CHAPTER 85

LONG-TERM CARE SERVICES

Authority

N.J.S.A. 30:4D-6.7, 6.8, 30:4D-6(a)(4)(a), 6b(14), 30:4D-7, 7(a), (b), and (c); and 12; 42 U.S.C. §1396a(a)(13)(A); 42 U.S.C. §1396r; and Executive Reorganization Plan 001-1996.

Source and Effective Date

R.2005 d.389, effective October 18, 2005.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).

Chapter Expiration Date

Chapter 85, Long-Term Care Services, expires on October 18, 2010.

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Chapter 63, Skilled Nursing Home Services Manual, was repealed and Chapter 63, Long-Term Care Services Manual, was adopted as new rules by R.1979 d.126, effective March 29, 1979.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was readopted as R.1994 d.624, effective November 23, 1994, and former Subchapters 1, 2, 2A and 4, and Appendix I were repealed and Subchapter 1, General Provisions, Subchapter 2, Nursing Facilities Services, and Appendices A through Q were adopted as new rules, and Subchapter 5,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: 31 N.J.R. 1759(a), 31 N.J.R. 3116(a).

In accordance with N.J.S.A.52:14B-5.1d, Chapter 63 Long-Term Care Services, was extended by gubernatorial order to March 23, 2006. See: 37 N.J.R. 1185(a).

Chapter 63, Long-Term Care Services, was readopted by R.2005 d.389, effective October 18, 2005. Chapter 63 was recodified as Chapter 85, Long-Term Care Services in Title 8, by R.2005 d.389, effective October 18, 2005. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:85-1.1 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. The following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement continues to apply to all government psychiatric hospitals, inpatient psychiatric services and programs in long term care facilities. These other types of facilities are addressed for regulatory and administrative matters in the appropriate chapters elsewhere in Title 10 of the New Jersey Administrative Code.

Recodified from N.J.A.C. 10:63-1.1 and amended by R.2005 d.389, effective January 17, 2006.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).
Rewrote the section.

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.

8:85-1.2 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).

"Bed" or "licensed bed" means "bed" or "licensed bed" as those terms are defined at N.J.A.C. 8:39-1.2.

"Beneficiary" means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

"Care management" means a process by which professional staff designated by the Department monitor the provision of NF care to:

1. Assure that services are rendered as recommended by the HSDP and in accordance with the NF's evaluation of the individual's health service needs;

2. Assure the delivery of timely and appropriate provider responses to changes in care needs;

3. Provide, direct or secure needed consultations with Medicaid professional or NF staff so that services are delivered in a coordinated, effective, and cost-prudent manner; and

4. Facilitate discharge planning and promote appropriate placement to alternate care settings.

"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.

"County welfare agency (CWA)" means that agency of county government with the responsibility to determine income eligibility for public assistance programs including Aid to Families with Dependent Children, the Food Stamp program, and Medicaid. The CWA may be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

"Department of Health and Senior Services" (Department or DHSS) means the New Jersey State Department of Health and Senior Services.

"Department of Human Services" (DHS) means the New Jersey State Department of Human Services.

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

"Division of Medical Assistance and Health Services" (DMAHS) means the New Jersey State Department of Human Services, Division of Medical Assistance and Health Services.

"Division of Mental Health Services" (DMHS) means the New Jersey State Department of Human Services, Division of Mental Health Services.

"Health Services Delivery Plan (HSDP)" means a plan of care prepared by professional staff designated by the Department 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.

"Long-Term Care Field Office" or "LTCFO" means the regional office of the Office of Community Choice Options of the Division of Aging and Community Services of the Senior Services Branch of the Department.

"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.

"Material fact" means any reported costs, statistics, data or supporting documentation submitted to the Medicaid program for the purpose of receiving any benefit, regardless of whether any benefit is ultimately received.

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

"Mental illness" or "MI" means mental illness as that term is defined at 42 CFR §483.102, incorporated herein by reference, as amended and supplemented.

"Mental retardation" or "MR" means mental retardation as that term is defined at 42 CFR §483.102, incorporated herein by reference, as amended and supplemented.

"Minimum Data Set" or "MDS" means the MDS version 2.0, incorporated herein by reference, as amended and supplemented a core set of screening, clinical and functional status elements, including common definitions and coding categories that forms the foundation of the comprehensive assessment required to be completed by a NF-registered professional nurse on all residents in Medicare- and/or Medicaid-certified long-term care facilities on or after June 22, 1998. The MDS identifies an individual NF resident's nursing and care needs.

