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N.J. HEALTH SERVICES PROGRAM

MEDICAL DAY CARE MANUAL

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MEDICAL DAY CARE MANUAL

N.J.A.C. TITLE 10

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

New Jersey Health Services Program **NEWSLETTER**

Volume P-259 February 25, 1980

TO: Medical Day Care Facilities

SUBJECT: Revised Standards for Medical Day Care Services

Attached is your copy of the revised Medical Day Care Manual. This edition establishes Medical Day Care as a separate Medicaid provider manual. It replaces Chapters IV and V of the Long Term Care Services Manual, dated May 1, 1979. Please destroy the outdated materials.

In a continuing effort to increase the availability and utilization of medical day care service, the program has been expanded and modified as follows:

1. Effective September 1, 1979, freestanding ambulatory care facilities which are licensed to provide non-residential medical day care services by the New Jersey Department of Health, may qualify for approval as a medical day care center by the Division of Medical Assistance and Health Services.

2. The reimbursement rate for medical day care centers has been modified so that:

   -- In long term care facilities, effective July 1, 1979, the per diem rate was reduced from 75% to 65% of the ICF-B rate;

   -- For freestanding facility, the rate will be based on an average of the rates paid to long term care facility medical day care providers in effect as of July 1st and January 1st of each year.

As before, medical day care claims are processed by the Prudential Insurance Company. Please review the procedure for obtaining prior authorization (p.6) and instructions for completing the Independent Outpatient Health Facility claim form (MC-14) (p. 19). Samples of completed claim forms have been included as Exhibits in Subchapter 2.

If you have any questions, contact Mrs. Carol Kurland, Coordinator, Medical Day Care Program, Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, N. J. 08625, or call (609) 292-1940.

MEDICAL DAY CARE MANUAL

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CHAPTER 65

SUBCHAPTER 1

1.1 SCOPE

The Medical Day Care Program is concerned with the fulfillment of the health needs of eligible recipients of New Jersey Medicaid Program, who could benefit from a health services alternative to total institutionalization. Medical Day Care is a program of medically supervised, health related services provided under the New Jersey Division of Medical Assistance and Health Services in an ambulatory care setting to persons who are non-residents of the facility, and who do not require 24 hour in-patient institutional care, yet due to their physical and/or mental impairment, need health maintenance and restorative services, supportive to their community living.

1.2 DEFINITIONS

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

"Administration-Medical Day Care Center" means:

The Medical Day Care Center shall provide an identifiable administrative unit, headed by a Director, responsible for the overall conduct of all day care program activities.

"Medicaid Eligibility" means:

In order to obtain Medical Day Care Services, the participant must be determined eligible to receive Medicaid services in the community under the existing programs of Aid to Families with Dependent Children, Supplemental Security Income, and/or Medicaid Only.

"Medical Day Care Center" means:

A Medical Day Care Center is an identifiable part of a long term care facility or a freestanding ambulatory care facility which is licensed by the New Jersey Department of Health to provide non-residential medical day care services and which possesses a valid and current provider agreement from the New Jersey Division of Medical Assistance and Health Services which provides services as described in Section 1.4.

"Medical Day Care Patricipant" means:

A Medical Day Care participant is a person who is medically eligible and whose assessed physical and psychosocial needs:

1. Do not require 24 hours a day on an in-patient basis in a hospital or long term care facility.
2. Cannot be met totally in any other ambulatory care setting, such as a physician's office or hospital out-patient clinic.

3. Require and can be met satisfactorily by a seven hour, day long active medical program provided by licensed and non-licensed personnel, including portal to portal travel time.

"Volunteer" means:

A person who gives his/her time and services regularly without renumeration is considered a volunteer.

1.3 PROGRAM PARTICIPATION

(a) A Medical Day Care Center, 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 requirements in order to participate in the New Jersey Medicaid Program:

1. Licensure and approval by the New Jersey State Department of Health as a non-residential medical day care center.

2. Certification that the Medical Day Care Center meets the Federal and State requirements for participation in accordance with the Manual of Standards for Licensure of Non-Residential Medical Day Care Facilities of the New Jersey State Department of Health.

3. Approval for participation as a Medical Day Care Center provider by the New Jersey Medicaid Program. This includes, at a minimum, the completion of the New Jersey Medicaid Provider Application FD-20C2 (Exhibit II), the Provider Agreement FD-62 (Exhibit III), and a narrative statement on the proposed Medical Day Care Program (Exhibit VI). Continued participation as a New Jersey Medicaid provider is contingent upon approval annually by the New Jersey Medicaid Program.

(b) A cost study, as defined by the Division, shall be prepared annually detailing expenditures of the Medical Day Care Program. Medical Day Care Program costs must be segregated from other operational costs. (Medicaid reimbursement rates may be based on cost study information or on a percentage of the ICF-B per diem rates.)

(c) The Division shall conduct an on-going evaluation of the Center's Medical Day Care Program by on-site visits to the Medical Day Care Center. A Medical Day Care On-Site Report MCNH-89 (Exhibit VII) shall completed by Division staff and a copy shall be forwarded to the Center.

