CHAPTER 60

HOME CARE SERVICES

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SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 Purpose and scope

(a) The purpose of the home care services program, as delineated in this chapter, is to provide home care services to those individuals determined eligible.

(b) This chapter provides requirements for, and information about, the following services and programs:

1. Home health services;
2. Personal care assistant services;
3. Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing (EPSDT/PDN) Services;
4. Home and Community-Based Services Waiver programs, which are administered by the Department of Human Services through 42 U.S.C. § 1915(c) waivers, as follows:
   i. Home and Community-Based Services Waiver for Blind or Disabled Children and Adults (Model Waivers 1, 2, and 3);
   ii. Home and Community-Based Services Waiver for Persons with AIDS and Children up to the age of 13 who are HIV Positive, known as AIDS Community Care Alternatives Program (ACCAP);
   iii. Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI);
   iv. Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (DDD-CCW) Individuals; and
   v. Home and Community-Based Services Waiver Program for Medically Fragile Children under the Division of Youth and Family Services (DYFS) Supervision (ABC); and
5. Home and Community-Based Services Waiver programs (1915(c) waivers) administered by the Department of Health and Senior Services (DHSS):
   i. Community Care Program for the Elderly and Disabled (CCPED); and
   ii. Enhanced Community Options Waiver (ECO), which provides home and community-based services to aged or disabled adults.

(c) Home health agencies, homemaker agencies, hospice agencies, and private duty nursing agencies are eligible to participate as Medicaid and NJ KidCare fee-for-service home care services providers. The services which each type of agency may provide and the qualifications required to participate as a Medicaid provider are listed in N.J.A.C. 10:60-1.2 and 1.3.

(d) General information about the home health agency services program and the personal care assistant services program are outlined in this subchapter. Specific program requirements are provided in N.J.A.C. 10:60-2 and 3, respectively.

(e) Requirements of the Home and Community-Based Services Waiver Programs are

provided in N.J.A.C. 10:60-6, 7, 8 and 9.

(f) 10:60-11 HCFA Common Procedure Coding System--HCPCS, outlines the procedure codes used to submit a claim for services provided under the personal care assistant services program, Home and Community-Based Services Waiver programs (except CCPED and ECO), Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing Services, and the Traumatic Brain Injury Program.

10:60-1.2 Definitions

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

"Calendar work week" means the time parameters which constitute a work week for personal care assistant services. These time parameters are from Sunday at 12:00 A.M. to Saturday at 11:59 P.M.

"Case management" is defined as the process of on-going monitoring by Division staff, of the delivery and quality of home care services, as well as the beneficiary/caregiver's satisfaction with the services. Such case management does not include the case management services provided under the home and community-based services waiver programs (N.J.A.C. 10:60-6.3(b)1 and 10.1(i)). Case management ensures timely and appropriate provider responses to changes in care needs and assures delivery of coordinated services which promote maximum restoration and prevents unnecessary deterioration.

"Class C boarding home" means a boarding home which offers personal assistance as well as room and board, as defined by the Department of Community Affairs (see N.J.A.C. 5:27).

"DHSS" means the Department of Health and Senior Services.

"Dietitian" means a person who is a graduate of an accredited college or university with courses meeting the academic standards of the American Dietetic Association, plus a dietetic internship or dietetic traineeship or master's degree plus six months experience. A registered dietitian is one who has met current requirements for registration.

"Discharge planning" means that component part of a total individualized plan of care formulated by all members of the agency's health care team, together with the beneficiary and/or his or her family or interested person which anticipates the health care needs of the beneficiary in order to provide for continuity of care after the services of the home care agency have terminated. Such planning aims to provide humane and

psychological preparation to enable the beneficiary to adjust to his or her changing needs and circumstance.

"Division" means the Division of Medical Assistance and Health Services.

"Early and periodic screening, diagnosis and treatment/private duty nursing (EPSDT/PDN)" means the private duty nursing services provided to Early and Periodic Screening, Diagnosis and Treatment Program beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify that need.

"Field security cost" means costs incurred by a home health agency in providing security personnel to accompany medical care staff of a home health agency during onsite visits to the patient's home.

"Health services delivery plan (HSDP)" means an initial plan of care prepared by DHSS during the preadmission screening (PAS) assessment process. The HSDP reflects individual problems and required care needs. The HSDP is to be forwarded to the authorized care setting and is to be attached to the beneficiary's medical record upon admission to a nursing facility or when the beneficiary receives services from home health care agencies. The HSDP may be updated as required to reflect changes in the beneficiary's condition.

"Home health agency" means a public or private agency or organization, either proprietary or non-profit, or a subdivision of such an agency or organization, which qualifies as follows:

1. Is approved by the New Jersey State Department of Health and Senior Services, including requirements for Certificate of Need and licensure when applicable;
2. Is certified as a home health agency under Title XVIII (Medicare) Program; and
3. Is approved for participation as a home health agency provider by the New Jersey Medicaid or NJ KidCare program or the Medicaid agent.

"Homemaker agency" means a proprietary or voluntary non-profit agency approved by the Department of Human Services, Division of Medical Assistance and Health Services to provide Personal Care Assistant Services, and homemaker services under any waiver program approved by the Health Care Financing Administration and accredited, initially and on an on-going basis, by the Commission on Accreditation for Home Care Inc., the National HomeCaring Council, a Division of the Foundation for Hospice and Homecare or the Community Health Accreditation Program (CHAP).

"Homemaker-home health aide" means a person who:

1. Successfully completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of

Nursing, as a homemaker-home health aide. A copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division is retained in the agency's personnel file.

2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and

3. Is supervised by a registered professional nurse employed by a Division approved home health agency provider.

"Hospice agency" means a public agency or private organization (or subdivision of such organization) that is Medicare certified for hospice care in accordance with N.J.A.C. 10:53A, and has a valid provider agreement with the Division to provide hospice services.

"Hospice service" means a service package provided by a Medicaid approved hospice agency to beneficiaries enrolled in the AIDS Community Care Alternatives Program (ACCAP) who are certified by an attending physician as terminally ill, with a life expectancy of up to six months. The service package supports a philosophy and method for caring for the terminally ill emphasizing supportive and palliative, rather than curative care, and includes services such as home care, bereavement counseling, and pain control. (For information regarding hospice services to regular Medicaid or NJ KidCare fee- for-service beneficiaries under Title XIX, see Hospice Services Manual N.J.A.C. 10:53A).

"Levels of care" means two levels of home health care services, acute and chronic, provided by a certified, licensed home health agency, as needed, to Medicaid or NJ KidCare fee-for-service beneficiaries, upon request of the attending physician.

1. "Acute home health care" means concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required.

2. "Chronic home health care" means either long or short-term uncomplicated, professional and non-professional services, where there is no anticipated change in condition and services required.

"Licensed practical nurse" means a person who is licensed by the State of New Jersey as a practical nurse, pursuant to N.J.A.C. 13:37, having completed formal accredited nursing education programs.

"Long Term Care Field Office (LTCFO)" means a unit of DHSS.

"Medicaid District Office" (MDO) means one of the community-based Division offices located throughout the State.

"Non-routine supplies" means non-routine supplies defined in the Medicare Medical Review Supply List published August 1994 by United Government Services, incorporated herein by reference, as amended and supplemented. (A copy of the list may be obtained from United Government Services, 115 Stevens Ave., Valhalla, N.Y. 10595.)

"Nutritionist" means a person who has graduated from an accredited college or university, with a major in foods or nutrition or the equivalent course work for a major in the subject area, and two years of full-time professional experience in nutrition. Successful completion of a dietetic internship of traineeship in hospital or community nutrition approved by the American Dietetic Association, or completion of a master's degree in the subject area may be substituted for the two years of full-time experience.

"Occupational therapist" means a person, who is registered by the American Occupational Therapy Association, or a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association. If treatment and/or services are provided in a state other than New Jersey, the occupational therapist shall meet the practice requirements of that state including licensure, if applicable, and shall also meet all applicable federal requirements.

"On-site monitoring" means a visit by Division staff to a homemaker agency, private duty nursing agency, provider of waiver services, or hospice agency to monitor compliance with this chapter.

"Performance standards" for the purpose of this chapter means the criteria established by this Division in order to measure the beneficiary/caregiver's satisfaction with the quality, quantity and appropriateness of the services delivered.

"Personal care assistant" means a person who:

1. Successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate or other documentation issued by the New Jersey Department of Law and Public Safety, Board of Nursing is retained in the agency's personnel file.
2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and
3. Is supervised by a registered professional nurse employed by a Division- approved homemaker/personal care assistant provider agency.

"Personal care assistant services" means health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.

"Physical therapist" means a person who meets all the applicable Federal requirements, and

1. If practicing in the State of New Jersey, is licensed by the State of New Jersey; or
2. If treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable.

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which the physician practices.

"Plan of care" means the individualized and documented program of health care services provided by all members of the home health or homemaker agency involved in the delivery of home care services to a beneficiary. The plan includes short-term and long-term goals for rehabilitation, restoration or maintenance made in cooperation with the beneficiary and/or responsible family members or interested person. Appropriate instruction of beneficiary, and/or the family or interested person as well as a plan for discharge are also essential components of the treatment plan. The plan shall be reviewed periodically and revised appropriately according to the observed changes in the beneficiary's condition.

"Preadmission screening (PAS)" means that process by which all eligible Medicaid and NJ KidCare fee-for-service beneficiaries, and individuals who may become Medicaid eligible within 180 days following admission to a Medicaid certified nursing facility, and who are seeking admission to a Medicaid certified nursing facility or a waiver program receive a preadmission screening by DHSS professional staff to determine appropriate placement prior to admission to a nursing facility or enrollment in a waiver program pursuant to N.J.S.A. 30:4D-17.10 (P.L. 1988, c.97).

"Primary caregiver" means an adult relative or significant other adult who accepts 24 hour responsibility for the health and welfare of the beneficiary. For the beneficiary to receive private duty nursing services under ACCAP, Model Waiver 3, ABC, or EPSDT, the primary caregiver must reside with the beneficiary and provide a minimum of eight hours of hands-on care to the beneficiary in any 24 hour period.

"Prior authorization" means the process of approval by the Division for certain services prior to the provision of these services. Prior authorization also may be applied in other service areas in situations of an agency's continued non-compliance with program requirements. In accordance with N.J.A.C. 10:60-2.1, if a patient is enrolled in an HMO,

authorization for reimbursement is required by the HMO prior to rendering any service.

"Private duty nursing" means individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to beneficiaries under Model Waiver 3, ABC, and ACCAP, as well as eligible EPSDT beneficiaries.

"Private duty nursing agency" means a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by the Division to provide private duty nursing services under Model Waiver 3, ABC, ACCAP or EPSDT. The private duty nursing agency shall be located/have an office in New Jersey and shall have been in operation and actively engaged in home health care services in New Jersey for a period of not less than one year prior to application.

"Public health nurse" means a person licensed as a registered professional nurse, who has completed a baccalaureate degree program approved by the National League for Nursing for public health preparation, or post- baccalaureate study which includes content approved by the National League for Nursing for public health nursing preparation.

"Quality assurance," for the purpose of this chapter, means a system by which Division staff shall conduct post payment reviews to determine the beneficiary/caregiver's satisfaction with the quality, quantity and appropriateness of home health care services provided to Medicaid and NJ KidCare fee-for-service beneficiaries.

"Registered professional nurse" means a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.A.C. 13:37.

"Residential health care facility (RHCF)" means a facility, licensed in accordance with N.J.A.C. 8:43, which provides food, shelter, supervised health care and related services to four or more persons 18 years of age or older who are unrelated to the owner or administrator.

"Routine supplies" means routine supplies defined in the Medicare Medical Review Supply List published August 1994 by United Government Services, incorporated herein by reference, as amended and supplemented.

"Social worker" means a person who is licensed by the State of New Jersey as a licensed social worker or licensed clinical social worker, pursuant to N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G.

"Social work assistant" means a person who has a baccalaureate degree in social work,

or psychology, or sociology or other field related to social work and has had at least one year of social work experience in a health care setting.

"Speech-language pathologist" means a person who meets all applicable Federal requirements, and

1. If practicing in the State of New Jersey, is licensed by the State of New Jersey; or
2. If treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable.

"Unit" means one full 15 minute interval of face-to-face service in which hands-on medical care is provided to a Medicaid or NJ KidCare fee-for-service beneficiary. (See N.J.A.C. 10:60-2.5 for further explanation.)

"Visit" means any combination of units of home health services which are provided when the home health agency staff arrives at the Medicaid or NJ KidCare fee-for-service beneficiary's residence and ends when the home health agency staff leaves the beneficiary's residence.

10:60-1.3 Providers eligible to participate

(a) A home care agency or organization, as described in (a)1 through 4 below, is eligible to participate as a New Jersey Medicaid provider of specified home care services in accordance with N.J.A.C. 10:49-3.2:

1. A home health agency, as defined in N.J.A.C. 10:60-1.2;

i. Out-of-State home health agencies providing services to Medicaid beneficiaries out of State, must meet the requirements of that state, including licensure, if applicable, and must meet all applicable Federal requirements.

2. A homemaker agency, as defined in N.J.A.C. 10:60-1.2;

i. A new provider shall be issued a Medicaid Provider Billing Number by the fiscal agent. Those Personal Care Assistance (PCA) providers already enrolled as providers of homemaker services in the CCPED program (see N.J.A.C. 10:60-10.1) shall use the same Medicaid Provider Billing Number issued for CCPED.

3. A private duty nursing agency, as defined in N.J.A.C. 10:60-1.2; and
4. A hospice agency, as defined in N.J.A.C. 10:60-1.2.

(b) The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis, by the Commission on Accreditation for Home Care, Inc., the Community Health Accreditation Program, or the Foundation for Hospice and Homecare.

1. Exception: A private duty nursing agency currently approved by the Division to provide private duty nursing services (except for the licensed home health agency which is exempt from the accreditation requirement) shall have up to July 1, 1996 to become

an accredited agency and meet the Division's requirements for accreditation. New private duty nursing agencies applying to become Medicaid providers after December 19, 1994 shall conform to the accreditation requirement at the time of application.

10:60-1.4 Out-of-State approved home health agencies

(a) For services rendered prior to January 1, 1999, final reimbursement shall be made to out-of-State approved home health agencies on the basis of 80 percent of covered reasonable charges. There is no cost filing required. No retroactive settlement shall be made.

(b) For services rendered on or after January 1, 1999, out-of-State home health agencies shall be reimbursed using the prospective payment rate established pursuant to N.J.A.C. 10:60-2.5(d) and (f). There is no cost filing required. No retroactive settlement shall be made.

10:60-1.5 Limitations of home care services

(a) When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the Division retains the right to limit or deny the provision of home care services on a prospective basis.

10:60-1.6 Advance directives

All agencies providing home health, private duty nursing, hospice and personal care participating in the New Jersey Medicaid program are subject to the provisions of State and Federal statutes regarding advance directives, including, but not limited to, appropriate notification to patients of their rights, development of policies and practices, and communication to and education of staff, community and interested parties. Detailed information may be located at N.J.A.C. 10:49-9.15, and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (42 U.S.C. § § 1396a(a)(58) and 1396a(w)).

