chapter 63, Long–Term Care Services Manual, was adopted as new rules by R.1979 d.126, effective March 29, 1979.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

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

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

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

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was readopted as R.1994 d.624, effective November 23, 1994, and former Subchapters 1, 2, 2A and 4, and Appendix I were repealed and Subchapter 1, General Provisions, Subchapter 2, Nursing Facilities Services, and Appendices A through Q were adopted as new rules, and Subchapter 5,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

Pursuant to Executive Order No. 66(1978), Chapter 63, Long–Term Care Services, was readopted as R.1999 d.364, effective September 24, 1999. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:63–1.1 Scope

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible children and adults in a nursing facility (NF) and addresses the provision of and reimbursement for services required to meet the individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. Although the scope of the Long–Term Care Services chapter encompasses other long-term care facilities such as governmental psychiatric hospitals, inpatient psychiatric services/programs for the under 21 (residential treatment centers) and intermediate care facilities/mentally retarded (ICF/MRs), the following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement applies to all the above cited long-term care facilities.

Case Notes

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

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

10:63–1.2 Definitions

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

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

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

"Case management" means a process by which the Division of Medical Assistance and Health Services Medical Social Care Specialist monitors the provision of nursing facility care to assure timely and appropriate provider responses to changes in care needs and delivery of coordinated services.

"Case mix" means a system of staffing and reimbursement for nursing services based on variation in patient acuity and care needs that influences the type and amount of service needed.

"Clinical audits" means a method of utilization control under the enforcement authority of Section 1902(a)(30)(A) of the Social Security Act, in accordance with 42 CFR 456.1(b)(1), to monitor the utilization of and payment for nursing facility care and services reimbursable under the Medicaid State Plan.

"Comprehensive assessment" means a process conducted by each member of the interdisciplinary team which, for each resident, identifies problems; determines care needs; and in conjunction with the resident and his or her significant other or legal representative, results in an interdisciplinary plan of care.

"Consultant pharmacist" means a pharmacist licensed by the New Jersey State Board of Pharmacy who meets the qualifications in N.J.A.C. 10:51–3.3.

"Conventional nursing facility"—see nursing facility.

"Department of Health" (DOH) means the New Jersey State Department of Health.

"Division of Developmental Disabilities (DDD)" means the Division of Developmental Disabilities within the New Jersey State Department of Human Services.

"Division of Mental Health and Hospitals (DMH & H)" means the Division of Mental Health and Hospitals within the New Jersey State Department of Human Services.

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared by the Regional Staff Nurse during the Pre-Admission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

"Interdisciplinary care plan" means the care plan developed by the interdisciplinary team which includes measurable objectives and time tables to meet the resident's medical, nursing, dietary and psychosocial needs that are identified through the comprehensive assessment process.

"Interdisciplinary team" means a team consisting of a physician and a registered professional nurse and may also include other health professions relative to the provision of needed services. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

"Low airloss therapy bed" means a bed frame that is equipped with air sacs which are grouped into zones corresponding to various body areas. The air sacs are inflated by a constant flow of air, some of which is directed through the air sacs to the patient surface.

"Medicaid occupancy level" means the average number of Medicaid recipients and recipients of public assistance under P.L.1947, c. 156, as amended (C44.8–107 et seq.) residing in a NF divided by the total number of licensed beds in the facility during the billing month.

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

"Medical evaluation team (MET)" means a team of Medicaid professionals consisting of a physician consultant, a regional staff nurse (RSN), a regional pharmaceutical consultant, a Medical Social Care Specialist I (MSCS I) and a Medical Social Care Specialist II (MSCS II) who are assigned to the Medicaid District Office (MDO). A MET has the responsibility to review medical, nursing, and social information 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. Members of the MET may review each recipient or potential recipient as individual team members or may perform the review as a multidisciplinary team.

"Medical social care specialist (MSCS)" means a social worker employed by the Division of Medical Assistance and Health Services who performs case management as required by N.J.A.C. 10:63.