1.4 REQUIRED SERVICES

(a) As a minimum the following services shall be provided by the Center for participation in the Medical Day Care Program.

1. Medical Services

i. The Center Director, with the Medical Director of the facility, shall establish written medical and administrative policies

governing the provision of medical services to the participants. The Medical Director shall be responsible for, but not be limited to, the following:

(1) Develop and amend these medical policies as needed.

(2) Supervise the provision of medical services.

(3) Advise the Center Director regarding medical and related problems.

(4) Establish procedures for medical matters, such as medical supervision, storage of medication, emergency coverage, emergency services, records, use of consultants, patient review, rehabilitation services, medication and discharge planning.

(5) Establish personnel relationships with other institutions, such as general or special hospitals, rehabilitation centers, home health agencies, clinics, laboratories, and related community resources. This would include but not be limited to arrangements for emergency room services, unavailable within the facility.

Procedures shall be located in the Center Director's office and at the Nurses' station, readily available to staff.

ii. The Medical Day Care Center shall provide:

(1) A <u>medical</u> evaluation of all participants, provided or arranged for by the Medical Director as needed, but at least every ninety days.

(2) An individual medical record on each participant.

(3) Medical orders for treatment of participant(s) which shall include medication, diet, activities permitted, and therapies, such as physical therapy, occupational therapy, and speech therapy.

2. <u>Nursing Services</u>

i. A registered professional nurse shall be available on the premises of the Medical Day Care Center at all times when the facility is operating, to evaluate the need of each participant for nursing care, initially, and on a continuing basis, and to provide for such care. If there is ancillary nursing staff, the registered professional nurse provides supervision of this staff.

ii. The Nursing Staff shall provide but not be limited to the following:

(1) Administration, and/or supervision of prescribed medications.

(2) Implementation of prescribed treatments

(3) Dressing changes

(4) Observation of and instruction in personal hygiene

(5) Rehabilitative and restorative nursing

(6) Taking vital signs as necessary in temporary illness

(7) Assistance in activities of daily living

(8) Necessary documentation of all nursing services

(9) Discharge planning, coordinated with the health care team

iii. The Center Nursing Staff shall assure that nursing services provided to participants are coordinated with health services currently received at home, as well as with existing community health agencies and services available to participants in time of need.

3. Social Services

i. A social worker or designate with qualified social work consultation shall be responsible for the implementation of the social services component, and accordingly, work closely with public and private community agencies in planning appropriately for the service needs of each participant.

ii. The social work staff shall provide but not be limited to the following social services:

(1) Continued identification of social and emotional needs of each individual, in relation to the home situation and in the Center.

(2) Direct counseling and referral in social, financial, and legal matters

(3) Assistance with housing and shopping

(4) Counseling in the availability, and utilization of community resources, and the coordination of these services

(5) Discharge planning, coordinated with the health care team

(6) Documentation of social service information

4. Transportation Services

i. The Center shall provide transportation for participants to and from their homes as well as to and from services provided indirectly by the Center. No participant's total daily commutation time shall exceed two hours.

ii. Transportation provided by the Center shall be included in the per diem costs of the Medical Day Care Program.

5. Personal Care Services

i. To insure quality personal care, the Center staff shall make daily checks to assure that participants are maintaining personal hygiene, receiving medications as prescribed (which includes assuring the renewal of prescriptions as necessary and the disposition of outdated or discontinued drugs), and participating in appropriate social and recreational activities.

ii. Personal care service shall include education in and assistance with activities of daily living (i.e., walking, eating, toileting, grooming) and supervision of personal hygiene.

6. Dietary Services

i. The Center shall provide a minimum of one meal per day. The meal and snacks shall supply at least one-third of the daily nutritional requirements recommended by the National Research Council.

ii. Special diets and supplemental feeding shall be made available as ordered by the physician involved in the documentation of the individualized plan of care, and the plan supervised by the facility dietitian.

iii. Dietary counseling and education shall be provided to participants and their families.

7. Social Activities

The Center staff, under the direction of the Activities Coordinator, shall provide a planned program of recreational, social and leisure activities suited to the needs of the participants, and designed to encourage physical exercise, social interaction and to complement community resources.

i. The Center may involve volunteers in the implementation of the social activities program.

ii. The current monthly schedule of activities shall be posted at a location convenient to participants, staff and families.

iii. Social activities shall include, but not be limited to:

(1) Opportunities for arts and crafts

(2) Development of hobbies

(3) Discussion groups

(4) Speakers and films

(5) Periodic excursions or outings

(6) Involvement of participants in community service projects which can be carried out at the Center.

iv. The activities program shall be coordinated with occupational and physical therapy programs so that a total plan of care is provided each participant.

v. The participants and their families when possible shall be involved in the planning and implementation of the activities program.

8. Rehabilitative Services

i. Rehabilitative Services, which include physical therapy, occupational therapy, and speech therapy shall be provided by the Center to those participants whose need for these services has been definitely described in the individualized plan of care.

ii. Physical and speech therapies provided by the Center shall not be included in the per diem costs for Medical Day Care. However, they are reimbursable and shall be billed separately.

iii. Occupational therapy shall be included in the per diem costs for Medical Day Care.