"New nursing facility" means a facility which satisfies the following criteria:

1. Does not replace a pre-existing facility which was licensed in accordance with N.J.A.C. 8:39;

2. Does not assume the per diem rate of a pre-existing facility; and

3. Does not have a specific pre-existing patient base.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health and Senior Services for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid beneficiaries (children and adults) who, due to medical disorders, developmental disabilities and/or related cognitive 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.

"Ombudsman" means the Office of the Ombudsman for the Institutionalized Elderly.

"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 beneficiaries 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 professional staff designated by the Department 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 resident review" or "PASRR" means that process by which an individual with MI or MR is screened prior to admission to a NF and when there is a significant change in the individual's condition to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for MI provided by the DMHS and/or MR provided by the DDD, and therefore is ineligible for NF services.

"Prior authorization" means approval granted by the Department through the appropriate Long-Term Care Field Office (LTCFO) for payment for NF services rendered to a Medicaid beneficiary, in accordance with this chapter.

"Professional staff designated by the Department" means a registered nurse or professional social worker who performs health needs assessments and counseling on alternative options and care management as required by this chapter. Professional social workers employed by the State or a political subdivision thereof are not required to be licensed or certified.

"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.

"Replacement nursing facility" means a facility which satisfies the following criteria:

1. Replaces a pre-existing facility which was licensed in accordance with N.J.A.C. 8:39;

2. Can assume the per diem rate of the pre-existing facility; and

3. Has a specific pre-existing patient base.

"Resident" means a Medicaid eligible or potentially eligible beneficiary 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.

"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 beneficiary 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 Department to provide care to New Jersey Medicaid beneficiaries who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. 8:85-2, Nursing Facility Services.

"Specialized services for MI" mean those services offered, in accordance with 42 CFR §483.120, when an individual is experiencing an acute episode of serious MI and psychiatric hospitalization is recommended, based on a psychiatric evaluation.

1. Specialized services for MI entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel.

2. During a period of 24-hour supervision of an individual with MI, specific therapies and activities are prescribed, with the following objectives:

i. To diagnose and reduce behavioral symptoms;

ii. To improve independent functioning; and

iii. As early as possible, to permit functioning at a level where less than specialized services are appropriate.

3. Specialized services for MI go beyond the range of services that a NF is required to provide.

"Specialized services for 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.

1. Specialized services for MR are those services needed to address such skill deficits or specialized training needs.

2. Specialized services for MR may be provided in an intermediate care facility for the mentally retarded or ICF/MR as defined at 42 CFR §440.150 or in a community-based setting that meets ICF/MR standards.

3. Specialized services for MR go beyond the range of services that 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 as determined by professional staff designated by the Department following PAS of an applicant for Medicaid clinical eligibility for NF placement or services, as follows:

1. "Track I" means long-term NF care and shall be designated for individuals with respect to whom long-term placement is required because clinical prognosis is poor, and as to whom PAS results in a determination that short-term stays are neither realistic nor predictable and that the individual is eligible for NF level of nursing care in accordance with N.J.A.C. 8:85-2.1.

i. A Track I designation shall not preclude the possibility of future discharge. The professional staff designated by the Department will monitor those individuals with discharge potential, reassess the individual, and update the HSDP for a change in the track of care if appropriate.

2. "Track II" means short-term NF care and shall be designated for individuals as to whom PAS results in a determination that the individual requires comprehensive and coordinated NF services, in accordance with N.J.A.C. 8:85-2.1, provided in a therapeutic setting that assures family counseling and teaching in preparation for discharge to the community setting and to achieve at least one of the objectives listed at 2i through iii below; provided that individuals designated for Track II shall also be assigned to short-term NF stays, in spite of technically complex care needs and guarded prognosis, particularly in cases in which the individual is motivated towards NF alternatives and/or in which caregivers, through case management intervention, may obtain services that make return to the community a viable option.

i. To stabilize medical conditions;

ii. To promote rehabilitation; or

iii. To restore maximum functioning levels.

3. "Track III" means long-term care services in the community and shall be designated for individuals as to whom PAS results in a determination of Medicaid clinical eligibility for NF care in accordance with N.J.A.C. 8:85-2.1, but who can be appropriately cared for in the community with supportive health care services. These individuals may be eligible for Medicaid State Plan services or Home and Community-Based Services Waiver Programs.