"Medical staff" means one or more licensed physicians who act as the attending physician(s) to Medicaid recipients in a nursing facility.

"Minimum data set (MDS)" means a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing facility resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24–hour basis to Medicaid recipients (children and adults) who, due to medical disorders, developmental disabilities and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for care and treatment of mental diseases which require continuous 24–hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

"Occupational therapist" means a person who is registered by the American Occupational Therapy Association, 1383 Piccard Drive, P.O. Box 1725, Rockville, MD 20849–1725, or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

"Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and the American Physical Therapy Association, 1111 N. Fairfax St., Alexandria, VA 22314 or its equivalent; and if practicing in the State of New Jersey, is licensed by the State of New Jersey, or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable, and also meets all applicable Federal requirements.

"Physician's services" means those services provided within the scope of medical practice 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 services which are rendered in the physician's presence.

"Pre-admission screening (PAS)" means that process by which all Medicaid eligible recipients seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF receive a comprehensive needs assessment by the Regional Staff Nurse to determine their long-term care needs and the most appropriate setting for those needs to be met, pursuant to N.J.S.A. 30:4D–17.10. (P.L.1988, c. 97).

"Pre-admission screening and annual resident review (PASARR)" means that process by which all individuals with mental illness (MI) or mental retardation (MR) are screened prior to admission to a NF and annually thereafter in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition.

"Prior authorization" means approval granted by the Division of Medical Assistance and Health Services through the appropriate Medicaid District Office (MDO) for payment for NF or before other Medicaid covered services are rendered to a Medicaid recipient, in accordance with this chapter.

"Regional staff nurse (RSN)" means a registered professional nurse employed by the Division of Medical Assistance and Health Services who performs health needs assessments as required by this chapter.

"Rehabilitative and/or restorative nursing care" means nursing care provided by a registered professional nurse, or under the direction of a registered professional nurse, qualified by experience in rehabilitative or restorative nursing care.

"Rehabilitative services" means physical therapy, occupational therapy, speech-language pathology services, and the use of such supplies and equipment as are necessary in the provision of such services.

"Resident" means a Medicaid eligible or potentially eligible recipient residing in an NF.

"Respiratory care practitioner" means an individual credentialed by the State Board of Respiratory Care, to practice respiratory care under the direction or supervision of a physician pursuant to State of New Jersey P.L.1971, c. 60; P.L.1974, c. 46; and P.L.1978, c. 73, amended August 1991.

"Section Q" means the resident classification portion of the standardized resident assessment (SRA) instrument which identifies an individual NF resident's nursing service requirements based on the standards at N.J.A.C. 10:63–2.2(a).

"Skilled nursing facility (SNF)" means a free-standing institution or an identifiable part of an institution which meets all the State and Federal requirements for participation in the Medicare Program as a skilled nursing facility.

"Social services" means those services provided to meet the emotional and social needs of the Medicaid recipient and significant other or guardian at the time of admission, during treatment and care in the facility, and at the time of discharge.

"Special care nursing facility (SCNF)" means a NF or separate and distinct unit within a Medicaid certified conventional NF which has been approved by the Division of Medical Assistance and Health Services to provide care to New Jersey Medicaid recipients who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. 10:63–2, Nursing Facility Services.

"Specialized services for mental illness (MI)" mean those services offered, in accordance with 42 CFR 483.120, when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based on a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24–hour supervision for the individual, specific therapies and activities are prescribed, with the following objectives: to diagnose and reduce behavioral symptoms; to improve independent functioning; and as early as possible, to permit functioning at a level where less than specialized services are appropriate. Specialized services go beyond the range of services which a NF is required to provide.

"Specialized services for mental retardation (MR)" mean those services offered, in accordance with 42 CFR 483.120, when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills. Specialized services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an intermediate care facility for the mentally retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is required to provide.