1.5 STAFF

(a) The Center shall have adequate staff capability to provide supervision of the participants at all times. The composition of the staff shall depend in part on the needs of the participants and on the number of participants the program is serving. As a minimum, the Center must have: a Medical Day Care Center Director, a registered Professional Nurse, a Social Worker, an Activities Coordinator and a Medical Director. If the freestanding facility has no Medical Director, a licensed physician shall be appointed to serve in this capacity.

1. Medical Day Care Center Director

The Director of the Center is responsible for the overall conduct and management of all program activities on a full-time basis. The Director shall:

i. Be a qualified health professional, such as a Nursing Home Administrator, licensed nurse, physician, licensed physical therapist, certified eligible occupational or speech therapist or social worker.

ii. Be experienced in the care of the elderly and disabled and knowledgeable regarding their physical, social and medical health needs.

2. Registered Professional Nurse

   The Registered Professional Nurse is a person who is licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-26 et seq and has at least one year full-time or full-time equivalent experience in a health care setting.

3. Social Worker

   The Social Worker shall possess a Master's degree in Social Work from an accredited graduate school of Social Work plus one year of full-time or full-time equivalent social work experience in a health care setting. If a designate is utilized, the designate shall possess a Bachelor's degree in the social sciences plus one year of social work experience in a health care setting. A designate must have available on-site consultation from a qualified social worker, a person with a Master's degree in Social Work from an accredited School of Social Work.

4. Activities Coordinator

   An Activities Coordinator is a person who has a bachelor's degree from an accredited college with a major in recreation, occupational therapy, or a field related to recreation, such as art, music, physical education, group work, or sociology; or

   An Associate degree in recreation and two years of full-time, or full-time equivalent, experience in recreation for the aged, handicapped, or retarded; or

   A high school diploma or equivalency certificate, two years of full-time, or full-time equivalent experience in a social or recreational program within the last five years, one year of which was full-time in a patient activities program in a health care facility, and has completed at least 36 hours of classroom training, approved by the Department, in activities programming; or

   Is certified by the New Jersey Board of Recreation Examiners as a recreation administrator or recreation supervisor, pursuant to Chapter 291, P.L. 1966; or

   Is an occupational therapy assistant.

5. Medical Director

   The Medical Director shall provide the medical consultation and supervision of the total health care program provided to the participants. The Medical Director must be licensed to practice medicine in the State of New Jersey.

6. Staff-Participant Ratio

   Adequate staff is defined as a ratio of one (1) regular full-time staff person to nine (9) participants, calculated on the basis of the daily census. The ratio shall include the Center Director and all other personnel (except the Medical Director) who are involved in direct patient care, excluding volunteers.

i. Without compromising the above required staff-patient ratio of 1-9, various staff positions could conceivably combine functions within one person, i.e., the Center Director may be a social worker or nurse, performing dual functions of the Director/Social Worker or Director/Nurse. New programs for start-up purposes, or programs with less than ten participants, may have no fewer than two full-time staff persons. The registered nurse must occupy one of the two positions. In programs of 60 or more participants, the Director may not serve a dual function.

1.6 PRIOR AUTHORIZATION

(a) Whenever the term "prior authorization", or "reauthorization", is used in this manual it shall mean approval granted by the Division of Medical Assistance and Health Services through the appropriate Local Medical Assistance Unit for payment for Medical Day Care services rendered to an eligible participant for a specific time period. Current Medicaid eligibility is a prerequisite for payment. Prior authorization must be obtained from the Local Medical Assistance Unit of the Division of Medical Assistance and Health Services before an applicant for Medical Day Care can be considered medically eligible for the service within the New Jersey Medicaid Program.

(b) A request for Medical Day Care Services Form FD-140 (Exhibit IV) must be submitted by the Medical Day Care Center on each potential participant as a basis for determining a prior authorization or reauthorization for Medical Day Care Services. In order to avoid delay in approval, all information must be individualized, complete and comprehensive. The FD-140 will be reviewed by the Local Medical Evaluation Team, consisting of the Medical Consultant, Regional Staff Nurse, and Medicaid Social Worker and a determination will be made as to the person's eligibility for Medical Day Care. The maximum duration for a single authorization or reauthorization is 90 days.

(c) The Medical Day Care Center may bill the Medicaid contractor, Prudential Insurance Company, for one initial visit evaluation for eligible recipients without prior authorization.

1.7 PARTICIPANT REVIEW AND EVALUATION

(a) Each participant in the Medical Day Care Program shall be seen by his/her attending physician, as needed but at least every 90 days. A record of the physician's visit, findings, and recommendations shall be documented on the participant's chart.

(b) Every ninety days the participant's individualized plan of care shall be updated by the Medical Day Care Center staff to reflect the needs of the participant for Medical Day Care and a Request for Medical Day Care form FD-140 must be submitted to the Local Medical Assistance Unit for review and reauthorization by the Medical Evaluation Team.