"Transfer of ownership" means, for reimbursement purposes, a change in the majority ownership that does not involve related parties, related corporations or public corporations. "Majority ownership" is defined as an individual or entity who owns more than 50 percent of the facility.

"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.

Amended by R.2001 d.1, effective January 2, 2001.
See: 32 N.J.R. 2859(a), 33 N.J.R. 54(a).
Added "Transfer of ownership" to section.
Amended by R.2001 d.120, effective April 2, 2001.
See: 32 N.J.R. 3710(a), 33 N.J.R. 1108(a).
Added "New nursing facility" and "Replacement nursing facility".
Recodified from N.J.A.C. 10:63-1.2 and amended by R.2005 d.389, effective January 17, 2006.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).
Added definitions "Bed", "Beneficiary", "County welfare agency (CWA)", "Department of Human Services", "Division of Medical Assistance and Health Services", "Long-Term Care Field Office", "Material fact", "Mental illness", "Mental retardation", "Minimum Data Set (MDS) version 2.0 or most recent version", "Ombudsman", and "Professional staff designated by the Department"; deleted definitions "Medical evaluation team (MET)", "Medical social care specialist (MSCS)", "Minimum data set (MDS)", "Regional staff nurse (RSN)"

and "Section Q"; rewrote "Case management", "Department of Health", "Division of Developmental Disabilities", "Division of Mental Health and Hospital (DMH & H)", "Health Services Delivery Plan (HSDP)", "Nursing facility (NF)", "Pre-admission screening (PAS)", "Prior authorization", "Resident", "Social services", "Special care nursing facility (SCNF)" and "Track of care".

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).

8:85-1.3 Program participation

(a) A NF shall comply with the following requirements in order to be eligible to participate in the New Jersey Medicaid program. An in-State NF shall:

1. Be licensed by the Department in accordance with N.J.A.C. 8:39;

2. Be certified by the Department, and in the case of both Medicare and Medicaid, by the Centers for Medicare & Medicaid Services (CMS), which assures that the NF meets the Federal requirements for participation in Medicaid and Medicare;

3. Be approved for participation as a NF provider by the New Jersey Medicaid program. This includes the filing of a New Jersey Medicaid Provider Application PE-1 that establishes eligibility to receive direct payment for services to recipients under the New Jersey Medicaid program (see Appendix A as posted at www.state.nj.us/health/ltc/formspub.htm), the signing of a Participation Agreement PE-3 which is the participation agreement between the nursing facility and DHSS which stipulates that a NF shall provide all NF services required by N.J.A.C. 8:85 (see Appendix B as posted at www.state.nj.us/health/ltc/formspub.htm), and submittal of the CMS-1513 that is required to be completed before the State agency or Federal agency will enter into a contract for reimbursement of medical services, Ownership and Control Interest Disclosure Statement (see Appendix C as posted at www.state.nj.us/health/ltc/formspub.htm). The agreement for participation in the New Jersey Medicaid program stipulates that a NF shall provide all NF services required by N.J.A.C. 8:85. Continued participation as a New Jersey Medicaid provider will be subject to recertification by the Department and compliance with all Federal and State laws, rules and regulations. Upon recertification by the Department, each NF will receive notification from the Department's Office of Provider Enrollment, informing the facility that their provider agreement is being continued.

4. File with the Department a completed Cost Study for Nursing Facility form in the form provided at Appendix D, incorporated herein by reference. After the initial cost study is filed, the provider shall file a Cost Study for Nursing Facility form annually.

5. In accordance with 42 C.F.R. 483.12(d)(1)(i)(ii), not require residents or potential residents to waive their rights to Medicare or Medicaid; and not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for Medicare or Medicaid benefits;

6. Accept as payment in full the Medicaid program's reimbursement for all covered services delivered during that period when, by mutual agreement between Medicaid and the facility, the beneficiary is under the provider's care, in accordance with 42 CFR § 447.15 and N.J.S.A. 30:4D-6(c); and

7. Except as provided in (a)7i below, by December 1, 1997, be certified by Medicare as a provider of skilled nursing services for no less than seven percent of the facility's total licensed long-term care beds.

i. This requirement shall not apply if a nursing facility cannot be certified as a Medicare skilled nursing facility due to its inability to meet structural requirements for a physical plant as required by the Medicare certification process.

ii. Upon receipt of the application, the Department shall determine whether the facility shall be recommended for Medicare certification in accordance with 42 CFR Part 483. If the facility cannot be certified for Medicare participation, the Department shall provide the facility with the reasons for the certification denial in writing.