"Speech-language pathologist" means a person who has a certificate of clinical competence from the American Speech and Hearing Association; meets all applicable Federal regulations; has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate, and, if practicing in the State of New Jersey is licensed by the State of New Jersey; or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable.

"Standardized Resident Assessment (SRA)" means an instrument developed by the State to report minimum data set requirements, including resident assessment protocols and additional State mandated data, which results in a comprehensive, standardized assessment of a NF resident's functional capabilities and service requirements.

"Track of care" means the designation of the setting and scope of Medicaid services determined by the PAS process conducted by the RSN following assessment of the Medicaid eligible or potentially eligible Medicaid recipient, as follows:

1. "Track I" means long-term NF care.
2. "Track II" means short-term NF care.
3. "Track III" means long-term care services in a community setting.

"Waiting list" means the standardized listing, maintained in chronological order by the NF, of the names of all individuals seeking admission to a Medicaid participating NF who have completed a written application.

Case Notes

County hospital which did not participate in pre-adoption rulemaking proceedings is not entitled to an agency or court hearing to explore reasons underlying regulations prescribing methodology for fixing rates paid for Medicaid patient care at long-term care facility; regulations not arbitrary or unreasonable. Bergen Pines County Hospital v. New Jersey Dept. of Human Services, 96 N.J. 456, 476 A.2d 784 (1984).

Adoptive parents who provided outstanding care for medically fragile child should not have been punished by having child removed from necessary community based services waiver program. K.S. v. DMAHS, 96 N.J.A.R.2d (DMA) 7.

Conditions of blindness and profound retardation established appropriateness of residential long-term pediatric care placement. N.C. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 34.

Presumption of reasonableness of agency's rate methodology not rebutted by sufficient evidence; burden of proof improperly shifted to agency at hearing (Director's Final Decision). Morris View Nursing Home v. Div. of Medical Assistance and Health Services, 8 N.J.A.R. 561 (1983), affirmed per curiam Dkt. No. A–973–83 (App.Div.1985).

Rate reimbursement system challenged by facility utilizing minimum staffing report prepared for other purposes by the Department of Health; Division of Medical Assistance and Health Services not bound by Department of Health determinations; denial of increased rate reimbursement not unreasonable agency action. In re: Preakness Hospital, 8 N.J.A.R. 389 (1983).

i. These calculations shall not include the "six month" acuity adjustment of rates for patient mix;

2. Determine the difference between the corresponding single salary region per diem reimbursement rate(s) for the period from July 1, 1992 to June 30, 1993 (excluding the acuity adjustment of rates) and the per diem rate(s) as calculated in (b)1 above;

3. Multiply the per diem rate difference(s) from (b)2 above by the number of the facility's Medicaid patient days paid (allocated to the applicable rate periods if appropriate) for the period from July 1, 1992 to June 30, 1993;

4. From the sum determined in (b)3 above deduct the amount of $55,000;

5. Divide the remainder from (b)4 above by four; and

6. Divide the quotient from (b)5 above by the total number of the facility's Medicaid patient days paid for the period from April 1, 1993 to June 30, 1993.

(c) The resulting per diem amount shall be paid as an add-on to each eligible facility's routine prospective rate for a three month period commencing July 1, 1993.

New Rule, R.1994 d.213, effective May 2, 1994.
See: 26 N.J.R. 894(a), 26 N.J.R. 1840(a).

10:63–3.23 Transitional relief for salary region adjustment; State Fiscal Year 1994

(a) In order to provide transitional relief for those nursing facilities most negatively impacted by the adjustment to a single Statewide salary region which began July 1, 1992, a rate adjustment shall be made for qualifying facilities. Nursing facilities which incurred reductions in Medicaid reimbursement in excess of $55,000 for services provided to Medicaid recipients during State fiscal year 1994 (July 1, 1993 to June 30, 1994), as a result of the implementation of the single Statewide salary region, shall receive a per diem rate adjustment.