1.8 RECORDS

(a) As a minimum, the participant's chart shall contain the following information:

1. Application for admission form

2. Individualized plan of care

3. Medical history, record of physical examination, medication record, and laboratory reports, performed initially and updated every ninety days thereafter, citing general medical condition, disabilities and limitations. Also included shall be any consultations performed

4. Daily nursing observations for the first five days of attendance and nursing progress notes at least every thirty days thereafter or more often as needed

5. Social history initially, and social service progress notes every ninety days

6. Activity progress notes every ninety days

7. Physical, Speech, and Occupational Therapy and dietary progress notes as indicated

8. Discharge Plan

(b) Individualized Plan of Care

An Individualized Plan of Care shall be written for each participant prior to admission to the Program, along with the participant, family, and interested community agencies. The plan shall state medical needs of the participant as evaluated by the attending physician, and/or Medical Director, and nursing, social service and other service needs as determined by the Center Staff, with in-put from community agencies. Overall goals and services to be provided by the Center to fulfill the needs expressed should be indicated.

1. The Individualized Plan of Care shall be signed by the physician and by all Center Staff preparing the report.

2. Up-date of this plan shall be made at least every ninety days.

1.9 DISASTER PLAN

The Facility Disaster Plan shall be posted at the Nurses' station and other conspicuous locations throughout the Medical Day Care Center.

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SUBCHAPTER 2

INTERIM BILLING PROCEDURES

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<u>Exhibit I</u> MC-14C2 Independent Outpatient Health Facility Claim Form

<u>Exhibit II</u> FD-20C2 Medicaid Provider Application

<u>Exhibit III</u> FD-62 Provider Agreement

<u>Exhibit IV</u> FD-140 Request for Medical Day Care Authorization or Reauthorization

<u>Exhibit V</u> HCFA-1483 Provider Billing for Medical and Other Health Services

Exhibit VI Outline for Written Narrative Statement on Proposed Medical Care Center

Exhibit VII MCNH-89 Medical Day Care On-Site Report

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SUBCHAPTER 2

INTERIM BILLING PROCEDURES

2.1 BILLING PROCEDURES

(a) This subchapter contains basic information and instructions necessary for the proper completion and submission of a claim. Included are exhibits to be utilized by medical day care centers for use in submitting claims for covered items or services. All forms to be completed by the facility are available from Prudential Insurance Company.

1. Payment: Payment will be based only on the number of days spent by participant at the medical day care center. Billing will be performed by using the Independent Outpatient Health Facility Form MC-14C2 (Exhibit 1) which must indicate days of participant attendance during the period of authorization or reauthorization.

2. Reimbursement: The center participating in the Medical Day Care Program must agree to accept the reimbursement rate established by the Medicaid Program. The reimbursement rates set for a Medicaid participant in medical day care centers may not exceed charges for non-Medicaid patients. The per diem reimbursement shall cover cost of all services listed in subchapter 1, section 4 with the following exceptions: physical and speech therapy services are not included in the per diem rate and these services must be billed separately on the MC-14C2 form.

3. Submission of Independent Outpatient Health Facility Claim Form (MC-14C2): A fully completed MC-14C2, Independent Outpatient Health Facility Claim Form must be submitted to Prudential Insurance Company with a copy of the FD-140 Form, Request for Medical Day Care Authorization or Reauthorization (Exhibit IV) issued by the local medical assistance unit.

4. Medicare/Medicaid coverage: The only possible services that can be considered for payment under Medicare/Medicaid are physical and speech therapy. When the medical day care participant is covered under both programs only the Medicare Form HCFA-1483 (Exhibit V) must be completed with the appropriate section completed showing the Health Services Case and Person Number (HSP #).

2.2 GENERAL POLICY

Billing should be done on a monthly basis. In all cases, claims must be submitted no later than ninety days after the last date services are furnished.

2.3 PARTICIPANT IDENTIFICATION

Verify that the participant is a covered person on the first visit and at least monthly thereafter. This is done by viewing the patient's validation

form. It is especially important to review a participant's validation form when extended plans of treatment have been authorized or reauthorized. Prior authorization is no guarantee that an individual is an eligible participant.

2.4 PRIOR AUTHORIZATION

(a) Prior authorization means approval by the local medical assistance unit for medical day care services.

(b) Following the initial visit, prior authorization is required. A claim for the initial visit must be submitted on the Independent Outpatient Health Facility Claim Form (MC-14C2) with a comment in item 13 C (Report of services) "Initial visit only". This should only be done when the authorization has been declined.

(c) Prior authorization is required for all persons participating under the Medical Day Care Program. An individual care plan must be submitted to the local medical assistance unit for approval and authorization on form FD-140. Authorization shall not exceed ninety days. Reauthorization can be obtained by the submission of the FD-140 form, Request for Medical Day Care Authorization or Reauthorization, which must include in item 19 recommendations for extension of such continued participation in medical day care. Allow at least two weeks prior to termination date of previous authorization for processing of a reauthorization of this request.