10:60-1.7 Relationship of the home care provider with the Medicaid District Office (MDO) and the DHSS Long-Term Care Field Office (LTCFO)

(a) Preadmission screening (PAS) shall be required for all Medicaid-eligible or NJ KidCare-Plan A-eligible individuals and other individuals applying for nursing facility (NF) services or the Home and Community-Based Services Waiver programs. DHSS professional staff will conduct PAS assessments of individuals in hospitals and community settings to evaluate need for nursing facility services and to determine the appropriate setting for the delivery of services. Individuals in hospitals or community settings who are referred for nursing facility care and who have been determined by the LTCFO not to require nursing facility placement, or who select alternatives to nursing facility care, will be referred for home care services.

(b) A health services delivery plan (HSDP) will be completed by the DHSS staff at the conclusion of the PAS assessment and shall be a component of the referral package to the home care provider. The HSDP shall be forwarded to the authorized care setting and shall be attached to the beneficiary's medical record upon admission to a nursing facility or when the beneficiary receives services from home care agencies. The HSDP may be updated as required to reflect changes in the beneficiary's condition. The HSDP provides data base history which reflects current or potential health problems and required services. The discharge planning unit or social service department of the hospital shall provide home care agencies with HSDPs for individuals who have been assessed in a hospital setting. DHSS will provide HSDPs for individuals who have been assessed in a community setting during the PAS process. For individuals deemed appropriate for a Home and Community-Based Services Waiver administered by the Department of Human Services, a copy of the appropriate HSDP will be forwarded to the MDO director.

(c) For the many individuals in the community setting referred for home care services outside the PAS process described in (a) above, an HSDP shall not be provided.

10:60-1.8 Standards of performance for concurrent and post payment quality assurance review

(a) An initial visit to evaluate the need for home health services or personal care assistant services shall be made by the provider. Following the initial visit, the provider shall advise the Division or its designated agent, using the HCFA 485 form, that services have begun for the beneficiary. Providers shall use this form even when the Medicaid or NJ KidCare fee-for-service beneficiary is not a Medicare beneficiary. The HCFA 485 form shall be submitted to the MDO that serves the county in which the beneficiary resides and shall be postmarked within five business days of initial assessment, reassessment, or termination. MDO's shall not accept faxed HCFA 485 forms. If the Division discovers that a home health agency did not submit the documentation within the prescribed time frame, the Division shall recover any payments for services rendered from the sixth business day of initial assessment until a completed HCFA 485 form is received by the Division. In cases when the beneficiary is eligible for both Medicare and Medicaid fee-for-service or NJ KidCare fee-for- service programs, the HCFA 485 form shall be completed and submitted to the MDO within five business days of when the Medicaid/NJ KidCare fee-for-service program becomes the primary payer.

1. The HCFA 485 shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services, however, shall be kept on file in the agency, with the prescription. Providers shall enter the Medicaid Eligibility Identification (MEI) Number or NJ KidCare Identification Number in block 1 when completing the HCFA 485, 486 or 487 form. For the non-Medicare certified agency, the provider shall submit to the MDO an MDO approved notification form which

shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services shall be kept on file in the agency.

2. The HCFA 485 shall be submitted to the MDO upon initiation of services and every 62 days thereafter on a continuing basis. If at any time there occurs a significant change in the beneficiary's plan of care and there is an increase of 50 percent or more of a particular skilled home care service, the agency shall submit a HCFA 485 or 486 or 487 as the circumstances warrant to the MDO. Providers shall notify the MDO, using the HCFA 485, when services have been terminated.

3. Upon receipt of the HCFA 485 form, using a case screening methodology, Division staff shall conduct concurrent reviews on a selected number of cases, by making on-site visits to Medicaid/NJ KidCare fee-for-service beneficiaries at their places of residence. Division staff will use the standards listed in (c) through (j) below to conduct the review.

4. If the Division determines that the services provided were in compliance with the standards listed in (c) through (j) below, payment shall continue to be made to the provider. If the Division determines that the services provided were not in compliance, or should be reduced, the Division shall notify the provider and beneficiary in writing if there is a disparity of need determined which would result in a change in service(s). If a provider and/or beneficiary disagrees with the Division's determination, a fair hearing may be requested in accordance with procedures set forth in N.J.A.C. 10:60-10 and 10:49- 9.14 and 10.

5. On a random selection basis, MDO staff shall conduct post-payment quality assurance reviews. At the specific request of the MDO, the provider shall submit a plan of care and other documentation for those Medicaid and NJ KidCare fee-for-service beneficiaries selected for a quality assurance review.

6. Upon completing the post-payment quality assurance review, the MDO shall forward a performance report to the provider, based on compliance with the standards described in this section.

(b) The professional staff from the MDO will use the standards listed in (c) through (j) below to conduct a post-payment quality assurance review of home care services as provided to the Medicaid or NJ KidCare fee-for-service beneficiary.

(c) Skilled nursing services and visits shall be based on a comprehensive assessment performed by a registered professional nurse to identify care needs and required services and shall be provided as designated by the plan of care.

1. Home visits for nursing services shall be provided to the beneficiary as ordered by the physician and as designated by the standards of nursing practice.

2. The nurse shall make home visits as appropriate and as scheduled in the plan of care. Supervision of home health aide services is an integral component of these visits.

3. Services shall be within the scope of practice of personnel assigned.

4. Appropriate referrals for required services shall be instituted on a timely basis.

5. Nursing progress notes and plans of care shall reflect the significant changes in condition which require changes in the scope and timeliness of service delivery.

(d) Homemaker-home health aide and personal care assistant services shall be provided by the agency in accordance with the plan of care.

1. The aide shall arrive and leave each day as scheduled by the agency.
2. The same aide shall be assigned on a regular basis, with the intent of assuring continuity of care for the beneficiary, unless there are unusual documented circumstances, such as a difficult beneficiary/caregiver relationship, difficult location, or personal reasons of aide or beneficiary/caregiver.
3. Services shall be within the scope of practice of personnel assigned.
4. Appropriate training and orientation shall be provide by licensed personnel to assure the delivery of required services.
5. The aide shall provide appropriate services as reflected in the plan of care and identified on the assignment sheet;
6. Home care services shall be provided to the beneficiary to maintain the beneficiary's health or to facilitate treatment of an illness or injury.

(e) Physical therapy, occupational therapy or speech-language pathology services shall be provided as an integral part of a comprehensive medical program. Such rehabilitative services shall be provided through home visits for the purpose of attaining maximum reduction of physical or mental disability and restoration of the individual to the best functional level.

1. The services shall be provided with the expectation, based on the assessment made by the physician of the beneficiary's rehabilitation potential, that the condition of the individual shall improve materially in a reasonable and generally predictable period of time, or that the services are necessary towards the establishment of a safe and effective maintenance program.
2. The complexity of rehabilitative services is such that it can only be performed safely and effectively by a therapist. The services shall be consistent with the nature and severity of the illness or injury. The amount and frequency of these services shall be reasonable and necessary, and the duration of each visit shall be a minimum of 30 minutes.
3. The services shall be specific and effective treatment for the beneficiary's condition and shall be provided in accordance with accepted standards of medical practice.
4. For physical therapy standards, see N.J.A.C. 10:60-2.1(d)5ii(1)(E).

(f) Visits of social service professionals are necessary to resolve social or emotional problems that are, or may be, an impediment to the effective treatment of the individual's medical condition or rate of recovery.

1. Medical social services shall be provided as ordered by the physician and furnished by the social worker.

2. Plan of care shall indicate the appropriate action taken to obtain the available community resources to assist in resolving the beneficiary's problems or to provide counseling services which are reasonable and necessary to treat the underlying social or emotional problems which are impeding the beneficiary's recovery.
3. The services shall be responsive to the problem and the frequency of the services shall be for a prescribed length of time.

(g) Visits of a dietitian or nutritionist shall be provided as needed to resolve nutritional problems which are or may be an impediment to the effective treatment of the beneficiary's medical condition or rate of recovery.
1. Nutritional services shall be provided as ordered by the physician and furnished by a dietitian or nutritionist in accordance with accepted standards of professional practice.
2. The plan of care shall indicate the nutritional care needs and the goals to meet those needs.
3. Services shall be provided to the beneficiary and/or the family/interested others involved with the beneficiary's nutritional care.
4. The services shall be specific and for a prescribed period of time.
5. The progress notes and care plan shall reflect significant changes or problems which require changes in the scope and timeliness of service delivery visits.

(h) The services shall be provided to the satisfaction of the beneficiary/caregiver.
1. There shall be documented evidence that the beneficiary/caregiver has participated in the development of the plan of care.
2. Identified problems shall be resolved between the agency and the beneficiary/caregiver, when possible.
3. The agency shall make appropriate referrals for unmet beneficiary needs.
4. The beneficiary/caregiver shall be promptly informed of changes in aides and/or schedules.
5. Beneficiaries/caregivers shall be aware of the agency name, telephone number, and contact person in the event of a problem.

(i) The home health agency shall be aware of the beneficiary's need for, and shall make the appropriate arrangements for, securing medical equipment, appliances and supplies, as follows:
1. The agency shall assist the beneficiary in obtaining equipment, appliances, and supplies when needed under Medicare and/or Medicaid or Medicare and/or NJ KidCare guidelines;
2. The agency shall monitor equipment, appliances and supplies to assure that all items are serviceable and used safely and effectively; and
3. The agency shall be responsible for contacting the provider for problems relating to the utilization of equipment, appliances and supplies.

(j) Recordkeeping shall be timely, accurate, complete and legible, in accordance with this chapter, and as follows:

1. There shall be a current aide assignment sheet for each beneficiary, available either in the home or at the agency, dated and signed by the nurse. The assignment shall be based on a nursing assessment of the beneficiary's needs and shall list the aide's duties as required in the plan or care;

2. The agency shall document significant changes in health and/or social status, including recent hospitalization, in the progress notes and make appropriate changes in the plan of care as needed;

3. Initial evaluations and progress notes shall be provided to the MDO upon request for all nursing services; and

4. Initial evaluations, progress notes and goals shall be provided to the MDO upon request for physical, occupational and speech-language therapies and social services.

10:60-1.9 On-site monitoring visits

(a) For a homemaker agency and a private duty nursing agency, on-site monitoring visits shall be made periodically by Division staff to the agency to review compliance with personnel, recordkeeping and service delivery requirements (Home Care Agency Review Form, FD-342). The results of such monitoring visits shall be reported to the agency, by the Division, and when indicated, a plan of correction shall be required. Continued non-compliance with requirements shall result in such sanctions as curtailment of accepting new beneficiaries for services, suspension or rescission of the agency's provider agreement.

(b) For a hospice agency, on-site monitoring visits shall be made periodically by Division staff to the agency to review compliance with personnel, recordkeeping and service delivery requirements (Hospice Agency Review Summary Form, FD-351). The results of such monitoring visits shall be reported to the agency with a copy to the Medicaid District Office, and when indicated, a plan of correction shall be required. Continued non-compliance with requirements shall result in such sanctions as curtailment of accepting new beneficiaries for services, suspension or rescission of the agency's provider contract.

10:60-1.10 Provisions for fair hearings

Providers and Medicaid or NJ KidCare-Plan A beneficiaries can request fair hearings as set forth in the Administration chapter at N.J.A.C. 10:49-9.14. NJ KidCare-Plan B and C fee-for-service beneficiaries can utilize the grievance board as set forth in N.J.A.C. 10:49-9.

10:60-1.11 (Reserved)

10:60-1.12 (Reserved)

10:60-1.13 (Reserved)

10:60-1.14 (Reserved)

10:60-1.15 (Reserved)

10:60-1.16 (Reserved)

10:60-1.17 (Reserved)

10:60-1.18 (Reserved)

END OF SUBCHAPTER 1

SUBCHAPTER 2. HOME HEALTH AGENCY (HHA) SERVICES

10:60-2.1 Covered home health agency services

(a) Home health care services covered by the New Jersey Medicaid and NJ KidCare fee-for-service programs are limited to those services provided directly by a home health agency approved to participate in the New Jersey Medicaid/NJ KidCare program or through arrangement by that agency for other services.

1. Medicaid/NJ KidCare reimbursement is available for these services when provided to Medicaid or NJ KidCare fee-for-service beneficiaries in their place of residence, such as a private home, residential hotel, residential health care facility, rooming house and boarding home.

i. In residential health care facilities, homemaker-home health aide or personal care assistant services are excluded from Medicaid/NJ KidCare fee- for-service coverage.

ii. Home health services shall not be available to Medicaid or NJ KidCare fee-for-service beneficiaries in a hospital or nursing facility.

(b) Covered home health care services are those services provided according to medical, nursing and other health care related needs, as documented in the individual plan of care, on the basis of medical necessity and on the goals to be achieved and/or maintained.

(c) Home health care services shall be directed toward rehabilitation and/or restoration of the beneficiary to the optimal level of physical and/or mental functioning, self-care and independence, or directed toward maintaining the present level of functioning and preventing further deterioration, or directed toward providing supportive care in declining health situations.

(d) The types of home health agency services covered include professional nursing by a public health nurse, registered professional nurse, or licensed practical nurse; homemaker home health aide services; physical therapy; speech- language pathology services; occupational therapy; medical social services; nutritional services; certain medical supplies; and personal care assistant services, as defined in this section.

1. The home health agency shall provide comprehensive nursing services under the direction of a public health nurse supervisor/director as defined by the New Jersey State Department of Health and Senior Services. These services shall include, but not be limited to, the following:

i. Participating in the development of the plan of care with other health care team members, which includes discharge planning;

ii. Identifying the nursing needs of the beneficiary through an initial assessment and periodic reassessment;

iii. Planning for management of the plan of care particularly as related to the coordination of other needed health care services;

iv. Skilled observing and monitoring of the beneficiary's responses to care and treatment;

v. Teaching,supervising and consulting with the beneficiary and family and/or interested persons involved with his or her care in methods of meeting the nursing care needs in the home and community setting;

vi. Providing direct nursing care services and procedures including, but not limited to:

(1) Wound care/decubitus care and management;

(2) Enterostomal care and management;

(3) Parenteral medication administration; and

(4) Indwelling catheter care.

vii. Implementing restorative nursing care measures involving all body systems including, but not limited to:

(1) Maintaining good body alignment with proper positioning of bedfast/chairfast beneficiaries;

(2) Supervising and/or assisting with range of motion exercises;

(3) Developing the beneficiary's independence in all activities of daily living by teaching self-care, including ambulation within the limits of the treatment plan; and

(4) Evaluating nutritional needs including hydration and skin integrity; observing for obesity and malnutrition;

viii. Teaching and assisting the beneficiary with practice in the use of prosthetic and orthotic devices and durable medical equipment as ordered;

ix. Providing the beneficiary and the family or interested persons support in dealing with the mental, emotional, behavioral, and social aspects of illness in the home;

x. Preparing nursing documentation including nursing assessment, nursing history, clinical nursing records and nursing progress notes; and

xi. Supervising and teaching other nursing service personnel.

2. Skilled nursing supervision of a home health aide, licensed practical nurse or personal care assistant shall be covered as an overhead administrative cost and shall not be billed as a separate unit of service.

3. If two health care workers are required to provide care and the second worker is not in a supervisory capacity, two or more units of service may be covered for the simultaneous care. If two health care workers are present, but only one is needed to provide the care, only the unit(s) of service for the one worker providing the care shall be covered.