Amended by R.1998 d.177, effective April 6, 1998.
See: 29 N.J.R. 4614(a), 30 N.J.R. 1284(b).
In (a), inserted "to be eligible" following "order" in the introductory paragraph, and added 7.
Recodified from N.J.A.C. 10:63-1.3 and amended by R.2005 d.389, effective January 17, 2006.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).
Rewrote the section.

2. The certified facility provides written documentation of a denial of Medicare coverage:

i. The certified facility shall indicate for all Medicare eligible beneficiaries through status reports, that the effort was made to apply for Medicare reimbursement prior to Medicaid billing. Status reports affirming denial shall be obtained from the Medicare Fiscal Intermediary. Status reports shall consist of:

(1) A copy of form Inpatient Hospital and Skilled Nursing Facility Admission and Billing SSA-1453; or

(2) A notice of denial of coverage form Notice of Medicare Claim Determination SSA-1954 or form Notice of Medicare Claim Determination SSA-1955; or

(3) The facility statement of non-coverage, signed by an administrator or officer, which shall be accepted only under the limitation of benefits.

(f) Medicare Part A coinsurance may be paid by the New Jersey Medicaid Program, but the total combined Medicare/Medicaid reimbursement may never exceed the ***facility's*** **Medicaid** Nursing Facility rate. If the Medicaid beneficiary has available income during the coinsurance period of Medicare eligibility, it shall be used to offset the coinsurance charges, prior to billing Medicaid. New Jersey Medicaid will pay Part B Medicare insurance premiums for all eligible Medicare-Medicaid beneficiaries. Claims for Part B services shall be billed to Medicaid only after Medicare benefits have been exhausted. Medicare timely filing requirements shall be met prior to the reimbursement of coinsurance by Medicaid.

1. Coinsurance and deductible payment shall be made as follows:

i. Medicaid will not assume responsibility for payment of coinsurance for certain services under Part B Medical Insurance when the basis of payment is fee for service (for example, physicians or podiatrists). However, coinsurance is paid for certain other Part B Provider services where the basis for payment is not fee for service (for example, durable medical equipment), but only in those instances where the Medicare allowable reimbursement is less than the Medicaid established reimbursement for those items.

ii. Medicaid will assume responsibility for deductible payments for Part B Medical Insurance services.

Amended by R.1998 d.177, effective April 6, 1998.
See: 29 N.J.R. 4614(a), 30 N.J.R. 1284(b).
In (a), made an internal reference change in the introductory paragraph, and added 1 and 2; inserted a new (d); recodified former (d) as (e), inserted a reference to denial of benefits in the introductory paragraph, and added a second sentence in 1; and recodified former (e) as (f).
Recodified from N.J.A.C. 10:63-1.18 and amended by R.2005 d.389, effective January 17, 2006.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).
Substituted "beneficiary" for "recipient" throughout; rewrote (b).

Case Notes

Medicaid reimbursement for nursing facility was in accordance with prior settlement agreement with Division of Medical Assistance and Health Services and not in accordance with subsequent nurse-staffing regulations. Bergen Pines County Hospital v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 7.

Claim for Medicaid reimbursement denied; untimely filing. Applewood Estates v. Division of Medical Assistance and Health Services, 95 N.J.A.R.2d (DMA) 1.

SUBCHAPTER 2. NURSING FACILITY SERVICES

8:85-2.1 Nursing facility services; eligibility

(a) Eligibility for nursing facility (NF) services will be determined by the professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the beneficiary requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2.

1. Individuals requiring NF services may have unstable medical, emotional/behavioral and psychosocial conditions which require ongoing nursing assessment, intervention and/or referrals to other disciplines for evaluation and appropriate treatment. Typically, adult NF residents have severely impaired cognitive and related problems with memory deficits and problem solving. These deficits severely compromise personal safety and, therefore, require a structured therapeutic environment. NF residents are dependent in several activities of daily living (bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating). Dependency in activities of daily living (ADL) may have a high degree of individual variability. Each separate ADL may be classified as either independent, requiring some assistance, or totally dependent.

i. Children requiring NF services exhibit functional limitations identified either in terms of developmental delay requiring nursing care over and above routine parenting or are limited in terms of specific age-appropriate physical and cognitive activities, functional abilities (ADL) or abnormal behavior, as demonstrated by performance at home, school or recreational activities.