1. How to obtain prior authorization:

   i. Request for Medical Day Care Authorization or Reauthorization Form FD-140, should be promptly completed by the medical director of the medical day care center or the attending physician with the involvement of the nursing and social work staff and submitted to the appropriate local medical assistance unit.

2. Completing the Request for Medical Day Care Authorization or Reauthorization form FD-140 (see Exhibit IV):

   All items, 1 through 21 inclusive must be completed on all FD-140 forms. All items should be typed or printed clearly.

   i. Distribution of form FD-140 (four part snap-out form)

      (1) Contractor's copies and provider copy and the local medical assistance unit (LMAU) copy are submitted to the LMAU, with the center retaining the second provider copy;

      (2) Upon the LMAU approval or decline of the request, the contractor copy and the provider copy will be returned to the medical day care center. The LMAU will retain their copy;

      (3) If physical or speech therapy services are to be provided and are not allowed under Medicare, or if Medicare benefits have been exhausted where a Medicaid beneficiary is involved, item 14 on form FD-140 must be signed by the medical day care center, certifying that the services requested are not allow-

able or have been exhausted under the Medicare Program and that Medicare has not or will not be billed by the center for the same services.

3. Submission of authorization to contractor: When the request for authorization has been approved, it must be submitted together with the MC-14C2, Independent Outpatient Health Facility Claim Form (Exhibit I) to Prudential Insurance Company for reimbursement for services provided.

4. Period covered by authorization: An approved request for authorization/reauthorization will only be valid for a period not to exceed three months as indicated in item 21 on form FD-140 - Request for Medical Day Care Authorization or Reauthorization.

2.5 DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS (LMAU)

(a) The following is a list of local medical assistance units, their addresses and telephone numbers.

1st Two Digits of HSP Case No.	County	Street Address	Municipality	Zip Code	P.O. Box	Telephone
01	Atlantic	22 So. North Carolina Ave.	Atlantic City	08404	1709	609-344-2861
02	Bergen	50 Main Street	Hackensack	07601		201-488-5667
03	Burlington	Chesley & Alloway Bldg. Rt. 38 & Eayrestown Rd.	Mt. Holly	08060		609-261-0448
04	Camden	530 Cooper Street	Camden	08101	1089	609-757-2870
06	Cumberland	501 Landis Ave. (basement)	Vineland	08360		609-696-0521
05	Cape May	" " "	"	"		"
07	Essex	155 Washington Street	Newark	07102		201-648-2470
08	Gloucester	Southwood Shopping Center	Woodbury	08096		609-845-7185
17	Salem	" " "	"	"		609-769-0299
09	Hudson	880 Bergen Avenue	Jersey City	07306		201-792-6390
10	Hunterdon	79 Main Street	Flemington	08822		201-782-1130
18	Somerset	" " "	"	"		"
21	Warren	" " "	"	"		"
11	Mercer	1424 So. Broad St.	Trenton	08610		609-292-7315
12	Middlesex	75 Paterson St. (basement)	New Brunswick	08903		201-246-0653
13	Monmouth	1200 Memorial Drive	Asbury Park	07712		201-775-5700
14	Morris	10 Park Place - 4th floor	Morristown	07960		201-267-1700
19	Sussex	" " " " "	"	"		"
15	Ocean	1861 Hooper Ave.	Toms River	08753		201-255-6226
16	Passaic	100 Hamilton Plaza - 9th fl.	Paterson	07505		201-523-2800
20	Union	333 N. Broad St. - 2nd floor	Elizabeth	07208		201-355-8860

1. Eligibility questions: Provider inquiries concerning patient eligibility and/or applications for eligibility may be directed to the appropriate eligibility determination agency (if known by the provider) or to the LMAU serving the provider area. The LMAU will assist the provider by answering the questions and/or by directing the provider to the appropriate eligibility determination agency.

2.6 INSTRUCTIONS; FORM MC-14

(a) Instructions for completion of the MC-14C2 - Independent Outpatient Health Facility Claim Form (see Exhibit 1)

1. Items 1-4 — Name, address, case number and person number: Copy patient's name, HSP Case Number, and patient person number exactly as it appears on the Medicaid Validation Form;

2. Items 5-6 — Self-explanatory;

3. Items 7-8 — Not applicable;

4. Item 9 — Name, address, and telephone number of provider: This information may be preprinted;

5. Item 10 — Not applicable;

6. Item 11 — Authorization: Insert in this space "authorization (or reauthorization) form FD-140 is attached"

7. Item 12 — Not to be completed;

8. Item 13 — Report of services:

   i. Item A — Enter each date on which service has been provided. Use a separate line for medical day care visit, for physical therapy treatment, for speech therapy treatment;

      NOTE: A visit means attendance at the medical day care center by the participant which consists of seven hours portal to portal.