4. Homemaker-home health aide services shall be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Services include personal care, health related tasks and household duties. In all areas of service, the homemaker-home health aide shall encourage the well members of the family, if any, to carry their share of responsibility for the care of the beneficiary in accordance with the written established professional plan of care.

i. Household duties shall be considered covered services only when combined with

personal care and other health services provided by the home health agency. Household duties may include such services as the care of the beneficiary's room, personal laundry, shopping, meal planning and preparation. In contrast, personal care services may include assisting the beneficiary with grooming, bathing, toileting, eating, dressing, and ambulation. The determining factor for the provision of household duties shall be based upon the degree of functional disability of the beneficiary, as well as the need for physician prescribed personal care and other health services, and not solely the beneficiary's medical diagnosis.

ii. The registered professional nurse, in accordance with the physician's plan of care, shall prepare written instructions for the homemaker-home health aide to include the amount and kind of supervision needed of the homemaker-home health aide, the specific needs of the beneficiary and the resources of the beneficiary, the family, and other interested persons. Supervision of the homemaker-home health aide in the home shall be provided by the registered professional nurse or appropriate professional staff member at a minimum of one visit every two weeks when in conjunction with skilled nursing, physical or occupational therapy or speech-language pathology services. In all other situations, supervision shall be provided at the frequency of one visit every 30 days. Supervision may be provided up to one visit every two months, if written justification is provided in the agency's records.

iii. The registered professional nurse, and other professional staff members, shall make visits to the beneficiary's residence to observe, supervise and assist, when the homemaker-home health aide is present or when the aide is absent, to assess relationships between the home health aide and the family and beneficiary and determine whether goals are being met.

5. Special therapies include physical therapy, speech-language pathology services and occupational therapy. Special therapists/ pathologists shall review the initial plan of care and any change in the plan of care with the attending physician and the professional nursing staff of the home health agency. The attending physician shall be given an evaluation of the progress of therapies provided as well as the beneficiary's reaction to treatment and any change in the beneficiary's condition. The attending physician shall approve of any changes in the plan of care and delivery of therapy services.

i. The attending physician shall prescribe in writing the specific methods to be used by the therapist and the frequency of therapy services. "Physical therapy as needed" or a similarly worded blanket order by the attending physician is not acceptable.

ii. Special therapists shall provide instruction to the home health agency staff, the beneficiary, the family and/or interested persons in follow-up supportive procedures to be carried out between the intermittent services of the therapists to produce the optimal and desired results.

(1) When the agency provides or arranges for physical therapy services, they shall be provided by a licensed physical therapist. The duties of the physical therapist shall include, but not be limited to, the following:

(A) Evaluating and identifying the beneficiary's physical therapy needs;

(B) Developing long and short-term goals to meet the individualized needs of the beneficiary and a treatment plan to meet these goals. Physical therapy orders shall be related to the active treatment program designed by the attending physician to assist the beneficiary to his or her maximum level of function which has been lost or reduced by reason of illness or injury;

(C) Observing and reporting to the attending physician the beneficiary's reaction to treatment, as well as, any changes in the beneficiary's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the beneficiary, care provided and the beneficiary's response to therapy along with the notification and approval received from the physician; and

(E) Physical therapy services which may include, but not be limited to, active and passive range of motion exercises, ambulation training, and training for the use of prosthetic and orthotic devices. Physical therapy does not include physical medicine procedures, administered directly by a physician or by a physical therapist which are purely palliative; for example, applications of heat in any form, massage, routine and/or group exercises, assistance in any activity or in the use of simple mechanical devices not requiring the special skill of a qualified physical therapist.

(2) When the agency provides or arranges for speech-language pathology services, the services shall be provided by a certified speech-language pathologist. The duties of a speech-language pathologist shall include, but not be limited to, the following:

(A) Evaluating, identifying, and correcting the individualized problems of the communication impaired beneficiary;

(B) Developing long and short-term goals and applying speech-language pathology service procedures to achieve identified goals;

(C) Coordinating activities with and providing assistance to a certified audiologist, when indicated;

(D) Observing and reporting to the attending physician the beneficiary's reaction to treatment, as well as, any changes in the beneficiary's condition; and

(E) Documenting clinical progress notes reflecting restorative procedures needed by the beneficiary, the care provided, and the beneficiary's response to therapy, along with the notification and approval received from the physician.

(3) The need for occupational therapy is not a qualifying criterion for initial entitlement to home health services benefits. However, if an individual has otherwise qualified for home health benefits, his or her eligibility for home health services may be continued solely because of his or her need for occupational therapy. Occupational therapy services shall include, but not be limited to, activities of daily living, use of adaptive equipment, and home-making task oriented therapeutic activities. When the agency provides or arranges for occupational therapy services, the services shall be provided by a registered occupational therapist. The duties of an occupational therapist shall include, but not be limited to, the following:

(A) Evaluating and identifying the beneficiary's occupational therapy needs;

(B) Developing long and short-term goals to meet the individualized needs of the

beneficiary and a treatment plan to achieve these needs;

(C) Observing and reporting to the attending physician the beneficiary's reaction to treatment as well as any changes in the beneficiary's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the beneficiary, the care provided, and the beneficiary's response to therapy along with the notification and approval received from the physician; and

(E) Occupational therapy services shall include but not be limited to activities of daily living, use of adaptive equipment, and homemaking task oriented therapeutic activities.

6. When the agency provides or arranges for medical social services, the services shall be provided by a social worker, or by a social work assistant under the supervision of a social worker. These shall include, but not be limited to, the following:

i. Identifying the significant social and psychological factors related to the health problems of the beneficiary and reporting any changes to the home health agency;

ii. Participating in the development of the plan of care, including discharge planning, with other members of the home health agency;

iii. Counseling the beneficiary and family/interested persons in understanding and accepting the beneficiary's health care needs, especially the emotional implications of the illness;

iv. Coordinating the utilization of appropriate supportive community resources, including the provision of information and referral services; and

v. Preparing psychosocial histories and clinical notes.

7. When the agency provides or arranges for nutritional services, the services shall be provided by a registered dietitian or nutritionist. These services shall include, but are not limited to, the following:

i. Determining the priority of nutritional care needs and developing long and short-term goals to meet those needs;

ii. Evaluating the beneficiary's home situation, particularly the physical areas available for food storage and preparation;

iii. Evaluating the role of the family/interested persons in relation to the beneficiary's diet control requirements;

iv. Evaluating the beneficiary's nutritional needs as related to medical and socioeconomic status of the home and family resources;

v. Developing a dietary plan to meet the goals and implementing the plan of care;

vi. Instructing beneficiary, other home health agency personnel and family/interested persons in dietary and nutritional therapy; and

vii. Preparing clinical and dietary progress notes.

8. Medical supplies, other than drugs and biologicals, including, but not limited to, gauze, cotton bandages, surgical dressing, surgical gloves, ostomy supplies, and rubbing alcohol shall be normally supplied by the home health agency as needed to enable the agency to carry out the plan of care established by the attending physician and agency staff.

i. When a beneficiary requires more than one month of medical supplies, prior authorization for the supplies shall be requested and received from the Division. Requests for prior authorization of an unusual or an excessive amount of medical supplies provided by an approved medical supplier shall be accompanied by a personally signed, legible prescription from the attending physician. If a beneficiary is an enrollee of a private HMO, prior authorization shall be obtained from the private HMO.

ii. When a beneficiary requires home parenteral therapy, the home health agency shall arrange the therapy prescribed with a medical supplier specialized to provide such services.

(1) Administration kits, supply kits and parenteral therapy pumps, not owned by the home health agency, shall be provided to the beneficiary and billed to the Medicaid or NJ KidCare program by the medical supplier.

(2) Provision of disposable parenteral therapy supplies which are required to properly administer prescribed therapy shall be the responsibility of the agency.

9. Personal care assistant services shall be as described in N.J.A.C. 10:60-3.

(e) Medical equipment is an item, article or apparatus which is used to serve a medical purpose, is not useful to a person in the absence of disease, illness or injury, and is capable of withstanding repeated use (durable). When durable medical equipment is essential in enabling the home health agency to carry out the plan of care for a beneficiary, a request for authorization for the equipment shall be made by an approved medical supplier. The request for authorization shall be submitted to the Division and shall include a personally signed, legible prescription from the attending physician, as well as a personally signed legible prescription from the HMO, if applicable. Durable medical equipment, either rented or owned by the home health agency, shall not be billed to the New Jersey Medicaid or NJ KidCare program, as applicable (see Medical Supplier Services Chapter, N.J.A.C. 10:59-1.5 through 1.7).

10:60-2.2 Certification of need for services

To qualify for payment of home health services by the New Jersey Medicaid and NJ KidCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the home health agency by the attending physician. The nurse or therapist shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.

10:60-2.3 Plan of care

(a) The plan of care shall be developed by the attending physician in cooperation with agency personnel. It shall include, but not be limited to, medical, nursing, and social care information. The plan shall be re-evaluated by the nursing staff at least every two months and revised as necessary, appropriate to the beneficiary's condition. The following shall be part of the plan of care:

1. The beneficiary's major and minor impairments and diagnoses;

2. A summary of case history, including medical, nursing, and social data;
3. The period covered by the plan;
4. The number and nature of service visits to be provided by the home health agency;
5. Additional health related services supplied by other providers;
6. A copy of physician's orders and their updates;
7. Medications, treatments and personnel involved;
8. Equipment and supplies required;
9. Goals, long and short-term;
10. Preventive, restorative, maintenance techniques to be provided, including the amount, frequency and duration;
11. The beneficiary's, family's, and interested persons involvement (for example, teaching); and
12. Discharge planning in all areas of care (coordinated with short and long- term goals);

i. As a significant part of the plan of care, a beneficiary's potential for improvement shall be periodically reviewed and appropriately revised. These revisions shall reflect changes in the medical, nursing, social and emotional needs of the beneficiary, with attention to the economic factors when considering alternative methods of meeting these needs.

ii. Discharge planning shall take the beneficiary's preferences into account when changing the intensity of care in his or her residence, arranging services with other community agencies, and transferring to or from home health providers. Discharge planning also provides for the transfer of appropriate information about the beneficiary by the referring home health agency to the new providers to ensure continuity of health care.

(b) The plan of care shall include beneficiary's needs, make a nursing diagnosis, develop a nursing plan of care, provide nursing services and coordinate other therapeutic services to implement the approved medical and nursing plan of care.

(c) The plan of care shall include an assessment of the beneficiary's acceptance of his or her illness and beneficiary's receptivity to home health care services.

(d) The plan of care shall include a determination of the beneficiary's psycho-social needs in relation to the utilization of other community resources.

(e) The plan of care shall include a description of social services, when provided by the social worker, and be reviewed, with any referrals required to meet the needs of the beneficiary.

10:60-2.4 Clinical records

(a) Clinical records containing pertinent past and current information, recorded

according to accepted professional standards, shall be maintained by the home health agency for each beneficiary receiving home health care services. The clinical record shall include, at a minimum, the following:

1. A plan of care as described in N.J.A.C. 10:60-2.3;
2. Appropriate identifying information;
3. The name, address and telephone number of beneficiary's physician;
4. Clinical notes by nurses, social workers, and special therapists, which shall be written, signed and dated on the day each service is provided;
5. Clinical notes to evaluate a beneficiary's response to service on a regular, periodic basis, which shall be written, signed and dated by each discipline providing services;
6. Summary reports of pertinent factors from the clinical notes of the nurses, social workers, and special therapists providing services, which shall be submitted to the attending physician at least every two months; and
7. When applicable, transfer of the beneficiary to alternative health care, which shall include transfer of appropriate information from the beneficiary's record.

10:60-2.5 Basis of payment of home health services

(a) For home health services provided before January 1, 1999, the New Jersey Medicaid and the NJ KidCare fee-for-service programs follow the Medicare principles of reimbursement which are based upon the lowest of:

1. 100 percent of reasonable covered costs; or
2. The published cost limits; or
3. Covered charges.

(b) For services provided prior to January 1, 1999, interim reimbursement shall be made on the basis of 100 percent or less (if reasonable allowable cost is anticipated to be less) of covered charges.

(c) For services provided prior to January 1, 1999, retroactive settlement and final reimbursement shall be based on Medicare principles of reimbursement.

(d) Effective for services rendered on or after January 1, 1999, home health agencies shall be reimbursed the lesser of reasonable and customary charges or the service-specific unit rates described in this subsection and (e) below. The following are the service-specific Statewide unit rates by each service:

Revenue Code	Description	Base Amount Per Unit
420	Physical Therapy	$24.06
430	Occupational Therapy	$23.81
440	Speech Therapy	$20.27
550	Skilled Nursing	$29.14

560	Medical Social Services and Dietary/ Nutritional Services	$25.90
570	Home Health Aide	$ 6.22

(e) Effective for services rendered on or after January 1, 1999 through December 31, 1999, home health agencies shall be reimbursed 90 percent to 100 percent of allowable cost, which is based on Medicare principles of reimbursement as defined in (a) above. To assure appropriate cash flow, the service-specific unit rates shall be modified by the Division to reflect provider-specific rates for each unit of service provided to Medicaid and NJ KidCare fee-for-service beneficiaries. The provider-specific unit rates shall be calculated by adjusting the base unit rates in (d) above to approximate the reimbursable cost the home health agency is incurring in providing covered services to Medicaid and NJ KidCare fee-for-service beneficiaries. A final reconciliation shall be completed for the first 12-month period after the date of adoption. The final reconciliation shall be calculated by subtracting interim payments from reimbursable cost. Reimbursable cost, which represents the 90 percent to 100 percent range of allowable cost, is calculated as follows:

1. If the Medicaid/NJ KidCare fee-for-service payment under the proposed rates described in (d) above is greater than the allowable cost, reimbursable cost is equal to the allowable cost, which is defined at (a) above.

2. If the Medicaid/NJ KidCare fee-for-service payment under the proposed unit rates described in (d) above is less than or equal to 90 percent of the allowable cost, reimbursable cost is equal to the sum of the following:

i. 90 percent of the allowable cost excluding escorts; and

ii. 95 percent of the Medicaid/NJ KidCare fee-for-service programs' share of field security costs for the period in which the reconciliation is calculated. In order to receive this escort cost adjustment, each home health agency which incurs escort costs shall submit source documentation demonstrating the total amount of field security costs incurred and the Medicaid/NJ KidCare fee-for-service programs' share of such costs. This documentation shall be sent along with the submission of the Medicaid cost report to be used for this reconciliation to the following address:

Office of Provider Rate Setting
Division of Medical Assistance and Health Services
PO Box 712
Mail Code #43
Trenton, New Jersey 08625-0712

3. If the payment under the proposed unit rates described in (d) above is greater than 90 percent but less than or equal to 100 percent of the allowable cost, reimbursable cost is equal to the Medicaid/NJ KidCare fee-for-service payment in accordance with (d) above.

(f) Effective January 1, 2000, and thereafter, the reimbursement rates shall be the service-specific Statewide per unit rates found in (d) above, incrementally adjusted each January 1, beginning on January 1, 2000, using Standard and Poor's DRI Home Health Market Basket Index, and published in the New Jersey Register as a notice of administrative change, in accordance with N.J.A.C. 1:30-2.7. Home health agencies shall maintain both unit and visit statistics for all services provided to Medicaid and NJ KidCare fee-for-service beneficiaries.