(b) Facilities shall be reimbursed the annual reduction of Medicaid reimbursement in excess of $55,000 for the period effective July 1, 1993 to June 30, 1994. The per diem add-on shall be calculated for each facility as follows:

1. Determine for each facility the prospective or interim to actual per diem rate(s) for the period from July 1, 1993 to June 30, 1994 using the salary region system effective prior to July 1, 1992;

i. These calculations shall not include the "six month" acuity adjustment of rates for patient mix;

2. Determine the difference between the corresponding single salary region per diem reimbursement rate(s) for the period from July 1, 1993 to June 30, 1994 (excluding the acuity adjustment of rates) and the per diem rate as calculated in (b)1 above;

3. Multiply the per diem rate difference(s) from (b)2 above by the number of the facility's Medicaid patient days paid (allocated to the applicable rate periods if appropriate) for the period from July 1, 1992 to June 30, 1993;

4. From the sum determined in (b)3 above deduct the amount of $55,000; and

5. Divide the remainder from (b)4 above by the total number of the facility's Medicaid patient days paid for the period from July 1, 1992 to June 30, 1993.

(c) The resulting per diem amount shall be paid as an add-on to each eligible facility's routine prospective rate for a 12–month period commencing July 1, 1993.

New Rule, R.1994 d.213, effective May 2, 1994.
See: 26 N.J.R. 894(a), 26 N.J.R. 1840(a).

10:63–3.24 Transitional relief for salary region adjustment; State Fiscal Year 1995

(a) In order to provide transitional relief for those nursing facilities most negatively impacted by the adjustment to a single statewide salary region which began July 1, 1992, a rate adjustment will be made for qualifying facilities. Nursing facilities which are expected to incur reductions in Medicaid reimbursement in excess of $27,500 for services to be provided to Medicaid recipients for the period July 1, 1994 to December 31, 1994, as a result of the implementation of the single statewide salary region, will receive a prospective per diem rate adjustment.

(b) Facilities will be reimbursed the six-month reduction of Medicaid reimbursement in excess of $27,500 for the period effective July 1, 1994 to December 31, 1994. The per diem add-on will be calculated for each facility as follows:

1. Determine for each facility the prospective or interim to actual per diem rate(s) for the period from July 1, 1994 to December 31, 1994 using the salary region system effective prior to July 1, 1992;

i. These calculations will not include the (six month) acuity adjustment of rates for patient mix.

2. Determine the difference between the corresponding single salary region per diem reimbursement rate(s) for the period from July 1, 1994 to December 31, 1994 (excluding the acuity adjustment of rates) and the per diem rate as calculated in (1) above;

3. Multiply the per diem rate difference(s) from (b)2 above by the number of the facility's Medicaid patient days paid (allocated to the applicable rate periods if appropriate) for the period from July 1, 1993 to December 31, 1993;

4. From the product determined in (b)3 above deduct the amount of $27,500;

5. Divide the remainder from (b)4 above by the total number of the facility's Medicaid patient days paid for the period from July 1, 1993 to December 31, 1993;

6. Multiply the quotient by six;

7. Divide the product by five.

(c) The resulting per diem amount will be as an add-on to each eligible facility's routine prospect rate for a five month period commencing August 1, 1994.

New Rule, R.1994 d.624, effective January 3, 1995.
See: 26 N.J.R. 3614(a), 27 N.J.R. 156(a).

SUBCHAPTER 4. AUDIT

10:63–4.1 Audit cycle

(a) Any cost study submitted by a Medicaid participating nursing facility (NF) which is selected for audit on or after February 7, 1983 may be audited within three years of the due date of the cost report or the date it is filed, whichever is later. This requirement shall be satisfied if the on-site audit of the NF is initiated within the three-year period and completed within a reasonable time thereafter. If a NF audit is not initiated within this time limit, the appropriate cost study or cost studies shall be excluded from the audit, subject to the conditions set forth in the balance of this subsection and the waiver provisions set forth in (b) below. Exclusion is subject to the following conditions:

1. Failure to initiate a timely audit shall not preclude the Division from collecting overpayments, interest or other penalties if the overpayments are identified by an agency other than the Division.