   ii. Item B — Enter separately the procedure code for medical day care visit (0001) or for physical therapy treatment (0030) or for speech therapy treatment (0032);

   iii. Item C — Specify primary diagnosis;

   iv. Item D — Corresponding with the procedure code as outlined above enter the following wording: medical day care visits or physical therapy treatment(s) or speech therapy treatment(s) including only the number of visits (or treatments) at the appropriate rate for each visit or treatment(s);

   v. Item E — Not applicable;

   vi. Item F — Enter the total charges represented by the number of visits or treatments times the approved rate for same. The sum of the charges entered in column E should be shown at the bottom under "total charges $";

9. Items 14-16 — Self-explanatory;

10. Item 17 Patient's certification: Under ordinary circumstances, the participant must sign the claim form when services have been received. The claim form to be signed should indicate services rendered, and the participant must not sign a blank claim form prior to receiving services or as a condition for receiving services;

i. However when the participant's signature is unobtainable, the following procedures may be used:

(1) Illiterate participant:

The participant may sign by marking (X), and the signature must be witnessed by another person including the provider of service who signs his name and address on the same line;

(2) Other

If a participant is physically or mentally incapable of signing the claim form, e.g., deceased or for other reasons, the participant's signature is not obtainable through reasonable effort, the form may be signed on his behalf by:

(A) A parent; or

(B) A legal guardian; or

(C) A relative; or

(D) A friend; or

(E) An individual provider; or

(F) A representative of an institution providing care or support; or

(G) A representative of a governmental agency providing assistance;

11. Provider's certification: The provider must sign and date the form before the claim may be considered.

2.7 MAILING INSTRUCTIONS

Mail the original copy (contractor copy) of the MC-14C2 Outpatient Claim Form together with the FD-140 form to:

The Prudential Insurance Company of America
P.O. Box 5000
Millville, New Jersey 08332

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

PLEASE TYPE OR PRINT

EXHIBIT I

08

INDEPENDENT OUTPATIENT HEALTH FACILITY

1. Patient's Last Name: DOE — First Name: JOHN
2. Patient's Street Address: 123 THIRD STREET — Telephone Number: (609) 292-1234
City: TRENTON — State: NEW JERSEY — Zip Code: 08625
3. Health Services Program Case No.: 1 1 1 1 0 7 0 0 0 7 1 7
4. Patient Person No.: 0 1
5. Age: 76
6. Sex: [X] Male [ ] Female
7. Other Health Insurance or Liability Coverage? [ ] Yes [ ] No
If Yes, attach copy of Decline Notice or Explanation of Payment from carrier.
No Fault Auto Coverage? [ ] Yes [ ] No
8. Was this service performed as a result of an EPSDT Program Referral? Yes [ ] No [ ]
10. Was Patient's Illness or Injury connected with employment? If Yes, give Name and Address of Employer here. [ ] Yes [ ] No
Did injury result from automobile accident? [ ] Yes [ ] No
9. PROVIDER OF SERVICE INFORMATION
Telephone Number: (609) 292-5678
Medicaid Provider Number (Enter only when not printed below): 123456
Name and Address:
MOUNT CREST NURSING HOME
423 ELEVENTH STREET
TRENTON, NEW JERSEY 08625
11. Prior Authorization Number: AUTHORIZATION - FD 140 ATTACHED
12. PRIOR AUTHORIZATION - FOR DIVISION USE ONLY

AUTHORIZING SIGNATURE — Date:

FOR CONTRACTOR'S USE ONLY

CLINIC TYPE		TOTAL AMOUNT A						TOTAL AMOUNT B						CODE	JAM	3PL
45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	70

13. REPORT OF SERVICES

A. Dates of Service	B. Procedure Code	C. Nature of Illness or Injury Requiring Services	D. Fully describe surgical or medical procedures and other services or supplies furnished for each date listed.	E. Check if Family Planning	F. Charge
4/1/79	0001	C.V.A. DIABETES	MEDICAL DAY CARE VISIT = X $	—	$ X000
4/2/79	0001	"	" " " "	—	X000
4/3/79	0001	"	" " " "	—	X000
4/4/79	0001	"	" " " "	—	X000
4/5/79	0001	"	" " " "	—	X000
4/1/79	0030	"	PHYSICAL THERAPY TREATMENT = X $	—	X000
4/3/79	0030	"	" " " "	—	X000
4/5/79	0030	"	" " " "	—	X000
4/2/79	0032	"	SPEECH THERAPY TREATMENT = X $	—	X000

Total Charges $ X00000

14. Referring Practitioner's Name
Individual Medicaid Practitioner Number
15. Attending Practitioner's Name: James Brown, M.D.
Individual Medicaid Practitioner Number: 98765
16. Operating Practitioner's Name
Individual Medicaid Practitioner Number

17. PATIENT'S CERTIFICATION. Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

Signature (Patient or authorized representative): John Doe — Date Signed: 4/5/79

18. PROVIDER CERTIFICATION. I certify that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State Agency may request; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

Provider Signature: William Smith — April 30, 1979 — Billing Date Mo./Day/Yr.