(g) Effective January 1, 1999, home health agencies shall bill the Medicaid and NJ KidCare fiscal agent as follows:

1. The unit of service shall be a 15 minute interval of a skilled nursing visit, a home health aide visit, a speech therapy visit, a physical therapy visit, an occupational therapy visit, or a medical social service visit, as defined in N.J.A.C. 10:60-1.4(d). A home health agency shall not bill when a Medicaid/NJ KidCare fee-for-service beneficiary is not home or cannot be found, and hands-on medical care was not provided;

2. The service-specific Statewide rate shall be billed for each full 15 minute interval of face-to-face service in which hands-on medical care was provided to a Medicaid or NJ KidCare fee-for-service beneficiary;

i. For instance, one unit of service shall be billed for services provided from the initial minute through 29 minutes. The second unit of service shall be billed for services provided from 30 minutes through 44 minutes. The third unit of service shall be billed for services provided from 45 minutes to 59 minutes and the fourth unit of service shall be billed for services provided from 60 minutes through 74 minutes;

3. Items including, but not limited to, nursing supervision, travel time, paperwork, and telephone contact at the home are included in the service- specific Statewide rate and, therefore, the time associated with these items is not billed directly;

4. A separate line shall be billed for each day the service is provided. A home health agency shall not "span bill" for services;

5. Routine supplies shall be considered visit overhead costs and billed as part of a unit of service. Non-routine supplies shall be billed using Revenue Code 270 on the UB-92 and HCPCS codes in accordance with N.J.A.C. 10:59-2;

6. A home health agency shall only bill the revenue codes listed in (d) above and Revenue Code 270. No other revenue codes will be reimbursed for home health services.

(h) Home health agencies shall submit a cost report for each fiscal year to the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #42, PO Box 712, Trenton, New Jersey 08625-0712 or the Director's designee. The cost report shall be legible and complete in order to be considered acceptable.

1. Cost reports and audited financial statements shall be due on or before the last day

of the fifth month following the close of the period covered by the report.

2. A 30-day extension of the due date of a cost report may be granted by the Division for "good cause." "Good cause" means a valid reason or justifiable purpose; it is one that supplies a substantial reason, affords a legal excuse for delay, or is the result of an intervening action beyond one's control. Acts of omission and/or negligence by the home health agency, its employees, or its agents, shall not constitute "good cause."

3. To be granted the extension in (h)2 above, the provider shall submit a written request to, and obtain written approval from, the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #42, PO Box 712, Trenton, New Jersey 08625-0712 or the Director's designee, at least 30 days before the due date of the cost report.

4. If a provider's agreement to participate in the Medicaid/NJ KidCare fee- for-service program terminates or the provider experiences a change of ownership, the cost report is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

5. Failure to submit an acceptable cost report on a timely basis may result in suspension of payments. Payments for claims received on or after the date of suspension may be withheld until an acceptable cost report is received.

10:60-2.6 Limitations of home health agency services

(a) When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the Division retains the right to limit or deny the provision of home care services on a prospective basis.

(b) For limitations on Personal Care Assistant (PCA) services see N.J.A.C. 10:60-3.8.

10:60-2.7 (Reserved)

10:60-2.8 (Reserved)

10:60-2.9 (Reserved)

10:60-2.10 (Reserved)

10:60-2.11 (Reserved)

10:60-2.12 (Reserved)

10:60-2.13 (Reserved)

10:60-2.14 (Reserved)

10:60-2.15 (Reserved)

10:60-2.16 (Reserved)

END OF SUBCHAPTER 2

SUBCHAPTER 3. PERSONAL CARE ASSISTANT (PCA) SERVICES

10:60-3.1 Purpose and scope

(a) Personal care assistant services shall be provided by a certified licensed home health agency or by a proprietary or voluntary non-profit accredited homemaker agency.

(b) Personal care assistant services are health related tasks performed by a qualified individual in a beneficiary's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. These services are available from a home health agency or a homemaker agency.

1. The purpose of personal care is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses.

10:60-3.2 Basis for reimbursement for personal care assistant services

(a) Personal care assistant services shall be reimbursable when provided to Medicaid beneficiaries in their place of residence, including:

1. A private home;
2. A rooming house;
3. A boarding home (not Class C);
4. A Division of Youth and Family Services' (DYFS) foster care home; or
5. A Division of Developmental Disabilities (DDD) foster care home.

10:60-3.3 Covered personal care assistant services

(a) Personal care assistant services are described as follows:

1. Activities of daily living shall be performed by a personal care assistant, and include, but not be limited to:

i. Care of the teeth and mouth;

ii. Grooming such as, care of hair, including shampooing, shaving, and the ordinary care of nails;

iii. Bathing in bed, in the tub or shower;

iv. Using the toilet or bed pan;

v. Changing bed linens with the beneficiary in bed;

vi. Ambulation indoors and outdoors, when appropriate;

vii. Helping the beneficiary in moving from bed to chair or wheelchair, in and out of tub or shower;

viii. Eating and preparing meals, including special therapeutic diets for the beneficiary;

ix. Dressing;

x. Relearning household skills; and

xi. Accompanying the beneficiary to clinics, physician office visits, and/or other trips made for the purpose of obtaining medical diagnosis or treatment or to otherwise serve a therapeutic purpose.

2. Household duties that are essential to the beneficiary's health and comfort,

performed by a personal care assistant shall include, but not be limited to:

i. Care of the beneficiary's room and areas used by the beneficiary, including sweeping, vacuuming, dusting;

ii. Care of kitchen, including maintaining general cleanliness of refrigerator, stove, sink and floor, dishwashing;

iii. Care of bathroom, including maintaining cleanliness of toilet, tub, shower and floor;

iv. Care of beneficiary's personal laundry and bed linen, which may include necessary ironing and mending;

v. Necessary bed-making and changing of bed linen;

vi. Re-arranging of furniture to enable the beneficiary to move about more easily in his or her room;

vii. Listing food and household supplies needed for the health and maintenance of the beneficiary;

viii. Shopping for above supplies, conveniently storing and arranging supplies, and doing other essential errands; and

ix. Planning, preparing and serving meals.

3. Health related activities, performed by a personal care assistant, shall be limited to:

i. Helping and monitoring beneficiary with prescribed exercises which the beneficiary and the personal care assistant have been taught by appropriate personnel;

ii. Rubbing the beneficiary's back if not contraindicated by physician;

iii. Assisting with medications that can be self-administered;

iv. Assisting the beneficiary with use of special equipment, such as walker, braces, crutches, wheelchair, after thorough demonstration by a registered professional nurse or physical therapist, with return demonstration until registered professional nurse or physical therapist is satisfied that beneficiary can use equipment safely;

v. Assisting the beneficiary with simple procedures as an extension of physical or occupational therapy, or speech-language pathology services; and

vi. Taking oral and rectal temperature, radial pulse and respiration.

10:60-3.4 Certification of need for services

To qualify for payment of personal care assistant services by the New Jersey Medicaid and NJ KidCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the home health agency or homemaker agency by the attending physician. The nurse shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.

10:60-3.5 Duties of the registered professional nurse

(a) The duties of the registered professional nurse in the PCA program are as follows:

1. The registered professional nurse, in accordance with the physician's certification of need for care, shall perform an assessment and prepare a plan of care for the personal care assistant to implement. The assessment and plan of care shall be completed at the start of service. However, in no case shall the nursing assessment and plan of care be

done more than 48 hours after the start of service. The plan of care shall include the tasks assigned to meet the specific needs of the beneficiary, hours of service needed, and shall take into consideration the beneficiary's strengths, the needs of the family and other interested persons. The plan of care shall be dated and signed by the personal care assistant and the registered nurse and shall include short-term and long-term nursing goals. The personal care assistant shall review the plan, in conjunction with the registered professional nurse.

2. Direct supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days, initiated within 48 hours of the start of service, at the beneficiary's place of residence during the personal care assistant's assigned time. The purpose of the supervision is to evaluate the personal care assistant's performance and to determine that the plan of care has been properly implemented. At this time, appropriate revisions to the plan of care shall be made. Additional supervisory visits shall be made as the situation warrants, such as a new PCA or in response to the physical or other needs of the beneficiary.

3. A personal care assistant nursing reassessment visit shall be provided at least once every six months, or more frequently if the beneficiary's condition warrants, to reevaluate the beneficiary's need for continued care.

10:60-3.6 Clinical records

(a) Recordkeeping for personal care assistant services shall include the following:

1. Clinical records and reports shall be maintained for each beneficiary, covering the medical, nursing, social and health related care in accordance with accepted professional standards. Such information shall be readily available, as required, to representatives of the Division or its agents.

2. Clinical records shall contain, at a minimum:

i. An initial nursing assessment;

ii. A six-month nursing reassessment;

iii. A beneficiary-specific plan of care;

iv. Signed and dated progress notes describing the beneficiary's condition;

v. Documentation of the supervision provided to the personal care assistant every 60 days;

vi. A personal care assistant assignment sheet signed and dated weekly by the personal care assistant;

vii. Documentation that the beneficiary has been informed of rights to make decisions concerning his or her medical care; and

viii. Documentation of the formulation of an advance directive.

3. All clinical records shall be signed and dated by the registered professional nurse, in accordance with accepted professional standards, and shall include documentation described in (a)2 above.

10:60-3.7 Basis of payment for personal care assistant services

(a) Personal care assistant services shall be reimbursed on a per hour, fee- for-service basis for weekday, weekend and holiday services. Nursing assessment and reassessment visits under this program shall be reimbursed on a per visit, fee-for-service basis.

(b) Personal care assistant services reimbursement rates (see N.J.A.C. 10:60-11) are all inclusive maximum allowable rates. No direct or indirect cost over and above the established rates may be considered for reimbursement. At all times the provider shall reflect its standard charge on the HCFA 1500 Claim Form (see Fiscal Agent Billing Supplement, Appendix A, incorporated herein by reference) even though the actual payment may be different. A provider shall not charge the New Jersey Medicaid/NJ KidCare programs in excess of current charges to other payers.

(c) For reimbursement purposes only, a weekend means a Saturday or Sunday; a holiday means an observed agency holiday which is also recognized as a Federal or State holiday.

10:60-3.8 Limitations of personal care assistant services

(a) For personal care assistant services, Medicaid and NJ KidCare-Plan A reimbursement shall not be made for services provided to Medicaid or NJ KidCare-Plan A beneficiaries in the following settings:

1. A residential health care facility;
2. A Class C boarding home;
3. A hospital; or
4. A nursing facility.

(b) Personal care assistant services provided by a family member shall not be considered covered services and shall not be reimbursed by the New Jersey Medicaid or NJ KidCare-Plan B and C programs.

(c) Personal care assistant services shall be limited to a maximum of 25 hours per calendar work week. However, if there is a medical need for additional hours of service, this limit may be exceeded by the provider up to an additional 15 hours per calendar work week under the criteria in (c)1 through 4 below. Under exceptional and extreme circumstances of medical necessity, more than 40 hours of PCA may be provided with written MDO approval.

1. If the caregiver is employed, ill, frail, or temporarily absent from the home for sickness or family emergency and therefore unable to participate adequately in providing medically necessary care to ensure the safety or well- being of the beneficiary;
2. If the beneficiary lives alone or has no caregiver, and is in need of medically

necessary care to ensure his or her safety and well-being;

3. If the beneficiary is severely functionally limited and requires care to meet activities in daily living (ADL) needs, both in the morning and afternoon/evening; or

4. If the beneficiary's physical status/medical condition suddenly deteriorates, resulting in an increased need for personal care on a short-term basis until the stabilization of the health status.

(d) Additional hours under (c) above shall be medically indicated, as documented by the beneficiary's physician, and shall not be a companion service. The agency providing these increased services shall obtain prior authorization from the Medicaid District Office (MDO) serving the beneficiary's county of residence, in accordance with N.J.A.C. 10:49-6.1, for more than 25 hours per calendar work week of PCA services. Failure to comply with the prior authorization requirement shall be subject to denial of payment and recoupment of funds not prior authorized in excess of 25 hours. Services provided to these beneficiaries shall be included by the MDO in the post-payment quality assurance reviews.

END OF SUBCHAPTER 3

SUBCHAPTER 4. PERSONAL CARE ASSISTANT SERVICES FOR THE MENTALLY ILL

10:60-4.1 Provision of personal care assistant services for the mentally ill

(a) The following applies to the provision of personal care assistant services:

1. Personal care assistant services (mental health) are health-related tasks performed by a qualified individual in a beneficiary's home under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care.

i. Each personal care assistant provider employing personal care assistants shall be individually approved by the New Jersey Medicaid and NJ KidCare programs before it will be reimbursed for services rendered to Medicaid or NJ KidCare-Plan A fee-for-service beneficiaries. The Division of Medical Assistance and Health Services will recognize upon approval, agencies under contract to the Division of Mental Health Services.

(1) For information and rules pertaining to personal care assistant services provided by a home health agency, refer to N.J.A.C. 10:60-3 in the Home Care Services chapter.

2. Personal care assistant services provided by a family member are not covered services.

3. Personal care assistant services shall be provided only in instances where a family support system or other informal care giver is unavailable, inaccessible or inappropriate.

4. The registered professional nurse, in accordance with the physician's plan of care, prepares written instructions for the personal care assistant to include the amount and kind of supervision needed, the specific needs of the patient and the resources of the patient, the family and other interested persons.

5. Supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days to assess the patient's health condition, as well as the quality of personal care assistant services received.

6. An initial nursing assessment visit must be made to evaluate the need for personal care assistant service. Following the initial visit, a nursing reassessment visit may be provided at least once every six months, or more frequently if the beneficiary's condition warrants, to reevaluate the beneficiary's need for continued care.

7. The personal care assistant shall enter progress notes on a weekly basis in the beneficiary's record, including the beneficiary's progress toward goals. These progress notes shall be signed and dated by the personal care assistant.

(b) Providers of personal care assistance services for the mentally ill shall not seek reimbursement when the beneficiary is receiving mental health rehabilitation services provided in/by community residence programs during the same day of service. (See N.J.A.C. 10:77 and 10:77A).

10:60-4.2 HCPCS procedure code numbers and maximum fee allowance schedule for PCA services for the mentally ill

(a) The New Jersey Medicaid program utilizes the Health Care Financing

Administration (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in N.J.A.C. 10:60-11.2(b) are relevant only to personal care assistant services for the mentally ill.

(b) The HCPCS procedure codes are used when requesting reimbursement for personal care assistant services provided to the mentally ill and when a HCFA 1500 Claim Form is required.

END OF SUBCHAPTER 4

SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

10:60-5.1 Purpose and scope

(a) Private duty nursing services shall be provided by a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by the Division.

(b) The purpose of private duty nursing services is to provide individual and continuous nursing care, as different from part-time intermittent care, provided by licensed nurses in the home to beneficiaries under Model Waiver 3, ABC, ACCAP, as well as eligible EPSDT beneficiaries.

10:60-5.2 Basis for reimbursement for EPSDT/PDN

(a) To be considered for EPSDT/PDN services, the beneficiary shall be referred by a parent, primary physician, hospital discharge planner, Special Child Health Services case manager, Division of Developmental Disabilities, or current PDN provider. Requests for services shall be submitted to the Division using a "Request for EPSDT Private Duty Nursing Services (FD-389)" form. The Request shall be completed and signed by a physician and agreed to and signed by a parent or guardian. All sections of the Request shall be completed and a physician's case summary and current treatment plan shall be attached. Incomplete requests shall be returned to the referral source for completion prior to further action by the Division.