(1) Children who have achieved developmental milestones within appropriate time frames and who require only well child care and/or treatment of acute, time limited illnesses or injuries shall not be eligible for NF services.

2. NF residents shall be those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be

delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates that deterioration was unavoidable.

(b) All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health and Senior Services licensing rules at N.J.A.C. 8:39. Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

(c) NF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

Recodified from N.J.A.C. 10:63-2.1 and amended by R.2005 d.389, effective January 17, 2006.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).
In introductory paragraph (a), substituted "professional staff designated by the Department", substituted "beneficiary" for "recipient" and changed reference to "N.J.A.C. 8:85-2.2"; in (a)1, added "(bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating)"; in (b), added "and Senior Services" and changed reference to "N.J.A.C. 8:85-3".

Case Notes

Physically disabled and profoundly retarded child qualified for nursing facility care but not for placement in a specialized pediatric facility. N. C. on Behalf of her Son, W. C. v. Division of Medical Assistance and Health Services, 94 N.J.A.R.2d (DMA) 38.

8:85-2.2 Delivery of nursing services

(a) The NF shall provide 24-hour nursing services in accordance with the Department's minimum licensing standards set forth by the Standards for Licensure of Long-Term Care Facilities, N.J.A.C. 8:39, incorporated herein by reference, employing the service-specific case mix system to classify recipients with similar care requirements and resource utilization. The NF shall provide nursing services by registered professional nurses, licensed practical nurses and nurses aides based on the total number of residents multiplied by 2.5 hours per day; plus the total number of residents receiving each of the following services, as more fully described at (f) below:

1.	Wound care	0.75 hour per day
2.	Tube feeding	1.00 hour per day
3.	Oxygen therapy	0.75 hour per day
4.	Tracheostomy	1.25 hours per day
5.	Intravenous therapy	1.50 hours per day
6.	Respiratory services	1.25 hours per day
7.	Head trauma stimulation; and advanced neuromuscular or orthopedic care	1.50 hours per day

(b) The NF level of nursing care means services provided to Medicaid beneficiaries who are chronically or sub-acutely ill and require care for these entities, disease sequela or related deficits.

(c) The NF level of nursing care shall incorporate the principles of nursing process which consists of ongoing assessment of the beneficiary's health status for the purpose of planning, implementing and evaluating the individual's response to treatment.

1. In his or her capacity as coordinator of the interdisciplinary team, the registered professional nurse, who has primary responsibility for the beneficiary, shall perform, beginning on the day of admission, a comprehensive assessment of the beneficiary to provide, communicate and record within the SRA: baseline data of physiological and psychological status; definition of functional strengths and limitations; and determination of current and potential health care needs and service requirements.

i. In addition to clinical observations and hands-on examination of the Medicaid beneficiary, the licensed nurse shall review the HSDP and any available transfer records. The assessment data shall be coordinated by the registered professional nurse with oral or written communication and assessments derived from other members of the interdisciplinary team and shall be consistent with the medical plan of treatment. The initial comprehensive assessment (SRA) shall be completed no later than 14 days after admission and on an annual basis thereafter. If there is a significant change in the beneficiary's status, the NF shall complete a full comprehensive assessment involving the SRA. The registered professional nurse shall analyze the data and utilize the resident assessment protocols (RAPs) to focus problem identification, structure the review of assessment information and develop an interdisciplinary care plan which documents specific interventions unique to the individual, which define service requirements and facilitate the plan of treatment.

2. The interdisciplinary care plan shall identify and document the beneficiary's problems and causative or contributing factors and is derived from the comprehensive assessment. The plan shall be coordinated and certified by the registered professional nurse with active participation of the Medicaid beneficiary and/or significant other. The scope of the plan shall be determined by the actual and anticipated needs of the Medicaid beneficiary and shall include: physiological, psychological and environmental factors; beneficiary/family education; and discharge

a conventional nursing facility as defined in N.J.A.C. 8:85-2. A SCNF or SCNF unit shall have a minimum of 24 beds.

1. The minimum bed requirement will be waived for SCNFs that were approved by DMAHS prior to November 23, 1994. In addition, the requirement will be waived in those instances where a SCNF's Certificate of Need stipulates a specific number of beds approved by the New Jersey Department of Health and Senior Services.

2. A SCNF receiving reimbursement through the Medicaid program shall not increase its total number of licensed beds for which a SCNF rate of reimbursement is received except upon approval from the Department.