2. When a timely audit is conducted and additional overpayments are discovered by another agency, the Division shall not be precluded from collecting such overpayments together with any applicable interest or other penalties.

(b) The Division shall not be precluded from waiving the three-year limitation for good cause, and good cause shall include, but not be limited to, the following circumstances:

1. The overpayments involved in the audit were generated as a result of fraudulent activity by the NF or NF-related party, whether or not that fraudulent activity has been the subject of a criminal investigation and/or prosecution;

2. The NF, its agents or employees have failed to cooperate in the initiation or conduct of the audit;

3. The Division could not have reasonably discovered by audit any evidence of the overpayment within the three-year period;

4. The audit could not be initiated within the three-year period because of delay or cessation of the audit resulting from a request by a law enforcement agency or an administrative agency with jurisdiction over the facility.

i. This provision shall not apply if the NF's records are available and no request for delay or cessation of the audit has been made by any of these agencies.

(c) Notice must be given to the NF when the three year requirement is waived together with the reasons for such action. The NF may request a hearing on any waiver by the Division to the extent authorized by applicable statutes, rules and regulations.

Amended by R.1981 d.23, effective February 1, 1981.
See: 12 N.J.R. 701(b), 13 N.J.R. 146(a).
Administrative change, recodified from N.J.A.C. 10:63–1.21.
See: 24 N.J.R. 3728(b).
Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).
See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

10:63–4.2 Audits

(a) For the exclusive purpose of calculating interest, under N.J.S.A. 30:4D–17(f), "completion of the field audit" for nursing facility providers shall be defined in the following manner:

1. For all such audits and audit recovery cases pending on February 7, 1983, it shall mean the date that field work is completed, or the date information requested from the provider during the course of that field work is received, whichever is later;

2. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other agency for criminal investigation, it shall mean the date the Office of Program Integrity Administration (OPIA) receives authorization to take administrative action.

3. For all such audits initiated on or after February 7, 1983, it shall mean the date the exit conference is completed or the date information requested from the provider during the course of the exit conference is received, whichever is later.

(b) Notwithstanding any of the previous subsections, if after the screening of any nursing facility provider audit the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires additional field work, for the exclusive purpose of calculating interest under N.J.S.A. 30:4D–17, the field audit shall be considered completed when the additional field work is completed.

(c) Notwithstanding any of the previous subsections, if after the screening of any nursing facility provider audit the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall, for the exclusive purpose of calculating interest, be considered reopened and interest shall again accrue for the period beginning 20 days from the date that the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.

(d) Notwithstanding any of the previous subsections, if all or part of any nursing facility provider audit initiated on or after the effective date of this subsection is referred to the Division of Criminal Justice or other agency for criminal investigation:

1. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation;

2. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OPIA receives authorization to take administrative action.

Amended by R.1983 d.5, effective February 7, 1983 (operative March 1, 1983).
See: 14 N.J.R. 1031(a), 15 N.J.R. 155(a).
Amended by R.1985 d.177, effective April 15, 1985.
See: 16 N.J.R. 2413(a), 17 N.J.R. 966(a).
(a)2 added; (a)2 recodified to (a)3.
Correction: (a)3 was inadvertently omitted from code. It has been added.
See: 18 N.J.R. 1205(c).
Administrative change, recodified from N.J.A.C. 10:63–1.22.
See: 24 N.J.R. 3728(b).
Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).
See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

10:63–4.3 Final audited rate calculation

(a) The Division of Medical Assistance and Health Services will calculate final per diem rates based on audit adjustment reports.

(b) The final per diem rates determined based on (a) above cannot exceed the prospective rates previously paid.

(c) Settlement after final rate calculation will be for fraud and/or abuse collections or recoveries of payments when the final rate is lower than the original rate.