(b) Upon receipt of the fully completed Request (FD-389), the Division’s Regional Staff Nurse shall conduct an assessment of the need for PDN services, as well as the level (LPN or RN) and amount of service required. A letter notifying the family and the person who referred the individual of the decision following the assessment shall be issued by the Division. When the child is found to be eligible for EPSDT/PDN services, the number of hours approved, the level of services, and the length of time of the approval (up to a maximum of six months) shall be noted.

(c) The PDN provider agency, selected by the family, shall submit a request to the Division for the PDN services on the "Prior Authorization Request Form (FD-365)" which contains a pre-printed prior authorization (PA) number. Telephone requests for prior authorization (PA) can be accommodated in an emergency but shall be followed immediately by a written request.

(d) Requests for continuation, or modification of PDN services during the treatment period, shall be submitted by the PDN agency, in writing, to the Division on the "Prior Authorization Request Form (FD-365)" In an emergency, requests for modification of services may be made by telephone but shall be followed immediately by a written prior authorization (PA) request.

10:60-5.3 Eligibility for early and periodic screening, diagnosis and treatment/private duty nursing (PDN) services

(a) Individuals under 21 years of age who are enrolled in the Medicaid/NJ FamilyCare FFS programs and who require private duty nursing services, which will allow them to be cared for in a community setting, may be referred for EPSDT/PDN services.

1. Individuals eligible for Medicaid services through the Medically Needy program are not eligible for EPSDT services, in accordance with N.J.A.C. 10:49-5.3(a)2.
2. For individuals who are enrolled in Medicaid managed care, private duty nursing is authorized and provided by the HMO.

(b) An individual must exhibit a severity of illness that requires complex skilled nursing interventions on an ongoing basis, to be considered in need of EPSDT/PDN services.

1. "Ongoing" means that the beneficiary needs skilled nursing intervention 24 hours per day/seven days per week.
2. "Complex" means the degree of difficulty and/or intensity of treatment/procedures.
3. "Skilled nursing interventions" means procedures that require the knowledge and experience of licensed nursing personnel, or a trained primary caregiver.

(c) EPSDT/PDN services are only appropriate when the following requirements are satisfied:

1. There is a capable adult primary caregiver residing with the individual who accepts ongoing 24-hour responsibility for the health and welfare of the beneficiary.
2. The primary caregiver agrees to provide a minimum of eight hours of hands-on care to the individual in any 24-hour period; and
3. The home environment can accommodate the required equipment and licensed PDN personnel.

10:60-5.4 Limitation, duration and location of EPSDT/PDN

(a) The following requirements shall apply to EPSDT/PDN services:

1. Private duty nursing shall be provided for eligible FFS beneficiaries in the community only and not in hospital inpatient or nursing facility settings.
2. The Division shall determine and approve the total PDN hours for reimbursement, in accordance with N.J.A.C. 10:60-5.2(b). A maximum of 16 hours of private duty nursing services may be provided in any 24-hour period;
3. The determination of the total EPSDT/PDN hours approved, up to the maximum 16 hours per 24-hour period, shall take into account alternative sources of PDN care available to the caregiver, such as medical day care or a school program.
4. In emergency situations, for example, when the sole caregiver has been

hospitalized, the Division may authorize, for a limited time, additional hours beyond the 16 hour limit.

(b) Medical necessity for EPSDT/PDN services shall be based upon, but may not be limited to, the following criteria in (b)1 or 2 below:

1. A requirement for all the following medical interventions:
   i. Dependence on mechanical ventilation;
   ii. The presence of an active tracheostomy; and
   iii. The need for deep suctioning; or
2. A requirement for any of the following medical interventions:
   i. The need for around-the-clock nebulizer treatments, with chest physiotherapy;
   ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or
   iii. A seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anti-convulsants.

(c) The following situational criteria shall be considered, once medical necessity has been established in accordance with (b) above, when determining the extent of the need for EPSDT/PDN services and the authorized hours of service:

1. Available parental support;
2. Additional sibling care responsibilities; and
3. Alternative sources of nursing care.

(d) Services that shall not, in and of themselves, constitute a need for PDN services, in the absence of the skilled nursing interventions listed in (b) above, shall include, but shall not be limited to:

1. Patient observation, monitoring, recording or assessment;
2. Occasional suctioning;
3. Gastrostomy feedings, unless complicated as described in (b)1 above; and
4. Seizure disorders controlled with medication and/or seizure disorders manifested by frequent minor seizures not occurring in clusters or associated with status epilepticus.

(e) Private duty nursing shall be a covered service only for those beneficiaries covered under EPSDT/PDN.

(f) While private duty nursing is a form of respite service available under certain waivered programs, such as Traumatic Brain Injury (TBI), Aids Community Care Alternatives Program (ACCAP), Division of Development Disabilities- Community Care Waiver (CCW-DDD), and Community Care Program for the Elderly and Disabled (CCPED), respite services are distinct from EPSDT/ PDN services and are not eligible for reimbursement as EPSDT/PDN services. Respite care is not a covered service under Medicaid/NJ FamilyCare.

10:60-5.5 Nursing Assessment for the determination of medical necessity for EPSDT/PDN Services

(a) An initial on-site nursing assessment by a DMAHS regional staff nurse assessor is necessary in order to review the complexity of the child's care. A hands-on examination of the child is not included in the assessment. The nursing assessment shall include an hour-by-hour inventory of all care-related activities over a 24-hour period, which accurately describes the child's current care.

(b) The nurse assessor shall describe the specific elements of care, and the individual who rendered the service. Frequency of skilled nursing interventions shall be noted, for example, indicating whether suctioning is occasional (EPSDT/PDN), or frequently required or regularly scheduled with chest PT, such as twice a day or every six hours.

(c) Activities that constitute skilled nursing interventions shall be identified by the nurse assessor, separate from non-skilled nursing activities. The presence and intensity of skilled nursing interventions shall determine whether EPSDT/PDN hours should be authorized.

(d) The presence or absence of alternative care, such as medical day care or nursing services provided by the child's school, shall be identified and recorded, and those hours shall be deducted from the total hours of EPSDT/PDN services to be authorized in accordance with N.J.A.C. 10:60-5.4.

(e) If EPSDT/PDN hours are authorized, the nurse assessor shall indicate the duration of the prior authorization (PA) period (not to exceed six months) and the timeframe for reassessment.

(f) A nursing re-assessment shall be conducted by the nurse assessor prior to the end of the PDN authorization period, in accordance with the following:

1. The reassessment will be conducted in the beneficiary's home, in order to determine the on-going medical necessity of EPSDT/PDN services, and shall include a 24-hour inventory of needed services.
2. The nurse assessor shall utilize the reports from the provider agency for documentation of specific functions performed by the provider agency nurse(s).
3. Any changes in the child's status or circumstances, including the frequency and type of interventions required, shall be noted. These changes shall be clearly identified in the reassessment summary, and shall be used to support any decision to continue, reduce or increase PDN hours.

10:60-5.6 Clinical records and personnel files

(a) An individual clinical record shall be maintained for each beneficiary receiving private duty nursing service. The record shall address the physical, emotional, nutritional, environmental and social needs according to accepted professional standards.

(b) Clinical records maintained at the agency shall contain at a minimum the following:
1. A referral source;
2. Diagnoses;
3. A physician's treatment plan and renewal of treatment plan every 90 days;
4. Interim physician orders as necessary for medications and/or treatment;
5. An initial nursing assessment by a registered nurse within 48 hours of initiation of services;
6. A six-month nursing reassessment;
7. A nursing care plan;
8. Signed and dated progress notes describing beneficiary's condition; and
9. Evidence that beneficiary was given information regarding advance directives.

(c) Direct supervision of the private duty nurse shall be provided by a registered nurse at a minimum of one visit every 30 days at the beneficiary's home during the private duty nurse's assigned time. Additional supervisory visits shall be made as the situation warrants.

(d) Clinical records maintained in the beneficiary's home by the private duty nurse shall contain at a minimum the following:
1. Diagnoses;
2. A physician treatment plan and interim orders;
3. A copy of the initial nursing assessment and six month reassessment;
4. A nursing care plan;
5. Signed and dated current nurse's notes describing the beneficiary's condition and documentation of all care rendered; and
6. A record of medication administered.

(e) Personnel files shall be maintained for all private duty registered nurses and licensed practical nurses and shall contain at a minimum the following:
1. A completed application for employment;
2. Evidence of a personal interview;
3. Evidence of a current license to practice nursing;
4. Satisfactory employment references;
5. Evidence of a physical examination; and
6. Ongoing performance evaluation.

(f) On-site monitoring visits shall be made periodically by Division staff to the private

duty nursing agency to review compliance with personnel, recordkeeping and service delivery requirements.

10:60-5.7 Payment for EPSDT/PDN

(a) Claims for payment for PDN services shall be submitted on the HCFA 1500 Claim Form. The PA number shall be noted on the claim form. Providers shall bill each date of service on a separate line (FIELD 24A) of the claim form. If more than one procedure code is billed for the same date of service, separate lines shall be used when billing each procedure code. Providers shall not span dates of service on a line of the claim form.

1. Private duty nursing provider charges may vary but reimbursement cannot exceed the maximum rates allowed by the Division in accordance with N.J.A.C. 10:60-11.2(e).

(b) EPSDT/PDN providers shall submit to the Division, every two months, comprehensive clinical summaries reflecting beneficiaries' medical status and need for ongoing services. Division staff shall review the submitted clinical data and may conduct on-site home visits before reauthorizing PDN services. In addition, Division staff shall perform Home Care Quality Assurance Reviews of these individuals. In accordance with N.J.A.C. 10:60-1.9, the Division shall continue on-site monitoring of private duty nursing agencies to review compliance with this chapter.

10:60-5.8 Eligibility for home and community-based services waiver/private duty nursing (PDN) Services

Home and community-based services waiver/private duty nursing is available only to a beneficiary who meets nursing facility level of care criteria, is based on medical necessity, and is prior approved by the Division in a plan of care prepared by a waiver program case manager. Home and community-based services waiver/private duty nursing is individual, continuous nursing care in the home, and is a service available to a beneficiary only after enrollment in ABC, ACCAP, or Model Waiver 3.

10:60-5.9 Limitation, duration and location of home and community-based services waiver/private duty nursing (waiver/PDN)

(a) Home and community-based services waiver/private duty nursing services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN).

1. Private duty nursing services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain EPSDT/PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing EPSDT/PDN services. Only those EPSDT/PDN beneficiaries who require, and are authorized by the Division to receive, private duty nursing services in the home may utilize the approved

hours outside the home during those hours when normal life activities take the beneficiary out of the home.

2. Due to safety concerns, the nurse shall not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle.

(b) Private duty nursing shall be a covered service only for those beneficiaries enrolled in Community Resources for People with Disabilities/Private Duty Nursing (CRPD/PDN), ABC, or ACCAP. Under CRPD/PDN, ABC and ACCAP, when payment for private duty nursing services is being provided by another source (that is, insurance), the Division shall supplement payment up to a maximum of 16 hours per day, including services provided by the other sources, if medically necessary, and if cost of service provided by the Division is less than institutional care.

(c) Private duty nursing services shall be limited to a maximum of 16 hours in a 24-hour period, per person in CRPD/PDN, ABC and ACCAP. There shall be a live- in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.)

10:60-5.10 Basis for reimbursement for home and community-based services waiver/PDN

(a) A provider of private duty nursing services shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for services provided. Providers shall be precluded from receiving additional reimbursement for the cost of these services above the fee established by the Medicaid program.

1. All costs associated with the provision of private duty nursing services by home health agencies shall be included in the routine Medicare/Medicaid cost-reporting mechanism.

(b) The HCFA 1500 Claim Form is used when billing for private duty nursing services.

1. The provider at all times shall reflect its standard charges on the HCFA 1500 Claim Form even though the actual payment may be different.

(c) Home health services are billed on the UB-92 HCFA-1450 form (see Fiscal Agent Billing Supplement).

(d) See N.J.A.C. 10:60-11 for codes to be used when submitting claims for waiver/private duty nursing services.

10:60-5.11 Prior authorization of home and community-based services waiver/PDN

(a) There is no 24-hour coverage except for a limited period of time under the following emergency circumstances and when prior authorized by the Bureau of Home and Community Services:

1. For brief post-hospital periods while the caregiver(s) adjust(s) to the new responsibilities of caring for the discharged beneficiary; or

2. In emergency situations such as the illness of the caregiver when private duty nursing is currently being provided. In these situations, more than 16 hours of private duty nursing services may be provided for a limited period until other arrangements are made for the safety and care of the beneficiary.

END OF SUBCHAPTER 5

SUBCHAPTER 6. HOME AND COMMUNITY-BASED SERVICES WAIVER

10:60-6.1 Purpose and scope

(a) The Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Model Waivers) are renewable Federal waiver programs funded under Title XIX (Medicaid). The waivers, prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981, Section 176, Public Law 97-35, encourage the development of community-based services. The purpose of these programs is to help eligible beneficiaries remain in the community, or return to the community, rather than be cared for in a nursing facility or hospital setting.

(b) New Jersey has three approved, Federally renewable Model Waivers: Model Waiver 1, Model Waiver 2 and Model Waiver 3. Each program serves a limited number of beneficiaries Statewide who meet the medical and financial eligibility requirements.

(c) The Division of Medical Assistance and Health Services administers the overall programs. Additionally, it has the responsibility for assessing a beneficiary's need for care and for determining which beneficiary will be served by the program.

10:60-6.2 Eligibility for Model Waivers 1, 2, and 3

(a) Program eligibility criteria for Model Waivers are as follows:

1. Beneficiaries shall be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria. Model Waiver 3 requires the need for private duty nursing services.
2. For Model Waiver 1 and 2, a beneficiary's total income shall exceed the SSI community standard, up to the institutional cap or the beneficiary must be ineligible in the community because of SSI deeming rules. Model Waiver 3, however, shall serve the beneficiary who is eligible for Medicaid in the community, including New Jersey Care ... Special Medicaid Programs, as well as the beneficiary whose total income exceeds the community standard, up to the institutional cap. Model Waiver 3 shall not serve a Medicaid beneficiary eligible under the Medically Needy segment of the New Jersey Care ... Special Medicaid Programs nor enrolled in a private Health Maintenance Organization (HMO) serving the Medicaid or NJ KidCare-Plan B or C eligible population.
3. Beneficiaries shall be blind or disabled children and adults. All beneficiaries who have not been determined disabled by the Social Security Administration (SSA) must be determined disabled by the Division of Medical Assistance and Health Services, Disability Review Section, using the same SSA criteria.
4. There is no deeming of spousal income or parental income or resources in the determination of eligibility. While the spouse's resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse.
5. A beneficiary's resources cannot exceed the resource limit established for beneficiaries eligible under the Medicaid Only Program. Financial eligibility is

established by the county board of social services located in the beneficiary's county of residence.

6. In order for an applicant to be enrolled in the program, a waiver slot must be available.

(b) Retroactive eligibility is not available to waiver beneficiaries for those Medicaid services provided only by virtue of enrollment in the waiver programs.

(c) A Medicaid Eligibility Identification (MEI) card (FD-73/178) or NJ KidCare-Plan A card shall be issued to the Model Waiver beneficiary by the county board of social services for the beneficiary applying for Model Waiver 1 or 2 and also for the beneficiary applying for Model Waiver 3 who is not categorically eligible for Medicaid or NJ KidCare-Plan A in the community. The county board of social services may issue a temporary MEI card.