3. A SCNF shall provide intensive medical, nursing and psychosocial management to the seriously ill individual who has potential for measurable and consistent maturation or rehabilitation, or has a technologically and/or therapeutically complex condition which requires the delivery of intensive and coordinated health care services on a 24-hour basis.

(b) A SCNF shall provide the services of an interdisciplinary team, under the direction of a physician specialist, who has training and expertise in the treatment specific to the medical condition and needs of the target population.

1. Within a focused therapeutic program, targeted, when appropriate, at timely discharge to alternative health care settings, such as conventional NF or community-based services, the SCNF shall provide:

i. Aggressive management and treatment to stabilize, improve and monitor current conditions;

ii. Appropriate, intensive rehabilitative therapies and counseling services; and

iii. Coordinated care planning and delivery of required services.

(c) A SCNF shall provide services to Medicaid beneficiaries who have been determined, through the PAS process, to require extended rehabilitation and/or complex care. The individual's progress and overall response to the therapeutic regimen shall determine length of stay.

1. Extended rehabilitation shall be considered for a medically stable individual with a condition whose prognosis indicates the potential for rehabilitative progress which requires a prescribed period of therapeutic treatment and goal-directed services provided by a qualified interdisciplinary team to restore the individual to the highest practical level of physical, cognitive and behavioral functioning. The individual may remain for a period of up to 12 months, with a review after six months. Length of stay will be extended for periods of six months, if continued benefit from the service can be demonstrated.

2. Complex care shall be considered for a medically stable individual judged to have plateaued who demonstrates the need for prolonged, technologically and/or therapeutically complex care. Although the rehabilitative component may be less intense, the individual continues to require focused assessment, coordinated care planning and direct services on a continuing basis provided by an interdisciplinary team with training and expertise in the treatment of the medical conditions and specialized needs of the resident population. The individual may remain for a period of up to two years with review every 12 months. Length of stay will be extended for periods of six months if continued benefit from the service can be demonstrated.

3. Medicaid beneficiaries who are suitably placed in the community, receiving care in appropriate alternative placements or referred for social reasons only shall not be authorized for admission to a SCNF.

(d) Discharge procedures shall include utilizing Medicaid discharge protocols established by this chapter, and shall be in accordance with the following:

1. The beneficiary shall be discharged upon achievement of maximum benefit from the specialized programming and maximum level of functioning and when the individual's condition can be appropriately managed in either the community or other forms of institutional care.

2. Outpatient treatment and supported community services may be needed to assist in community integration.

3. When a beneficiary residing in a SCNF unit of a conventional NF is determined by Department staff to no longer require special programming, yet continues to require conventional NF services, the beneficiary shall be accepted for placement into a conventional NF bed in the facility. If a conventional NF bed within the facility is not available within a reasonable time, the SCNF shall assist the individual in finding placement in another conventional nursing facility. The SCNF shall be afforded 30 to 60 days from the date of the determination to effect transfer of the beneficiary to a bed within the facility's conventional bed allocation or arrange transfer to another conventional NF.

(e) The SCNF shall provide all required services, as defined in this subchapter.

1. A SCNF shall provide those medical services as defined in N.J.A.C. 8:85-2.3, with the following modifications and/or additions:

i. A freestanding SCNF shall have a designated medical director who is board eligible/certified in a medical specialty as targeted by the medical diagnoses, medical conditions and/or resident population of the SCNF. The medical director shall also function as a primary care attending physician. If a medical group provides medical services, a member of that group shall be designated as the medical director.

(1) In lieu of the requirements contained in (e)1i above, a freestanding SCNF may have a designated medical director who is a licensed physician and was serving as medical director prior to November 23, 1994.

ii. For each resident there shall be a designated primary care physician specialist who is board eligible/certified in a medical specialty determined by the medical diagnoses, medical conditions and or resident population;

iii. Responsibilities of the primary care physician include but are not limited to:

(1) History, physical exam and diagnosis on admission and a comprehensive physical exam conducted on a yearly basis;

(2) Medical assessment shall reflect a correlation of the staging of existing diagnosis and premorbid conditions to the prognosis for rehabilitation.

(3) Each resident shall be examined and evaluated as required by the individual's condition as designated by the medical care plan.

2. A SCNF shall provide those nursing services as defined in N.J.A.C. 8:85-2.2 with the following modifications and/or additions:

i. A freestanding SCNF shall have a director of nurses or a nursing administrator who is a registered professional nurse in the State of New Jersey and possesses a Master's Degree or a Baccalaureate Degree in Nursing and has a minimum of two years experience as a nursing administrator or who has at least two years of supervisory experience in either an acute or long-term care setting.

