

- ii. The hospice provider shall use the authorization number which is imprinted on the top right hand corner of the GSHP-7 form when billing for services provided to a member of the GSHP.

Amended by R.1994 d.508, effective October 17, 1994.
See: 26 N.J.R. 1283(a), 26 N.J.R. 4185(a).

10:53A-3.3 Benefit periods

(a) There are two 90-day benefit periods, one 30-day period, and a fourth unlimited period. The two 90-day periods must be used before the 30-day period and all three periods must be used before the fourth unlimited benefit period. The benefit periods shall be recorded on a Hospice Benefits Statement, FD-379 (6/92) Form # 2 in the (Appendix, incorporated herein by reference) and filed in the recipient's medical record.

(b) Contents of the Election of Hospice Benefits Statement, FD-378 (6/92) (Appendix Form # 1) shall include the following:

1. The identification of the particular hospice that will provide the care to the applicant;
2. The applicant's or his or her representative's acknowledgment, that he or she has been given a full understanding of hospice services;
3. The applicant's or his or her representative's acknowledgment that he or she understands that the regular Medicaid services other than hospice services are waived by the signing of the Election of Hospice Benefits Statement, FD-378 (6/92) and/or the Representative Statement for the Election of Hospice Benefits, FD-380 (Form # 3 in the Appendix, incorporated herein by reference), unless the services are prior authorized;¹
4. The effective date of the election statement; and
5. The signature of the applicant or the applicant's representative.

(c) The hospice applicant is eligible for three benefit periods of hospice services (90 days, 90 days, and 30 days, totaling 210 days) and a fourth unlimited benefit period with the approval of the hospice provider, if the applicant or his or her representative files an Election of Hospice Benefits Statement, FD-378 (6/92) with a particular hospice.

1. A hospice recipient shall designate an effective date for the beginning of hospice services which shall not be earlier than the date the election is made.

(d) Revocation of election of hospice services shall be as follows:

1. The recipient may choose at any time to institute a "break" (a time period when care other than hospice care is given) between benefit periods or by a revocation of hospice services.

2. The Election of Hospice Benefits Statement, FD-378 (6/92) shall be considered to be valid through subsequent benefit periods if there is no "break" in care.

3. A new Election of Hospice Benefits Statement, FD-378 (6/92) is required to be filed following a break or revocation of hospice service.

- i. The recipient or his or her representative shall file a signed statement with the hospice provider that indicates the recipient revokes the election for Medicaid coverage of hospice services for the remainder of the election period with the date that the revocation is to be effective.

- ii. When revoked, the recipient forfeits hospice services for any remaining days in the benefit period. A recipient may not receive hospice services later than the effective date that the revocation is signed.

- iii. The hospice shall immediately notify the agency that determined hospice eligibility (either CWA, DYFS or the MDO) of the revocation of hospice, verbally if possible, and also by filling out and submitting the Hospice Eligibility Form, FD-383 (6/92) to the eligibility source (CWA, MDO or DYFS, as applicable) so that the recipient's hospice eligibility may be terminated. The hospice shall also fill out the Termination of Hospice Benefits, FD-382 (6/92) (Form # 5 in the Appendix, incorporated herein by reference) and retain this form in the recipient's medical record.

(e) Entitlement to all other Medicaid services may be restored if the recipient continues to be Medicaid eligible, under the following circumstances:

1. When the 210 days of hospice entitlement has expired, and the recipient does not choose the fourth unlimited benefit period; or
2. When the recipient revokes hospice services.

(f) When a hospice recipient residing in a nursing facility revokes the hospice benefits and returns to the status of a patient of the NF, the hospice shall proceed as follows:

1. The Hospice Eligibility Form, FD-383 (6/92) shall be completed and submitted to the MDO after the recipient has signed the Revocation of Hospice Benefits, FD-381 (6/92) form indicating he or she has revoked the Medicaid hospice benefit.
2. The nursing facility shall conform to the nursing facility rules in the Long Term Care Facilities Services Manual, N.J.A.C. 10:63 for admission and placement for this recipient similar to any admission to the NF.