FOR PAYMENT MAIL TO: The Prudential Insurance Co. of America — P.O. Box 5000 — Millville, N.J. 08332

FOR CONTRACTOR'S USE ONLY

CARD	DATES OF SERVICE YR		FROM MO		FROM DAY		TO MO		TO DAY		# OF VISITS		PROCEDURE CODE					AMOUNT A						AMOUNT B						CODE	AUTH	JAM	PRIMARY DX						SECONDARY DX						FP
3																																													
11	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56		
4																																													
5																																													
11	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56		

EXHIBIT II

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. ______________________ Legal and/or Trade Name of Organization
2. ______________________ Type of Business or Facility
3. ______________________ Address Street City County State Zip Code
4. ______________________ SSA and/or 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, 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 III

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

NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

P R O V I D E R A G R E E M E N T
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

____
PROVIDER

PROVIDER AGREES:

1. To comply with all applicable State and Federal "Medicaid" laws and policy, and rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid Program;

3. To furnish the Division of Medical Assistance and Health Services with such information regarding any payments claimed for providing services under the Medicaid Program as the Division may from time to time request.

The provider may, on thirty days written notice to the Division, terminate this Agreement.

______________________________ ______________________________
Date Signature of Provider

____
Title

FD-62 Rev. 2/77

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

EXHIBIT IV

REQUEST FOR MEDICAL DAY CARE AUTHORIZATION OR REAUTHORIZATION

PATIENT INFORMATION

1. Participant Information — Last Name: DOE — First Name: JOHN
2. Sex: M
3. Age: 76
4. Address: 123 Third Street, Trenton, New Jersey 08625
5. Social Security No.: 520-34-6000
6. Health Services Program Case Number: 1110700077
7. Person No.: 01
8. Telephone No. (include area code): (609)292-1234
9. Attending Physician's Name — Last: BROWN — First: JAMES
10. MD's, DO's Telephone No. (area code): (609)292-0111
11. Provider Identification (Name and Address):
MountCrest Nursing Home
423 Eleventh Street
Trenton, New Jersey 08625
12. Provider Telephone No. (area code): (609)292-5678
13. Provider No.: 123456
14. Provider Certification: In my judgment, physical or speech therapy requested herein are not allowable under the Medicare (Title XVIII) Program; accordingly, that program has not or will not be otherwise billed.
Signature: William Smith

MEDICAL, NURSING, AND SOCIAL INFORMATION

15. Name of Last Hospital or Long Term Care Facility: XYX Nursing Home — Admitted: 12/30/76 — Discharged: 3/30/79

16. Diagnosis (including surgery and date)
Primary: CVA, Diabetes
Secondary: Slight paralysis and aphasia
Diagnosis known by: [X] Patient [X] Family [ ] Neither

17. Functional Limitations:
[X] Partial Paralysis [X] Speech
[ ] Amputation [ ] Hearing
[ ] Colostomy [ ] Vision
[ ] Wheelchair bound [ ] Language barriers

Mental Behavior:
[ ] Confused
[ ] Underactive/Regressed
[X] Anxious
[ ] Behavior problem

Activities Permitted:
[X] Ambulation [ ] Full
[ ] Stairs [X] Part
[ ] None

Diet:
[ ] Regular
[X] Special (specify): Diabetic Diet #1

Nursing Components:
[X] Administer medication [ ] Personal care
[ ] Treatments [ ] Restorative care
[ ] Observation/Supervision [X] ADL
[X] Instruction [ ] Follow-up of Special Therapy
[X] Other (specify): occupational therapy

[X] Assistive devices (explain): uses walker

[X] Current Medication(s):
Aldomet 250 mg. p.o. t.i.d.
Lente insulin 40 units a.c. breakfast

[X] Special Therapies, if needed: paralysis, aphasic

[ ] Special Problems (describe):

18. Social Information (i.e., living arrangements, family & community supports, attitudes, etc.) Lives with adult employed daughter and family who transports Mr. Doe on a daily basis. Interested and supportive to MDC plan.

19. Goals: [X] Rehabilitation [ ] Maintenance [ ] Preventive

Time required: 3 months
Discharge plan: 7/1/79 (tentative)
Plan of treatment: progressive ambulation; improved speech and independent A.D.L.

SERVICES REQUEST INFO

20. Services requested: Projected start date: 4/1/79 — End date: 7/1/79
Specify services indicating frequency, amount totals:
Medical day care visits: (0001) 5 times per week
Physical therapy treatments: (0030) 3 times per week
Speech therapy treatments: (0032) 5 times per week

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AUTHORIZATION

21. Authorization Information: [X] Authorization granted [ ] Authorization denied, letter attached [ ] Authorization granted, as amended above

Authorized: From: 4/1/79 To: 7/1/79

James Brown 4/30/79
Signature of Medical Director or Attending Physician & Date

AUTHORIZED BY Signature	Date	Title
Robert Johnson, M.D.	4/30/79	[X] Medical Consultant
Mary Reilly	4/30/79	[X] RSN
Carol White	4/30/79	[X] Social Worker II

EXHIBIT V

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: DOE — First name: JOHN — MI: J
2. Health insurance claim number: 123456789A
3. Patient's address (Street number, City, State, ZIP Code): 123 THIRD STREET TRENTON, NEW JERSEY 08625
4. Date of birth: 01 30 03
5. Sex: [X] M [ ] F
6. Provider name and address (City and State): MOUNT CREST NURSING HOME, 423 ELEVENTH STREET, TRENTON, NEW JERSEY 08625
7. Provider number: 123456
8. Medical record number: 3456789
9. Type of service: A. [ ] Inpatient B. [ ] Outpatient C. [X] Other (Specify) PHYSICAL THERAPY, SPEECH THERAPY

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: NEW JERSEY HEALTH SERVICES PROGRAM
11. Policy and/or medical assistance number: 11107000 77-01

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.