(1) In lieu of the education and experience requirements of (e)2i above, the director of nurses or nursing administrator shall have served in that capacity prior to November 23, 1994.

(2) A SCNF unit within a conventional NF whose director of nursing does not meet the qualifications of (e)2i above shall have a nurse manager who meets the qualifications assigned full time to the unit.

ii. Registered professional nurses certified in intravenous therapy shall be available on a 24 hour basis.

iii. Two and one-half hours of basic nursing services by registered professional nurses, licensed practical nurses and certified nurse aides as defined in N.J.A.C. 8:85-2.2 shall be provided per beneficiary per day. Additional nursing services in a SCNF up to a maximum of three hours may be provided due to technically complex nursing needs and/or intensive rehabilitative/ restorative nursing care needs. A SCNF which is an identifiable unit within a conventional NF shall calculate the nurse staffing level separate and apart from the nurse staffing level of the conventional beds.

iv. Provision of additional nursing services as defined in N.J.A.C. 8:85-2.2 does not apply to nurse staffing rules in a SCNF. The additional nursing services described at N.J.A.C. 8:85-2.2(a) are included in the three hours.

(1) Sixty percent of the additional hours of care under iii above shall be provided by registered professional nurses, and forty percent shall be provided by licensed practical nurses. There shall be a minimum of one registered professional nurse, one licensed practical nurse and one certified nurse aide on each shift.

v. Responsibilities of the nursing staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1) Expertise and understanding of the physiologic impact, prognosis and treatment needs specific to the medical condition or specialized needs of the target population to enhance integration of the resident and family goals with adjustment and rehabilitation.

(2) Utilization and application of specialized equipment essential to provide services required for the care and treatment of the SCNF population.

(3) Comprehensive and coordinated program of restorative and rehabilitative nursing services to prevent complications and promote and/or restore the individual's physical, psychosocial function to a realistic level.

(4) Individual/family education and instruction of self care to promote optimum level of health in preparation for discharge to a less restrictive environment.

(5) Evaluation and management of moderate to extreme emotional and behavioral disorders related to illness.

3. A SCNF shall provide those social services as required by N.J.A.C. 8:85-2.6, with the following modifications and/or additions:

i. The social services coordinator shall possess a Master's Degree or Baccalaureate Degree in Social Work from a college or university accredited by the Council on Social Work and have at least two years of full time social work experience in a health care setting.

ii. An average of at least 50 minutes of social work services per week for each resident. This is equal to one half-time equivalent social worker for every 24 residents.

iii. In a SCNF with more than 48 beds, one of the direct care social workers shall be designated as the Director of Social Services.

iv. Responsibilities of the social service staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1) Knowledge of alternative care programs and resources in the community to assist the resident/family with appropriate discharge planning.

(2) Maintain a library of information and resources pertinent to the resident's diagnosis, educational/vocational training needs and applications to community based programs.

(3) Facilitate on-going collaboration and coordination among health care providers, the resident and the family to promote long-range social and health care planning.

(4) Coordinate programming with community-based resources to facilitate continuity of care and assimilation into community/family environment.

(5) On-going supportive intervention with the resident/family in dealing with the confusion, anger, fear, depression, guilt and conflict associated with illness.

4. A SCNF shall provide resident activities required by N.J.A.C. 8:85-2.5, with the following modifications and/or additions:

i. The director of resident activities shall possess a Master's Degree or Baccalaureate Degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, occupational therapy or therapeutic recreation. In addition, three years of experience in a clinical, residential or community-based therapeutic recreation program is required.

(1) In lieu of (e)4i above, the individual shall have served as director of resident activities prior to November 23, 1994; or

(2) In lieu of (e)4i above, hold current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, 520 Stewart, Park Ridge, Illinois 60068) or the National Council of Therapeutic Recreation Certification (National Council of Therapeutic Recreation Certification, P.O. Box 16126, Alexandria, Virginia 22302.

ii. An average of at least 100 minutes of resident activity services per week for each resident. This is equal to one full-time equivalent resident activities staff for every 24 residents. This staff person shall serve as the Director of Resident Activities.

iii. For each additional 24 beds, the facility shall provide the services of a full-time resident activities assistant.

iv. Responsibilities of the resident activities staff, in concert with other members of the interdisciplinary team, shall include, but are not limited to:

(1) Utilization of all possible community, social, recreational, public and voluntary resources to promote the resident's ties with community life.