1. A Model Waiver 3 beneficiary who is categorically eligible for Medicaid or NJ KidCare-Plan A shall continue to receive a MEI Card or NJ KidCare-Plan A Card in the same manner as before his or her participation. The Medicaid District Office may issue a temporary MEI Card.

10:60-6.3 Services available under Model Waiver programs

(a) Except for nursing facility services, all approved services under the New Jersey Medicaid program as described in N.J.A.C. 10:49, Administration, are available under the Model Waiver programs from approved Medicaid providers.

(b) Waiver services are as follows:

1. Case management: A process in which a professional nurse or social worker is responsible for planning, locating, coordinating, and monitoring a group of services designed to meet the individual health needs of the beneficiary being served. The case manager shall be the pivotal person in establishing a service package.

i. Special Child Health Services (SCHS) units under contract to the New Jersey State Department of Health and Senior Services shall provide case management to children up to the age of 21.

ii. Beneficiaries 21 years of age or older shall be referred for case management services to those sites approved by the Division, in accordance with this Chapter.

iii. Case management shall not be provided when a beneficiary is in an inpatient hospital setting and the stay extends a full calendar month.

2. Private duty nursing: A waiver service provided under Model Waiver 3 only and not under Model Waiver 1 or 2. Private duty nursing shall be provided in the community only, not in an inpatient hospital setting. The beneficiary shall have a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the beneficiary. A maximum of 16 hours of private duty nursing may be provided in any 24-hour period. A minimum of eight hours of hands-on care shall be provided by the primary caregiver. There is no 24-hour coverage except for a

limited period of time under the following emergency circumstances and when prior authorized by the Bureau of Home and Community Services:

i. For brief post-hospital periods while the caregiver(s) adjust(s) to the new responsibilities of caring for the discharged beneficiary; or

ii. In emergency situations such as the illness of the caregiver when private duty nursing is currently being provided. In these situations, more than 16 hours of private duty nursing services may be provided for a limited period until other arrangements are made for the safety and care of the beneficiary.

(c) The items and services provided to covered beneficiaries shall be limited in duration or amount depending upon the cost of the service plan under the Model Waiver. Any limitation imposed shall be consistent with the medical necessity of the beneficiary's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the New Jersey Medicaid program.

(d) The need for private duty nursing services is established initially by DHSS upon completion of the PAS-1 and HSDP (N.J.A.C. 10:60-1.7). The number of hours of private duty nursing included in the service plan is based upon the beneficiary's medical need and the cost of service. The total cost of all services provided through Model Waiver 3 must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the beneficiary's medical status changes, and correspondingly, as the service cost cap changes.

1. An individual clinical record shall be maintained for each beneficiary receiving private duty nursing service. The record shall address the physical, emotional, nutritional, environmental and social needs according to accepted professional standards.

2. Clinical records maintained at the agency shall contain at a minimum the following:

i. A referral source;

ii. Diagnoses;

iii. A physician's treatment plan and renewal of treatment plan every 90 days;

iv. Interim physician orders as necessary for medications and/or treatment;

v. An initial nursing assessment by a registered nurse within 48 hours of initiation of services;

vi. A six-month nursing reassessment;

vii. A nursing care plan;

viii. Signed and dated progress notes describing beneficiary's condition; and

ix. Evidence that beneficiary was given information regarding advance directives.

3. Direct supervision of the private duty nurse shall be provided by a registered nurse at a minimum of one visit every 30 days at the beneficiary's home during the private duty nurse's assigned time. Additional supervisory visits shall be made as the situation

warrants.

4. Clinical records maintained in the beneficiary's home by the private duty nurse shall contain at a minimum the following:

i. Diagnoses;

ii. A physician treatment plan and interim orders;

iii. A copy of the initial nursing assessment and six month reassessment;

iv. A nursing care plan;

v. Signed and dated current nurse's notes describing the beneficiary's condition and documentation of all care rendered; and

vi. A record of medication administered.

5. Personnel files shall be maintained for all private duty registered nurses and licensed practical nurses and shall contain at a minimum the following:

i. A completed application for employment;

ii. Evidence of a personal interview;

iii. Evidence of a current license to practice nursing;

iv. Satisfactory employment references;

v. Evidence of a physical examination; and

vi. Ongoing performance evaluation.

6. On-site monitoring visits shall be made periodically by Division staff to the private duty nursing agency to review compliance with personnel, recordkeeping and service delivery requirements.

10:60-6.4 Basis for reimbursement for Model Waiver services

(a) A provider of case management or private duty nursing services shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for services provided. Providers shall be precluded from receiving additional reimbursement for the cost of these services above the fee established by the Medicaid program.

1. All costs associated with the provision of private duty nursing services by home health agencies shall be included in the routine Medicare/Medicaid cost-reporting mechanism.

(b) The HCFA 1500 Claim Form is used when billing for case management or private duty nursing services.

1. The provider at all times shall reflect its standard charges on the HCFA 1500 Claim Form even though the actual payment may be different.

(c) Home health services are billed on the UB-92 HCFA-1450 form (see Fiscal Agent Billing Supplement).

(d) See N.J.A.C. 10:60-11 for codes to be used when submitting claims for waiver services for Model Waiver Program 1, 2 or 3.

10:60-6.5 Procedures used as financial controls for Model Waiver programs

(a) Total program costs shall be restricted by limits placed on the maximum number of beneficiaries served Statewide in each of the three programs.

(b) A case manager shall be responsible for the development of the service plan with each beneficiary/family and with input from the provider agencies and the Medicaid professional staff. The case manager shall be responsible for monitoring the cost of the service package.

(c) The cost of Medicaid services provided shall not exceed the cost of institutionalization for the beneficiary.

END OF SUBCHAPTER 6

SUBCHAPTER 7. AIDS COMMUNITY CARE ALTERNATIVES PROGRAM (ACCAP WAIVER)

10:60-7.1 Purpose and scope

(a) The AIDS Community Care Alternatives Program (ACCAP) is a renewable Federal waiver program which offers home and community-based services to beneficiaries with Acquired Immune Deficiency Syndrome (AIDS) and children up to the age of 13 who are HIV positive.

(b) The waiver, prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), encourages the development of community-based services. The purpose of the program is to help eligible beneficiaries to remain in, or to return to, the community rather than be cared for in a nursing facility or hospital setting.

(c) The program is Statewide with slots allocated to each county based upon the estimated number of AIDS beneficiaries to be served.

(d) The Division of Medical Assistance and Health Services administers the overall program. Additionally, it has the responsibility for assessing a beneficiary's need for care and for determining which beneficiaries will be served by the program.

10:60-7.2 Application process for ACCAP

(a) Individuals who are not currently Medicaid or NJ KidCare-Plan A eligible and who wish to apply for ACCAP, shall make application to the county board of social services located in the county where the individual resides.

(b) Supplemental Security Income (SSI) beneficiaries who wish to apply for ACCAP shall make application to the appropriate Medicaid District Office serving their county of residence.

(c) Applications for children under the supervision of the Division of Youth and Family Services (DYFS) shall be initiated by DYFS.

10:60-7.3 Eligibility criteria for ACCAP

(a) Beneficiaries eligible for ACCAP shall be:

1. Diagnosed as having AIDS, or be a child up to the age of 13 who is HIV positive;
2. In need of institutional care and meet, at a minimum, the nursing facility level of care criteria established by the New Jersey Medicaid Program (N.J.A.C. 10:63-1.3);
3. Categorically needy, that is, beneficiaries who are Medicaid eligible in the community, except for those served under the Medically Needy segment of the New

Jersey Care ... Special Medicaid Programs; or enrolled in a private HMO serving the Medicaid eligible population.

4. Optional categorically needy, that is, beneficiaries who have incomes which exceed the SSI community standard up to the institutional CAP and have resources which fall within the institutional standard. There is no deeming of spousal income or parental income or resources in the determination of eligibility for ACCAP. While the spouse's resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse.

i. Optional categorically needy beneficiaries under the age of 65 shall be determined disabled by the Social Security Administration (SSA) or by the Division of Medical Assistance and Health Services, Disability Review Section, using SSA disability criteria.

(b) Retroactive eligibility is not available to waiver beneficiaries for those Medicaid services provided only by virtue of enrollment in the waiver program.

(c) All beneficiaries determined to be eligible for ACCAP shall be issued a Medicaid Eligibility Identification card or NJ KidCare-Plan A card.

(d) In order for an applicant to be enrolled in the program, a waiver slot must be available.

10:60-7.4 ACCAP services

(a) All Medicaid or NJ KidCare-Plan A services, except for nursing facility services, are available under ACCAP in accord with an individualized plan of care. Additionally, the following services are available to the eligible beneficiary:

1. Case management: A process in which a public health nurse or social worker (MSW) in a community agency is responsible for planning, locating, coordinating and monitoring a group of services designed to meet the individual needs of the beneficiary being served.

i. Special Child Health Services (SCHS) units under contract to the New Jersey State Department of Health and Senior Services shall provide case management services to children up to the age of 21.

ii. Beneficiaries 21 years of age or older shall be referred to case management sites which provide case management services for New Jersey Medicaid's ACCAP.

iii. Case management shall not be provided when a beneficiary is in an inpatient hospital setting and the stay extends a full calendar month or beyond.

2. Private duty nursing (PDN): Care provided by a registered professional nurse or licensed practical nurse. PDN is continuous rather than part-time or intermittent, provided in the community only, not in an inpatient hospital setting. A nurse shall be employed by a licensed home health agency, voluntary non-profit homemaker/home health aide agency, private employment agency and temporary-help service agency approved by Medicaid or NJ KidCare to provide PDN services. PDN services may be

provided up to 16 hours per day, per person, but only when there is a live-in primary adult caregiver who accepts 24-hour per day responsibility for the health and welfare of the individual (see N.J.A.C. 10:60-6.3(d) for recordkeeping requirements) unless the sole purpose of the private duty nursing is the administration of IV therapy. A minimum of eight hours of hands-on care in any 24 hour period shall be provided by the primary caregiver.

i. The need for private duty nursing services is established initially by DHSS upon completion of the PAS-1 and HSDP (N.J.A.C. 10:60-1.7). The number of hours of private duty nursing included in the service plan is based upon the beneficiary's medical need and the cost of service. The total cost of all services provided through ACCAP must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the beneficiary's medical status changes, and correspondingly, as the service cost cap changes.

3. Certain narcotic and drug abuse treatments at home: The program allows drug treatment centers, approved as Medicaid providers, to provide methadone treatment, individual psychotherapy and family therapy at home.

4. Personal care assistant service: These are health-related tasks performed in the beneficiary's home by a certified individual who is under the supervision of a registered professional nurse. These services shall be prescribed by a physician and shall be provided in accord with a written plan of care. Personal care assistant service under ACCAP may exceed the maximum program limitation. Only Medicaid-approved personal care assistant providers shall provide personal care assistant service under ACCAP. All personal care assistants must meet the requirements defined in N.J.A.C. 10:60-1.2.

5. Medical day care: This allows for health, social and supportive services on an outpatient basis, several days a week, in an approved medical day care center.

6. Specialized group foster care home for children: This allows for an array of health care services provided in a residential health care program for children from birth to 18 years of age. All children served by the home are under the supervision of the Division of Youth and Family Services (DYFS). Specialized group foster care home for children services must be prior authorized by the Division, using the FD-352 form (see Appendix A, Fiscal Agent Billing Supplement).

7. Hospice care: This provides optimum comfort measures (including pain control), support and dignity to beneficiaries certified by an attending physician as terminally ill, with a life expectancy of up to six months. Family and/or other caregivers are also given support and direction while caring for the dying beneficiary. Services shall be provided by a Medicaid/NJ KidCare approved, Medicare certified hospice agency and available to a beneficiary on a daily, 24-hour basis. Hospice care shall be approved by the attending physician. Hospice services include: skilled nursing visits; hospice agency medical director services; medical social service visits; occupational therapy, physical therapy and speech-language pathology services; intravenous therapy; durable medical

equipment; medication related to symptom control of terminal illness and case management. Reimbursement shall be at an established fee paid on a per diem basis.

(b) Total program costs in ACCAP are limited by the number of community care slots used each year and by costs per beneficiary. The cost of those beneficiaries' service packages shall be no more than the cost of institutional care for those beneficiaries, determined at a projected weighted cost of institutional care by the Division of Medical Assistance and Health Services.

10:60-7.5 Basis for reimbursement for ACCAP services

(a) A fee-for-service reimbursement methodology shall be utilized for ACCAP waiver services.

(b) The HCFA 1500 Claim Form is used when requesting reimbursement for services provided.

(c) See N.J.A.C. 10:60-11 for codes used when submitting claims for ACCAP.

10:60-7.6 Procedures used as financial controls for ACCAP

Total program costs in the ACCAP waiver are limited by the number of community care slots used each year and by costs per beneficiary. The cost of the beneficiary service package shall be no more than the cost of institutional care for the beneficiary determined at a projected weighted cost of institutional care by the Division. The Division may elect to exclude individuals from the waiver program for whom there is an expectation that costs to the Division for services under the waiver may exceed the cost of nursing facility care.

END OF SUBCHAPTER 7

SUBCHAPTER 8. HOME AND COMMUNITY-BASED SERVICES WAIVER FOR MEDICALLY FRAGILE CHILDREN UNDER DIVISION OF YOUTH AND FAMILY SERVICES SUPERVISION (ABC WAIVER)

10:60-8.1 Purpose and scope

(a) The purpose of the ABC Waiver is to help eligible children remain in the community or return to the community, rather than be cared for in a nursing facility or hospital setting.

(b) The ABC Waiver was prepared by the Division of Youth and Family Services (DYFS) in cooperation with the Division of Medical Assistance and Health Services (DMAHS), in response to the Omnibus Budget Reconciliation Act of 1981, Section 2176, Public Law 97-35 and the amendments under P.L. 99- 509.

(c) DYFS has responsibility for the overall administration of the program. Medically fragile children entering the program must meet nursing facility of care criteria. DYFS case managers carry out the reassessment of nursing facility care. DMAHS will review and approve individual plans of care and will meet regularly with DYFS to monitor the program.

10:60-8.2 Eligibility criteria for ABC Waiver

(a) Application for the ABC program is made by DYFS for children under its care and supervision.

(b) Program eligibility criteria for the ABC Waiver are as follows:

1. Children must be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria.
2. Children through the age of 21 who are under the care and supervision of DYFS shall be served.
3. Children may be categorically needy or optional categorically needy.
4. There shall be no deeming of parental income or resources in the determination of eligibility.
5. Optional categorical eligibles also must be determined disabled.

10:60-8.3 ABC Waiver services

(a) ABC shall offer all New Jersey Title XIX Medicaid services except nursing facility coverage.

(b) Waiver services are as follows:

1. Case Management: A process in which a BSN is responsible for assisting waiver children to gain access to needed services and also for the ongoing monitoring of the provision of services included in the plan of care. DYFS administers the case

management function.

2. Homemaker: Consists of general household activities provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for the beneficiary in the home.

3. Respite Care: Services given to individuals unable to care for themselves on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care will be provided in the beneficiary's home or place of residence, foster home, nursing facility and specialized group foster care home.

4. Environmental Modifications: Physical adaptations to the home required by the beneficiary's plan of care which are necessary to ensure the health, welfare and safety of the individual or which enable the individual to function with greater independence. These adaptations may include such things as ramps and grab bars, widening of doorways, modification of bathrooms or installation of electrical or plumbing systems necessary to accommodate medical equipment and supplies.