(d) The basis for establishing guidelines for the prospective per diem rates, and costs which may be reported, are the CARE (Cost Accounting and Rate Evaluation System) Guidelines which appear at N.J.A.C. 10:63–3.

(e) This section applies to all current, pending or future audits for rate years on or after March 20, 1995.

Amended by R.1984 d.572, effective December 16, 1984.
See: 16 N.J.R. 2335(a), 16 N.J.R. 3436(b).
Administrative change, recodified from N.J.A.C. 10:63–1.23.
See: 24 N.J.R. 3728(b).
Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).
See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

APPENDIX A

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

PROVIDER APPLICATION

1. _____ Legal Name of Provider
2. _____ Type of Business or Facility

_____ Business Name, if Different From Above

3. _____ Address (Service Location Only) Street City County State Zip Code

4. _____ Employer ID Number
5. _____ Telephone Number
6. _____ Length of time at above address

7. _____ Billing Address, if different
8. _____ Name of Administrator, Chief Executive Officer, or other responsible official

_____

9. Indicate legal status of your organization: Profit ____ . Non-Profit ____ . Private ____ . Public ____ . Municipal ____ . State ____ . Charity ____ . School Nurse ____ . County ____ . Other ____ . If other, please specify: _____

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

_____

11. Do you operate from more than one location? _____ Yes _____ No. If yes, list all other subsidiary or affiliated organizations below: (Name and service address)

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

Please attach additional sheet if necessary

12. Please indicate if you are a member of a chain organization. _____ Yes _____ No. If yes, indicate name: _____

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

_____ to each satellite location:
_____ to central location at _____

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.

14. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? _____ Yes _____ No. If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate.

15. If your business or facility requires a license/permit, indicate type _____ and number _____
Please attach a copy of the license/permit, i.e., Independent Laboratory Certification.

16. CERTIFICATION, ACCREDITATION OR APPROVAL Specify type and attach copy. For example JCAHO (hospitals); New Jersey Department of Health (clinics); Division of Mental Health and Hospitals (mental health clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services); American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist). See Item 16.

17. Approved by Medicare? _____ Yes _____ No. If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval.

18. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? _____ Yes _____ No. If Yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

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19. Have any of the entities named in response to questions 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? _____ Yes _____ No. If yes, please explain.

20. Have any of the entities named in response to question 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? _____ Yes _____ No. If yes, please explain.

21. Have any of the entities named in response to questions 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction? _____ Yes _____ No. If yes, please explain. _____

22. Do any of the entities named in response to question 1. or 11. or their officers or partners, or any of the other individuals named in response to questions 8. own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid (Title XIX) Progam of any other state or jurisdiction? _____ Yes _____ No If yes, please list provider name and nature of relationship.

23. 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 arrangement and attach a copy of your fee schedule.

24. List days and hours of operation.

25. List the names, SSA Number, License/Permit Number and Degree(s) for all professional staff in the organization. Include physicians, dentists, psychologists, pharmacists, registered nurses, licensed practical nurses, registered physical therapists, optometrists, etc. If more space is needed, attach additional sheets. (NOTE: Not required for health care providers certified for Medicaid and/or Medicare participation by the State Department of Health and/or HCFA.)

NAME	SSA NUMBER	DOB	LICENSE/PERMIT NUMBER	DEGREE, e.g., MD, DO, DDS, RPT, PhD, CPO, OD, RN, LPN, etc.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

26. For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey Medicaid (Title XIX) Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me in this application are willfully false, I am subject to punishment, including but not limited to suspension, debarment or disqualification from the New Jersey Medicaid Program in accordance with N.J.A.C. 10:49-1.17(d)22. I agree to notify the Division of Medical Assistance and Health Services' Provider Enrollment Unit, at least quarterly, of all future additions to any of those named in questions 19. - 22. for whom the response to those same questions would be affirmative.

Signature of Provider Representative _____ Title _____ Date _____

FOR DIVISION AND/OR FISCAL AGENT USE ONLY

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

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

Provider Type(s)	Category of Service	Specialty