3. Periodic review and updating of the plan of care for each recipient receiving hospice services with the attending physician;

4. Establishment of policies governing the day-to-day provision of hospice services; and

5. In-service education for volunteer staff before he or she begins providing care for a hospice recipient.

(d) A hospice recipient, family members, and/or significant others shall participate in the formulation of the final plan of care.

(e) If the hospice has more than one interdisciplinary group, it shall designate, in advance, the group it chooses to execute the functions described above.

(f) The Medical Director or Director of Nursing of the hospice shall designate a registered professional nurse to coordinate the implementation of the plan of care for each recipient.

(g) Volunteer assistance is an integral part of hospice services. The hospice shall document and maintain a volunteer staff sufficient to provide administrative and patient care in an amount that, at a minimum, equals five percent of the total compensated patient care hours provided by all paid hospice employees and contracted staff regardless of the payment source.

10:53A–2.5 Administrative policy for admission and discharge from room and board services in a nursing facility

(a) If a recipient of hospice services is admitted to a nursing facility (NF) from any location, or is changed from nursing facility status to hospice status (while residing in a nursing facility), or is discharged from the hospice or dies, the NF shall submit to the CWA and the MDO, a completed Notification from Long–Term Care Facility of Admission or Termination of a Medicaid Patient (MCNH–33) (Form # 9 in the Appendix, incorporated herein by reference) to prompt a change in the recipient's status.

(b) If the recipient residing in an NF chooses hospice benefits, the NF shall submit to the fiscal agent, a completed Long Term Care Turnaround Document (TAD)(MCNH–117) (Form # 11 in the Appendix herein incorporated by reference) to remove the patient from the Long Term Care Facility billing system. The following information shall be placed on the MCNH–117 in the REMARKS column (Field # 38 on the bottom):

"DISCHARGED FROM NURSING FACILITY TO HOSPICE"

1. The hospice recipient is removed from the Long Term Care Facility billing system effective on the date the Election of Hospice Benefits Statement, FD–378 (6/92) (Appendix Form # 1) is signed. On that date and thereafter, the Medicaid fiscal agent will directly reimburse the hospice for services rendered to the hospice recipient and the NF will no longer be reimbursed for care beginning this date. The hospice shall be responsible for reimbursing the NF for room and board services provided under contract with the hospice.

2. If the recipient revokes hospice and returns to NF care, the NF shall complete and submit the Long Term Care Turnaround Document (TAD)(MCNH–117) form to the fiscal agent. The following information shall be placed on the MCNH–117 in the REMARKS column (Field # 38 on the bottom):

"ADMITTED TO NURSING FACILITY AND DISCHARGED FROM HOSPICE"

3. The effective date of the change from hospice care to NF care is the date the Revocation of Hospice Benefits, FD–381 (6/92) (Form # 4 in the Appendix incorporated herein by reference) is signed. The NF will be reimbursed for care provided on this date and thereafter, and the hospice will no longer be reimbursed for care beginning on this date.

10:53A–2.6 Recordkeeping

(a) The medical record of the hospice recipient maintained by the hospice shall be complete and accurate and reflect the services provided. The medical record shall include, at a minimum, the following information:

1. Identification information;

2. Certification/recertification documents;

3. Informed consent documents;

4. Election forms;

5. Hospice eligibility forms;

6. Pertinent medical history and physical examination data;

7. Test results;

8. Initial and subsequent assessments;

9. Plan of care and updates; and

10. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

(b) All medical records shall be signed and dated by the professional staff person providing the service.

(c) The medical record shall be maintained and made available, as necessary, to the Division of Medical Assistance and Health Services or its agent for audit and review purposes in accordance with State law (see N.J.S.A. 30:4D–12 and (N.J.A.C. 10:49–13.1).

10:53A–2.7 Monitoring

(a) On a random selection basis, the Division shall conduct post-payment quality assurance reviews based on Surveillance and Utilization Review System (SURS) reports and other sources to assure compliance with program, personnel, recordkeeping and service delivery requirements. Provisions shall be made to recover funds, when reviews by the Division reveal that overpayments to the hospice have been made. At the specific request of the Division, the hospice shall submit a plan of care and other documentation for those Medicaid recipients selected for a quality assurance review.

1. The review shall involve contact with the hospice and the recipient and will focus on the following areas:

i. Number of recipients;

ii. Cost per recipient including the "cap" requirements;

iii. Number of days of service per recipient and the quality of services;

iv. Comparative analysis between claim payments and the plan of care; and

v. Completion of forms necessary for eligibility for hospice services.

(b) On-site monitoring visits shall be made by the Division staff for the purpose of determining compliance with the provisions of the Medicaid hospice rules and for quality assurance purposes. The results of the on-site monitoring shall be reported to the hospice with a copy for the Division. When indicated, a plan of correction will be required. Continued non-compliance with requirements may result in such sanctions as: the curtailment of accepting new recipients for services; termination of the hospice's provider contract; and/or the suspension, debarment or disqualification of the hospice or hospice-related parties from participation in the Medicaid program.

10:53A–2.8 Provision for provider fair hearings

Pursuant to the N.J.A.C. 10:49–10, Notices, Appeals and Fair Hearings, providers with the New Jersey Medicaid program have the right to file for fair hearings.

10:53A–2.9 Advance directives

(a) All hospices participating in the New Jersey Medicaid program are required to comply with the provisions of the Federal Patient Self Determination Act (P.L. 101–108) and must notify Medicaid hospice recipients about their rights under State law to make decisions concerning their medical care and their right to formulate an advance directive.

1. All hospice providers are required by Federal law to:

i. Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the hospice agency about their rights under State law to make decisions concerning their medical care and the right to formulate an advance directive;

ii. Provide the New Jersey State Department of Health statement of New Jersey law (Your Right to Make Health Care Decisions in New Jersey) to recipients upon initial receipt of hospice care, regarding their rights to make decisions concerning their medical care. This includes the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive for their health care;

iii. Provide written information to recipients, upon initial receipt of hospice care, concerning the hospice agency's written policies on the implementation of such rights;

iv. Document in the recipient's medical record whether or not the recipient has executed an advance directive;

v. Not condition the provision of care or otherwise discriminate against a recipient based on whether or not the recipient has executed an advance directive;

vi. Ensure compliance with requirements of State law respecting advance directives; and

vii. Provide education for staff and the community on issues concerning advance directives.

2. The provisions in (b)1 above do not prohibit the application of a State law which allows a hospice to refuse to implement an advance directive based on conscientious objection. The New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, does allow private religious affiliated health care institutions to develop institutional policies and practices defining circumstances in which they will decline to participate in the withholding or withdrawing of specific measures to sustain life. Such policies and practices are to be included in the hospice's written policies.

SUBCHAPTER 3. RECIPIENT REQUIREMENTS

10:53A–3.1 Eligibility for covered hospice services

(a) For the purposes of this subchapter only, the term "applicant" refers to an individual applying for hospice eligibility who may or may not be Medicaid eligible at the time of application.

(b) In order to receive hospice services, an individual must be eligible for Medicaid either in the community or in an institution. Additionally, an individual is eligible for hospice services in the community if he or she would be eligible for Medicaid if he or she were institutionalized. Eligibility rules are found at N.J.A.C. 10:71, and 10:72, incorporated herein by reference. Persons eligible only for the Medically Needy component of the New Jersey Medicaid program are not eligible for hospice services.