[X] Contained in provider's record — Signature (Patient or authorized representative) (Signature by mark must be witnessed): John Doe — Date: 4/5/79

13. Nature of illness or injury: C.V.A. - CEREBRAL VASCULAR ACCIDENT, DIABETES — [ ] Check here if illness or injury was connected with employment

Do not use this space

14. Surgical procedures

15. Statement of services	Covered Charges	
A. Clinic visit ( )		
B. Emergency room ( )		
C. Laboratory		
D. Radiology		
E. Pharmacy		
F. Blood		
G. Ambulance		
H. Physical therapy	$ X COST	
I. Other (Specify) SPEECH THERAPY	$ X COST	
J. TOTAL	$ X COST	

16. Statement Covers Period — First service: 04 01 79 — Last service: 04 05 79

17. Blood Information — A. Pints furnished — B. Pints replaced — Not Replaced: C. Pints — D. Charge per pint — E. Patient paid for deductible

18. Professional component (hospital inpatients) — A. Pathology — B. Radiology

19. Other professional component

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. William Smith

23. Date received

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24. Verified Patient Liability — A. Blood deductible — B. Cash deductible — C. Coinsurance

25. Payment Distribution — Provider — Patient

26. Date approved

Remarks:

FORM HCFA-1483 (2-78) (FORMERLY SSA-1483)

Department of Health, Education, and Welfare
Health Care Financing Administration

MEDICAL DAY CARE

Outline for Written Narrative Statement on Proposed Medical Day Care Center

1. Describe the philosophy, goals and objectives for providing medical and ancillary health services to a non-resident population on a day care basis.

2. Describe the physical facilities to be used for the proposed Medical Day Care Center (diagram acceptable).

3. Describe the proposed Medical Day Care Program, including hours of operation; services to be provided, in-house and/or arrangement and staff who will be implementing the program.

4. Provide staff position descriptions and state qualifications of personnel selected for each position.

5. State total number of participants who will be served by Medical Day Care and give anticipated daily population.

6. Submit a projection of costs to be incurred by the Medical Day Care program. State the period of projection and provide the basis of cost allocation if applicable.

7. Will the Medical Day Care Center be funded by other than Title XIX; i.e., Title XX and Title III?

8. Is the proposed Medical Day Care Program a new service of your facility or an expansion of an existing Day Care program?

9. Additional comments relevant to the application for Medical Day Care under the New Jersey Medicaid Program.

EXHIBIT VII

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
MEDICAL DAY CARE ON-SITE REPORT

Name of Program ____________________ Survey Date ____________

Address ____________________ Telephone Number ____________

Facility Administrator ____________________ Initial Approval Date ____________

Medical Day Care Center Director ____________________ Latest Contract Renewal Date ________

Current Total Enrollment ________ Av. Daily Attendance ________ Medicaid Census ________

Number of Paid Staff ________ (full-time) Number of Volunteers ________

R.N. Yes ( ) No ( ) Social Worker Yes ( ) No ( ) Activity Coordinator Yes ( ) No ( )
Medical Director Yes ( ) No ( )

Check Each Item if Applicable	Yes	No		Yes	No
Services Provided					
1. Medical	____	____	13. Initial Physical Exams	____	____
2. Nursing	____	____	Every 90 Days	____	____
3. Social	____	____	14. Medical Orders	____	____
4. Transportation	____	____	15. Current Laboratory Reports	____	____
5. Personal Care	____	____	16. Nurses Notes	____	____
6. Dietary	____	____	Daily 1st 5 Days	____	____
7. Social Activities	____	____	Every 30 Days	____	____
8. Rehabilitative Services	____	____	17. Social History	____	____
9. Dental	____	____	18. Social Progress Notes	____	____
10. Podiatry	____	____	Every 90 Days	____	____
Records			19. Initial Activity Plan	____	____
11. Admission Form	____	____	20. Activity Progress Notes	____	____
12. Individualized Plan of Care	____	____	Every 90 Days	____	____
Updated Every 90 Days	____	____	21. Therapy Progress Notes	____	____
			22. Discharge Plan	____	____
			23. Emergency Provisions	____	____
			24. Disaster Plan	____	____

Comments: Indicate deficient areas according to item number in preceding section

Team Recommendations to Facility:

Projected Revisit ______________________

Facility Staff Present:

Medical Consultant

RSN/RNS

ASWS