- i. Upon discharge from the hospice, the recipient, upon admission or readmission to the NF, is counted in the "occupancy rate" by the NF. The recipient is not

counted as part of the NF census or "occupancy rate" if he or she is a hospice patient residing in the NF.

¹ So in original.

10:53A-3.4 Covered hospice services

(a) The amount, character, and scope of New Jersey Medicaid hospice services shall be the same for all hospice recipients and shall not be less than the hospice services provided under Medicare (Title XVIII) (Section 1861(dd) et seq. of the Social Security Act, codified as 42 U.S.C. Section 1395x(dd)1).

(b) The Division reimburses for covered hospice services that are reasonable and necessary for the palliation and management of the terminal illness, and which are provided to a hospice recipient consistent with the recipient's individualized plan of care.

1. Required hospice services which shall be available to the hospice recipient include nursing care, medical social services, supervisory physician services, counseling services, durable medical equipment and supplies including drugs and biologicals, homemaker/home health aide services, physical therapy, occupational therapy and speech-language pathology services.

i. The following services are considered "core" hospice services: nursing care, medical social services, physician services and counseling services.

(1) A hospice provider shall ensure that substantially all core services are routinely provided directly by hospice employees.

(2) A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of hospice recipients during periods of peak patient loads or under extraordinary circumstances or to obtain physician specialty services.

(3) If contracted staff is used, the hospice shall maintain professional, financial and administrative responsibility for the services and shall assure the qualifications of the staff and that services meet all requirements under each level of care.

(c) Covered hospice services are reimbursed at predetermined, prospective, inclusive rates corresponding to one of four levels of care. Two of the levels of care are reimbursed for services provided in the home: Routine Home Care and Continuous Home Care; and two levels of care are reimbursed for services provided on an inpatient basis: Inpatient Respite Care and General Inpatient Care in either a hospital or nursing facility (see also, N.J.A.C. 10:53A-4.1). The provisions at (c)1 through 4 below apply to the levels of care provided by the hospice.

1. The routine home care rate is reimbursed if less skill than professional registered nursing, or licensed practical nursing, or less intensity than continuous home care is needed to enable the person to remain at home.

i. The routine home care rate includes the following services: routine nursing services, social work, counseling services, durable medical equipment, supplies, drugs, home health aide/homemakers, physical therapy, occupational therapy, and speech-language pathology services. The routine home care rate includes respite care delivered in the home that is not predominately nursing care.

ii. The routine home care rate is reimbursed when the recipient is not receiving continuous home care, regardless of the volume and intensity of routine home care services.

2. The continuous home care rate is reimbursed only during a period of medical crisis to maintain the recipient at home where most of care is skilled nursing care on a continuous basis to achieve palliation or management of the recipient's acute medical symptoms and only as necessary to maintain the recipient at home.

i. A minimum of eight hours of nursing care must be provided during a 24-hour day which begins and ends at midnight before the Continuous Home Care rate can be paid. The nursing care need not be sequential, that is, four hours may be provided in the morning and four hours in the evening of the same day.

ii. The nursing care must be provided either by a registered professional nurse, or a licensed practical nurse under the supervision of a registered professional nurse. More than half (four hours or more) of the period of care must be nursing care provided by licensed nurses.

iii. The Continuous Home Care rate includes homemaker/home health aide services which may be provided to supplement the nursing care, but not to substitute for the minimal amount of nursing care provided by the licensed nurses.

3. Inpatient respite care is short-term, occasional, inpatient care provided to the recipient in a hospital or nursing facility only when necessary to relieve the family members or other persons caring for the recipient at home.

i. The inpatient respite care rate is not reimbursed for more than five consecutive days.

ii. Inpatient respite care is provided by a hospice to a Medicaid hospice recipient in either a hospital or a nursing facility. The inpatient respite care rate or the payment of room and board services under hospice is not provided when a recipient is considered a nursing facility patient and not a hospice patient.