(2) Provision of therapeutic resident activities which endorse the therapeutic plan of care.

(3) Incorporation of family-centered activities which provide a supportive, therapeutic environment to give residents and families an opportunity to work together toward achieving common goals.

5. A SCNF shall provide, directly in the facility, the rehabilitation services as required by N.J.A.C. 8:85-2.4 on an intensive level which are specifically targeted to meet the goals of the prescribed treatment plan.

i. Rehabilitative therapies shall include, but shall not be limited to:

(1) Physical therapy;

(2) Occupational therapy;

(3) Speech/language pathology; and

(4) Cognitive or remedial therapies (including neuropsychological treatment)

ii. Rehabilitation services shall focus on developing and/or restoring maximum levels of function within the limits of the resident's impairment. Through collaboration with other members of the interdisciplinary team, a comprehensive rehabilitation plan shall be developed which:

(1) Identifies rehabilitation needs and establishes realistic criteria for measuring the need for continued rehabilitative services;

(2) Projects targeted outcomes (goals) and defines the parameters to measure response to treatment goals; and

(3) Establishes realistic time frames to meet outcome criteria.

6. Mental health services provided by a licensed psychiatrist, psychologist or other appropriately credentialed professional shall be provided to residents with mental health disorders in accordance with N.J.A.C. 8:85-2.9.

7. A SCNF that provides ventilator management of New Jersey Medicaid eligible children or adults shall provide respiratory therapy services beyond the scope of N.J.A.C. 8:85-2, which shall include, but not be limited to:

i. A respiratory care practitioner who is currently licensed by the New Jersey State Board of Respiratory Care be available on the premises on a 24 hour basis.

ii. Respiratory life support systems must be provided inclusive of, but not limited to:

(1) Mechanical ventilators (pressure/volume/time cycled), (portable/stationary); and

(2) Oxygen therapy delivery systems.

iii. Administration of medically prescribed respiratory care which includes, but is not limited to:

(1) Nasopharyngeal aspiration;

(2) Maintenance of natural and mechanical airways;

(3) Insertion and maintenance of artificial airways;

(4) Aerosol treatment;

(5) Administration of nebulized bronchodilators;

(6) IPPB;

(7) Oxygen therapy;

(8) Mechanical ventilation with/without supplemental oxygen;

(9) Monitoring of blood gases;

(10) Under the direction of the pulmonologist, the respiratory therapist applies weaning parameters and provides direct supervision during the weaning process;

(11) Postural drainage and chest percussion; and

(12) Breathing exercise and respiratory rehabilitation.

iv. Medically prescribed respiratory therapy may be provided to non-ventilator dependent children or adults who, due to cardio-respiratory deficiencies and/or abnormalities, require:

(1) Apparatus for cardio-respiratory support and control;

(2) Respiratory rehabilitation/chest physiotherapy;

(3) Maintenance of natural airway patency;

(4) Insertion and maintenance of artificial airway;

(5) Measurement of cardio-respiratory volume, pressure and flow;

(6) Drawing and analyzing samples of arterial, capillary and venous blood;

(7) Administration of aerosolized respiratory medications such as nebulized bronchodilators or antiprotozoals;

(8) Assessment, intervention, and evaluation by a registered professional nurse; and/or

(9) Protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by the physician or advanced practice nurse.

Amended by R.1996 d.147, effective March 18, 1996.
See: 27 N.J.R. 3314(a), 28 N.J.R. 1535(a).
Recodified from N.J.A.C. 10:63-2.21 and amended by R.2005 d.389, effective January 17, 2006.
See: 36 N.J.R. 4700(a), 37 N.J.R. 1185(a), 38 N.J.R. 674(a).
Rewrote the section.

Case Notes

Special care nursing facility recipient continues to receive services if evaluation supports continued intensive care coordinated health care required. J.B. v. Division of Medical Assistance and Health Services, 97 N.J.A.R.2d (DMA) 17.

SUBCHAPTER 3. COST REPORT, RATE REVIEW GUIDELINES AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

8:85-3.1 Purpose and scope

(a) These rules describe the methodology to be used by the State of New Jersey, Department of Health and Senior Services (Department), to establish prospective per diem rates for the provision of nursing facility services to residents under the State's Medicaid program.

(b) The Department believes that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The Department recognizes, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c) Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the Department is prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d) On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the Department reserves the right to question and