5. Transportation: Special Home Service Providers will be reimbursed to provide transportation related to the child's arranged plan of care.

6. Specialized Medical Equipment and Supplies: Includes devices, controls or appliances specified in the plan of care which enables the beneficiary to increase abilities to perform activities of daily living or to perceive, control, or communicate. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items or durable and non-durable medical equipment not available under the State Plan.

7. Private Duty Nursing: Individual and continuous nursing care (in contrast to part-time or intermittent care) provided by licensed nurses.

8. Specialized Nutrition: State Plan coverage is expanded to provide nutritionally dense, high caloric supplements or special infant formulas to be taken orally.

9. Pediatric Hospice: A package of services provided in the home to a child certified by an attending physician as terminally ill with a life expectancy of up to six months.

10. Special Home Service Provider (SHSP) Supervision: SHSPs provide care that goes beyond the expectation of ordinary foster parents, as related to the medical diagnosis and health care needs of the child. These providers receive a difficulty-of-care fee as compensation for extra services provided.

11. Specialized Group Foster Care Homes: Approved specialized transitional care homes which provide health care and residential services, including medical services, nursing services, social services and transportation services.

12. Non-Legend Drugs: FDA-approved drugs commonly referred to as "over-the-counter" drugs.

10:60-8.4 Basis for reimbursement for ABC services

The only provider of waiver services in the ABC waiver is the Division of Youth and Family Services. The New Jersey Medicaid program on a fee-for-service basis shall reimburse only DYFS for waiver services provided to children enrolled in this program.

10:60-8.5 Procedures used as financial controls for the ABC Waiver

Total program costs are restricted by the number of community care slots and by aggregate costs. DYFS Central Office will allocate slots to its District Offices and apportion available funds, centrally controlling the aggregate costs of the program. DYFS will serve as the single provider of all services, contracting with individuals and agencies which meet Division standards.

END OF SUBCHAPTER 8

SUBCHAPTER 9. HOME AND COMMUNITY-BASED SERVICES WAIVER FOR PERSONS WITH TRAUMATIC BRAIN INJURIES (TBI WAIVER)

10:60-9.1 Purpose and scope

(a) The Traumatic Brain Injury (TBI) Waiver Program is a renewable Federal waiver program which offers home and community-based services to a beneficiary with an acquired traumatic brain injury. The purpose of the TBI program is to help eligible beneficiaries to remain in the community, or to return to the community rather than be cared for in a nursing facility.

(b) The waiver, prepared by the Division in response to the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Section 2176, Public Law 97-35) and amendments under the Omnibus Budget Reconciliation Act of 1986 (P.L. 99- 509), encourages the development of community-based services in lieu of institutionalization.

(c) The program is Statewide with slots allocated as individuals, ages 18 through 65, are admitted to the program.

(d) The Division administers the overall program, and has the responsibility for assessing an applicant's need for care and for determining which applicants will be served by the program.

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services. The delivery of home care services to TBI Waiver beneficiaries will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63-1.12.

10:60-9.2 Eligibility criteria

(a) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age at the time of enrollment;
2. Have a diagnosis of acquired brain injury which occurred after the age of 16;
3. Exhibit medical, emotional, behavioral and/or cognitive deficits;
4. Meet the DHSS nursing facility standard care criteria for preadmission screening (PAS), at N.J.A.C. 10:60-1.7;
5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix B);
6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid or NJ KidCare- Plan A in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care ... Special Medicaid Programs, or enrolled in a private health maintenance organization serving Medicaid or NJ KidCare-

Plan A beneficiaries are not eligible for this program.

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.

(b) If the individual is dually diagnosed; for example, with a head injury and psychiatric illness or developmental disability or substance abuse addiction, a determination will be made during the initial review as to the most appropriate service system to manage the beneficiary's care. This decision will be made based on clinical evidence, age of onset of injury, and professional evaluation.

(c) Retroactive eligibility shall not be available to waiver beneficiaries for those Medicaid or NJ KidCare-Plan A services provided only by virtue of enrollment in the waiver program.

(d) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid or NJ KidCare-Plan A Eligibility Identification card.

(e) In order for an applicant to be enrolled in the program, a waiver slot must be available.

10:60-9.3 Application process for TBI waiver

(a) Prior to formal application for the TBI waiver, a referral shall be submitted to the Bureau of Home and Community Services (BHCS) of the Division which shall review the referral to determine if the individual meets the basic criteria for the program. If it is determined that the individual referred is a potential candidate for the TBI waiver, the following shall occur:

1. Supplemental Security Income (SSI) beneficiaries shall be referred to the Medicaid District Office serving their county of residence;

2. Children under the supervision of the Division of Youth and Family Services (DYFS) shall be referred to DYFS for the initiation of the formal application. If the beneficiary has not been determined disabled, DYFS has the responsibility for assuring that the disability determination is completed by the Disability Review Unit. It is then sent to the appropriate Medicaid District Office (MDO) serving the beneficiary's county of residence; and

3. Individuals who are not currently Medicaid or NJ KidCare-Plan A eligible shall be referred by BHCS to the county board of social services (CBOSS) located in the county where the individual resides, for a determination of financial eligibility, which includes the referral for disability determination.

(b) After the applicant has been determined financially eligible for Medicaid or NJ KidCare-Plan A, he or she shall be referred to the Medicaid District Office (MDO) of the applicant's residence for a determination of medical eligibility by DHSS. The need for nursing facility care and the continued need for waiver services shall be conducted by the Division after six months and at the end of the first year of client eligibility and subsequently this determination shall be performed by the case manager.

(c) When the applicant is determined financially and medically eligible for the TBI waiver program, the MDO shall assign the case to a case management site and notify the BHCS of the beneficiary's approval for participation in the program.

(d) The MDO shall review and approve the plan of care prepared by the case manager initially and at six month intervals. Program oversight shall be provided by the Division and the delivery of services will be subject to a post-payment utilization review, in accordance with N.J.A.C. 10:63-1.8.

10:60-9.4 Termination criteria for the TBI waiver

(a) An individual shall be terminated from the TBI waiver program for the following reasons:

1. He or she no longer meets the income and resource requirements for Medicaid or NJ KidCare-Plan A;
2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;
3. He or she attains a Level eight or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;
4. He or she refuses to accept case management services; or
5. He or she is categorically eligible for Medicaid State Plan or NJ KidCare- Plan A services and does not require waiver services as part of the plan of care.

10:60-9.5 TBI waiver services

(a) All approved services under the New Jersey Medicaid or NJ KidCare-Plan A program, except for nursing facility services, are available under the TBI waiver from approved Medicaid or NJ KidCare providers in accord with an individualized plan of care. Additionally, the following waiver services shall be available to the eligible beneficiary:

1. Case management services is a process in which a social worker with a Bachelor of Social Work (BSW), or Master of Social Work (MSW), or a nurse with a Bachelor of Science in Nursing (BSN), or Master of Science in Nursing (MSN), or a certified rehabilitation counselor (CRC), or a certified insurance rehabilitation specialist (CIRS), employed by a licensed Medicare-certified home health agency or a private incorporated case management consulting firm or a non-profit human service agency, is responsible for planning, locating, coordinating and monitoring a group of services

designed to meet the individual needs of the beneficiary being served.

i. Case management shall not be provided when a beneficiary is in an inpatient hospital or nursing facility setting and the stay extends beyond a full calendar month.

ii. Case management shall include discharge planning and arrangements for other services when the beneficiary is no longer appropriate for waiver services.

iii. Acceptance of case management services shall be required for program participants.

2. Personal care assistant services are health related tasks performed in the beneficiary's home or place of residence by a certified homemaker/home health aide who is under the supervision of a registered professional nurse. The frequency or intensity of supervision shall be designated by the plan of care. Tasks shall include assistance with eating, bathing, dressing, personal hygiene, activities of daily living. They may include assistance with meal preparation, but not the cost of the meal itself. When specified in the plan of care, this service shall also include such housekeeping chores as bedmaking, dusting and vacuuming, which are essential to the health and welfare of the beneficiary. A personal care assistant shall be under contract to, or employed by a licensed Medicare certified home health agency or accredited homemaker/home health aide agency or a community residential services provider (see (a)9 below). Personal care assistant services shall be provided consistent with Medicaid and NJ KidCare-Plan A program limitations of hours in accordance with N.J.A.C. 10:60-3.8(c). Family members who provide personal care assistant services shall meet the same standards as providers who are unrelated to the beneficiary.

3. Respite care service is care provided on a short term basis because of the absence or need for relief of those persons normally providing the care. Respite care shall be provided in the beneficiary's home or place of residence. Services shall also be provided in a licensed nursing facility, licensed residential health care facility, or by a community residential services program. A community residential services program shall be licensed by the Division of Developmental Disabilities. Home health agencies providing respite care shall also be licensed by the Department of Health and Senior Services and homemaker/home health aide agencies providing respite care shall be accredited in accordance with N.J.A.C. 10:60-1.2.

i. In-home or place of residence respite care shall be provided up to 14 days per year.

ii. Out-of-home respite care shall be provided up to 42 days per year.

iii. A community residential services program shall provide respite service to individuals living with their families, but this service is not available to beneficiaries residing in a community residential service setting.

4. Environmental modification services are physical adaptations to the beneficiaries home, required by the beneficiary and included in the plan of care, which are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence in the home, without which the beneficiary would require institutionalization. Such adaptations shall include the installation of ramps and grabbers, widening of doorways, modification of bathrooms, or

installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies for the beneficiary's welfare. Vehicle modification for the beneficiary's/family vehicle shall also be included. Also included shall be electronic monitoring systems to protect the beneficiary's safety, as determined by the plan of care. Excluded are adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary, such as carpeting, roof repair, and/or central air conditioning. All environmental modification services provided shall be in accordance with applicable State and local building codes.

i. Case managers shall be responsible to assure that contractors are qualified to provide the necessary modifications.

ii. A provider of environmental modification services shall be required to execute a purchase agreement for the service with the case manager who shall submit a claim for the service to the Division's Fiscal Agent.

5. Transportation services are offered to enable beneficiaries to gain access to services described in the plan of care. A transportation service is offered in addition to medical transportation provided under 42 CFR 431.53 and transportation offered under the State Plan as defined at 42 CFR 440.170(a), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies that are able to provide this service without charge shall be utilized. Family members shall not be reimbursed for the provision of transportation services under this waiver, in accordance with N.J.A.C. 10:50.

i. Providers of this service shall include community residential services providers, community mental health agencies, family services agencies, Commission on Accreditation of Rehabilitation Facilities (CARF) certified day programs.

ii. All drivers or carriers shall have a valid driver's license and not less than the minimum insurance coverage required by New Jersey law.

iii. Vehicles utilized shall be properly registered and pass inspection standards for bus, taxicab and other commercial carriers or private automobile and can be either regular or specially equipped for those unable to use common carrier transportation.

iv. Reimbursement paid to the transportation provider shall include the cost of the transportation plus additional cost of the personal care assistant or companion if any, who may accompany the beneficiary, as long as that person is not a family member. In no case shall a family member be reimbursed for transportation services under the waiver.

v. Transportation shall be covered in the service package provided by a community residential services provider to a beneficiary living in a supervised residence. No additional reimbursement shall be paid for this service.

vi. Transportation shall be covered in the service package provided by the structured day program during the hours the beneficiary is participating in the program. No additional reimbursement shall be paid for this service.

6. Chore services are services needed to maintain the home in a clean, sanitary and safe environment. These services shall include heavy household chores, such as

washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture to provide safe access for the beneficiary inside the home, shoveling snow to provide access and egress. These services shall be provided only where neither the beneficiary nor any other person in the household is capable of performing or financially providing for them, or when a relative, caretaker, landlord or community volunteer agency or third party payer cannot provide them. Prior to approving chore services for rental property, the case manager shall determine if it is the responsibility of the landlord to provide these services.

i. Services shall be provided by accredited homemaker/home health aide agencies, county service agencies, employment or cleaning service agencies licensed by the Division of Consumer Affairs, Department of Law and Public Safety. The case manager shall assure that the chore service provider meets all applicable laws, rules and regulations.

ii. Chore services shall be covered in the service package for anyone living in a community residential service provider residence. No additional reimbursement shall be paid for this service.

7. Companion services are non-medical care, supervision and socialization provided to a functionally and mentally impaired adult. A companion shall assist the beneficiary with such tasks as meal preparation, laundry, and shopping, but shall not perform these activities as discrete services. This service shall not entail hands-on medical care. A companion shall perform light housekeeping incidental to the care and supervision of the beneficiary. Companion service shall be provided in accordance with a therapeutic goal of engaging the beneficiary to the extent possible with his or her own care, surroundings and other people. Companion services are appropriate for those beneficiaries who need a person to be with them to provide prompting or cueing to initiate or complete daily activities. Companions provide assistance with shopping and meal preparation, and are available for socialization or to encourage socialization, depending upon the individual's care plan. Companion services may be a less costly service approach to enabling a beneficiary to remain in the community.

i. Companion service shall be provided by an accredited homemaker/home health aide agency, a private non-profit community service agency, community mental health agency, family service agency, a community residential services provider, or a Commission on Accreditation of Rehabilitative Facilities (CARF) accredited day program.

ii. Companion service shall be covered under a Community Residential Services Program when the beneficiary is residing in the CRS program and companion services is not reimbursed as a separate service. Companion service shall not be reimbursed as a separate service during the hours the beneficiary is participating in a structured day program.

iii. The case manager shall insure that the companion meets the following standards:

(1) Is able to read, write and follow simple directions;

(2) Passes a post-employment-offer physical exam prior to placement;

(3) Works under the intermittent supervision of the employment agency;
(4) Is able to handle emergency situations;
(5) Understands and is able to work with individuals with TBI;
(6) Maintains confidentiality; and
(7) Has a valid driver's license and appropriate insurance coverage, if responsible for transporting residents.

8. Therapy services include physical and occupational therapy, speech- language pathology and cognitive therapy services. Therapy shall be offered alone or in combination to enhance or maintain beneficiary functioning as required by the plan of care. Therapies shall focus on the reattainment of physical or cognitive skill lost or altered as a result of trauma. The aim is to maximize beneficiary functioning in real world situations through retraining, use of compensatory strategies and orthotic and prosthetic devices, if necessary.

i. Physical therapists (PT) and physical therapy assistants (PTA) shall meet the New Jersey licensure standards and requirements for practice (see N.J.A.C. 13:39A). PT and PTA shall be under contract to or on the staff of a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the PT services.

ii. An occupational therapy provider shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of an OTR. An OTR and COTA shall be under contract to or on the staff of a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the OT services.

iii. A speech-language pathologist provider shall be licensed by the State of New Jersey (see N.J.A.C. 13:44C). A speech-language pathologist shall be under contract to a community residential services provider, rehabilitation hospital or agency, or home health agency, which shall be reimbursed for the speech-language therapy services.

iv. A cognitive therapy provider shall meet certification standards for cognitive therapy, established by the Society for Cognitive Rehabilitation Inc. (Society for Cognitive Rehabilitation, P.O. Box 3335, Cherry Hill, NJ 08034, phone, 1-856-751-0680) and shall be under contract to a community residential services provider, rehabilitation hospital or agency which shall be reimbursed for the cognitive therapy services.

9. Community residential services (CRS) is a package of services provided to a beneficiary living in a community residence owned, rented or supervised by a licensed community residential services provider.

i. The package of services shall include personal care, companion services, chore services, transportation, night supervision and therapeutic activities. The reimbursement for this service to the CRS provider does not include room and board or a personal needs allowance (PNA). The beneficiary shall be responsible for the costs of room and board. The CRS shall not be reimbursed when the beneficiary is absent from the residence for a 24-hour period since the cost of such absence has been incorporated

into the per diem CRS rate.

ii. The CRS provider shall be responsible for coordinating the package of services to ensure the beneficiary's safety and access to these services as determined by the beneficiary and case manager.

(1) The CRS program shall be licensed by the Division of Developmental Disabilities as a CRS provider;

(2) Employees of CRS providers shall meet all applicable professional standards; and

(3) All employees shall be trained to understand and provide appropriate care to head injured individuals.

10. Night supervision services include intermittent or ongoing overnight supervision to an individual in his or her own home for a period of not less than eight hours and not more than 12 hours. Night supervision staff shall be trained and supervised by CRS providers or home health or homemaker home health aide agencies to provide supervision and are prepared to call for assistance in the event of an emergency. They shall also be available to perform turning or repositioning tasks, to remind the patient to take medication and to assist with personal care, if needed. It is expected that one night support attendant shall provide assistance for up to three beneficiaries in the same household. Night supervision is not available for beneficiaries receiving CRS in a community residential services program, since supervision is provided as a component of the program:

i. This service shall be provided by a community residential service provider, a home health or homemaker/health aide agency provider.

ii. CRS providers shall be licensed by the Division of Developmental Disabilities (DDD); home health agencies shall be licensed by the Department of Health and Senior Services (DHSS); and homemaker/home health aide agencies shall be accredited in accordance with this chapter.

11. Structured day program services is a program of daily meaningful supervised activities directed at the development and maintenance of independence and community living skills. Services may take place at home or in a setting separate from the home in which the beneficiary lives. Services shall include group or individualized life skills training that will prepare the beneficiary for community reintegration, including attention skills, task completion, problem solving, safety and money management. The services shall include nutritional supervision, health monitoring and recreation as appropriate to the individualized plan of care. The service shall cover transportation during the hours of participation in the program, including transportation to program activities. The program shall be provided in half day (a minimum of three hours) or full day (a minimum of six hours, including lunch) segments. The program excludes medical day care which may be provided as a State Plan service. This service is not otherwise available under a program funded under the Rehabilitation Act of 1973, P.L. 94-142. Beneficiaries are not eligible to receive this service if they are participating in programs for the same time period funded by other agencies.

i. Structured day programs shall be provided by CRS, rehabilitation hospitals or agencies, comprehensive outpatient rehabilitation facilities (CORF) and incorporated head injury service providers which have post-acute day programs that meet standards for post-acute head injury services developed by the Head Injury Special Interest Group of the American Congress of Rehabilitation Medicine or Commission of Accreditation of Rehabilitation Facilities (available from the Bureau of Home and Community Services, PO Box 712, Mail Code 35, Trenton, NJ 08625-0712).

12. Supported day program services is a program of independent activities in- home or out-of-home requiring initial and periodic support from a professional to sustain the program. Interventions shall include placement development, evaluation, and counseling, placement and follow-up in a setting where the setting itself is not paid to supervise the beneficiary. The professional shall be a person trained and licensed or certified in a specific profession. Examples include, but are not limited to, social work, vocational rehabilitation, psychology, nursing and therapeutic recreation. The program of activities shall promote independence and community reintegration. The professional support shall be reimbursed on an hourly basis, depending on the amount of support required within the plan of care. This service is not otherwise available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142.

i. Supported day program staff employed by the day program are paid to develop and monitor a community-based placement for the individual beneficiary as part of the plan of care. The community-based placement is not paid to provide the activity to the beneficiary. Examples include prevocational settings, volunteer programs or social clubs where the beneficiary can participate in meaningful activities. The supported day program provider is paid on an hourly basis for activity development and follow-up to ensure that the beneficiary has made a satisfactory adjustment in the placement. Supported day care program is a step-down alternative to structured day program and a less costly service.

(1) "Placement development" means the identification of and negotiation with an organization, business, association or other group in the community to accept a brain injured person to participate in or engage in some productive activity as a part of that group. The activity shall be related to the brain injured person's skills, interests and abilities.

(2) "Evaluation and counseling" means review of the supported day program to determine that the placement is suitable for the beneficiary, and availability to the beneficiary and the community program to resolve any problems or to support the beneficiary's placement.

(3) "Placement and follow-up in the setting where the setting is not paid to supervise the beneficiary" means that the supported day program provider arranges the placement, provides intervention if there are problems, but will not provide ongoing supervision of the beneficiary at his or her activity site.

ii. Supported day program services shall be provided as an alternative to structured day program, when the beneficiary does not require continual supervision.

iii. The providers of supported day program services shall be the same as those providing structured day programs.

13. Counseling services shall be provided to resolve intrapsychic or interpersonal conflict resulting from brain injury as an adjunct to behavioral program services in severe cases or for substance abuse problems. Counseling shall be provided to the beneficiary and family if necessary. Counseling for substance abuse problems shall be provided by a certified alcohol and drug counsel (CADC) familiar with brain injury or by a local alcohol/drug treatment program. Due to the high correlation between TBI and substance abuse, detailed drug/alcohol abuse history shall be obtained by the case manager for each beneficiary to monitor a potential for substance abuse. Waiver services shall be utilized only if State Plan counseling services for mental health or drug treatment are either unavailable or inappropriate to meet beneficiary needs.

i. Providers of counseling service shall be licensed mental health professionals, practicing independently, employed by an agency or under contract to an agency. These professionals include psychologists, psychiatrists, social workers and nurses.

ii. Registered professional nurses shall be licensed by the State of New Jersey and certified as a clinical specialist in psychiatric or mental health nursing by the American Nurses Association (N.J.A.C. 13:37).

iii. A social worker shall be licensed as a clinical social worker (LCSW) under New Jersey statutes and rules. (N.J.S.A. 45:1-15 and N.J.A.C. 13:44G).

iv. A psychologist shall be licensed (see N.J.A.C. 13:42) as a clinical psychologist under New Jersey statute, with competencies in areas related to diagnosis and treatment of brain injury.

v. A psychiatrist shall be a physician licensed under the New Jersey Board of Medical Examiners and Board Certified or Board Eligible under the American Board of Psychiatry and Neurology (N.J.A.C. 13:35).

vi. A certified alcohol drug counselor (CADC) shall be certified by the Alcohol and Drug Counselor Certification Board of New Jersey (ADCCBNJ, 5-A Auer Court, East Brunswick, NJ 08816, Phone 1-800-325-7979).

vii. All mental health professionals providing counseling services shall have experience and knowledge in treating persons with brain injuries.

14. Behavioral program services is a daily program provided by and under the supervision of a licensed psychologist and by behavioral aides (specialists) trained by a licensed psychologist, which is designed to serve beneficiaries who display severe maladaptive or aggressive behavior which is potentially destructive to the individual or others. The program provided in or out of the home, is time limited and designed to treat the individual and caregivers, if appropriate, on a short term basis.

i. Behavior programming shall include a complete assessment of the maladaptive behavior(s), development of a structured behavior modification plan, ongoing training and supervision of caregivers and behavioral aides (specialists) and periodic reassessment of the plan. The goal of the program shall be to return the individual to prior level of functioning which is safe for himself or herself and others.

ii. Enrollment in the behavioral program shall require prior authorization and recommendation by a licensed clinical psychologist (N.J.A.C. 13:42) or psychiatrist (N.J.A.C. 13:35), with subsequent consultation by same on an as needed basis. The case manager shall also prior-approve the service within the plan of care.

iii. Providers of this service shall be a licensed CRS provider (N.J.A.C. 10:44A and 10:44B), rehabilitation hospital (N.J.A.C. 8:43H), community mental health agency (N.J.A.C. 10:37 and 10:37C), clinical psychologist (N.J.A.C. 13:42), or Board Certified, Board eligible psychiatrist (N.J.A.C. 13:35).

iv. Rehabilitation hospitals shall have been licensed by the Department of Health and Senior Services (DHSS) (N.J.A.C. 8:43H).

v. Community mental health agencies shall be approved by the Division of Mental Health Services (DMHS) (N.J.A.C. 10:37 and 10:37C).

vi. Community residential services providers shall be licensed by the Division of Developmental Disabilities (DDD) (N.J.A.C. 10:44A and 10:44B).

vii. Additionally, to supervise the program, the provider shall employ staff or contract with a Board Certified or Board Eligible psychiatrist or licensed clinical psychologist with two years experience in head injury and/or behavioral programming.

viii. Behavioral aides (specialists) employed to implement the behavior modification program shall possess a high school diploma at a minimum and have 24 hours of behavioral training from a qualified psychologist or psychiatrist. Behavioral aides (specialists) shall also receive an additional 16 hours of training in crisis management during the first 90 days of employment.

10:60-9.6 Procedures used as financial controls for the TBI waiver

Total program costs in the TBI waiver are limited by the number of community care slots used each year and by costs per beneficiary. The cost of the beneficiary service package shall be no more than the cost of institutional care for the beneficiary determined at a projected weighted cost of institutional care by the Division. The Division may elect to exclude individuals from the waiver program for whom there is an expectation that costs to the Division for services under the waiver may exceed the cost of nursing facility care.

10:60-9.7 Basis for reimbursement for TBI services

(a) A fee-for-service reimbursement methodology shall be utilized for TBI waiver services. Providers shall be precluded from receiving additional reimbursement for the cost of these TBI Waiver services above the fee established by the Medicaid program. (See N.J.A.C. 10:60-11.2(f).)

(b) The HCFA 1500 Claim Form shall be used when billing for waiver services provided. Refer to the Fiscal Agent Billing Supplement (Appendix A of this chapter) for information in the completion of the HCFA 1500.

(c) Fees for TBI waiver services are established for each service by the Division.

10:60-9.8 Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) for Traumatic Brain Injury Program

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in N.J.A.C. 10:60-11.2(f) are relevant only to the Traumatic Brain Injury Program.

(b) The HCPCS procedure codes are used when requesting reimbursement for services provided through the Traumatic Brain Injury Program and when a HCFA 1500 Claim Form is required.

END OF SUBCHAPTER 9

SUBCHAPTER 10. HOME AND COMMUNITY-BASED SERVICES WAIVERS ADMINISTERED BY OTHER STATE AGENCIES

10:60-10.1 Community Care Program for the Elderly and Disabled (CCPED)

(a) The Federal Omnibus Budget Reconciliation Act of 1981 (Section 2176, P.L. 97-35) encouraged the development of community-based service programs rather than institutional service programs. This law was codified as Section 1915(c) of the Social Security Act (see 42 U.S.C. 1936n). This law was subsequently amended by the Balanced Budget Act of 1997 (P.L. 105-33), and the Omnibus Reconciliation Act of 1990 (P.L. 101-108).

1. Under the provision of this Federal legislation, a request for a home and community-based services waiver for elderly and disabled individuals was submitted by the New Jersey Department of Human Services and approved by the United States Department of Health and Human Services. The waiver is renewable every five years and serves a limited number of beneficiaries Statewide who must meet the medical and financial eligibility requirements.

2. Under the Governor's Reorganization Plan No. 001-1996, CCPED was transferred to the Department of Health and Senior Services (DHSS).

(b) The Community Care Program for the Elderly and Disabled (CCPED) is a waiver program, administered by DHSS, initiated to help eligible beneficiaries remain living in the community rather than in a nursing facility. (See N.J.A.C. 8:81 For DHSS policies regarding this program.)

1. The program allows for the allocation of community care slots which are assigned Statewide in accordance with the needs of the population and the resources available to meet those needs. Each county has a designated case management site such as a county board of social services, Office on Aging, home health agency or homemaker agency.

(c) Financial eligibility for CCPED is determined by the county board of social services which serves the county where an individual resides. The standards used for income eligibility are set forth in N.J.A.C. 10:71-5.6(c) 4, Table B, entitled "Variations in Living Arrangements." Both the Supplemental Security Income (SSI) community standard and the Medicaid institutional standard appear in this table. The actual amounts, recomputed periodically based upon the cost-of-living increase, are subject to change each time a cost-of-living increase occurs.

1. Beneficiaries financially eligible for Medicaid services under the community eligibility standards are not covered under CCPED. CCPED also does not serve beneficiaries who are eligible under the New Jersey Care ... Special Medicaid Programs, including the Medically Needy segment of that program or enrolled in a private HMO serving the Medicaid or NJ KidCare eligible population.

(d) Program eligibility criteria are as follows:

1. An applicant 65 years or older shall be eligible for Medicare benefits or have other medical insurance which includes physician coverage and hospitalization.
2. An applicant under 65 shall be determined disabled by the Social Security Administration (SSA) and be eligible for Medicare benefits or be determined disabled by the Division of Medical Assistance and Health Services, Disability Review Section, and have other medical insurance which includes physician coverage and hospitalization.
3. An applicant shall be ineligible in the community for Supplemental Security Income (SSI), or the applicant's total income, excluding deemed income, shall exceed the appropriate SSI community standard up to the Medicaid institutional standard. Parental and spousal income are not considered in the determination of eligibility.
4. An applicant's own resources shall not exceed the Medicaid Only limits. Resources of a parent are not deemed. While the spouse's resources are considered, up to one-half of the total resources are protected for the use of the spouse.
5. An applicant shall be in need of the type of care provided in an institutional setting and meet, at a minimum, the New Jersey's Medicaid Program's nursing facility's level of care criteria.
6. In order for an applicant to be enrolled in the program, a waiver slot shall be available.

(e) The total cost of services for the beneficiary in the community reimbursed by the Medicaid program shall not exceed the established cost limitation for institutional care for that beneficiary.

(f) A Medicaid Eligibility Identification (MEI) or NJ KidCare-Plan A card shall be distributed to the beneficiary eligible for CCPED. Approved services are listed on the card as exhibited in the Appendix to N.J.A.C 10:49.

(g) Retroactive eligibility is not available to CCPED beneficiaries; no service received prior to the date of enrollment shall be considered for reimbursement.

(h) Services provided under CCPED complement the services provided under the Medicare Program or other physician and hospital benefit coverage for non- Medicare eligible individuals.

(i) Services provided under CCPED include the following:

1. Case Management;
2. Home health;
3. Homemaker services;
4. Medical day care;
5. Social adult day care;
6. Medical transportation;

7. Respite care; and
8. Pharmaceuticals.

(j) The services listed under (i) above may be limited in duration or amount depending upon the cost of the service plan under CCPED and the medical needs of the beneficiary.

(k) Other services covered by the New Jersey Medicaid program are not available to the CCPED beneficiary.

10:60-10.2 Enhanced Community Options (ECO) Waiver

(a) The Federal Omnibus Budget Reconciliation Act of 1981 (Section 2176, P.L. 97-35) encouraged the development of community-based service programs rather than institutional service programs. This law was codified as Section 1915(c) of the Social Security Act (see 42 U.S.C. 1936n). This law was subsequently amended by the Balanced Budget Act of 1997 (P.L. 105-33), and the Omnibus Reconciliation Act of 1990 (P.L. 101-108).

1. Under the provisions of this Federal legislation, a request for a home and community-based services waiver for aged and disabled individuals was submitted by the New Jersey Department of Human Services and approved by the United States Department of Health and Human Services. The waiver is renewable every five years and serves a limited number of beneficiaries statewide who must meet the medical and financial eligibility requirements.

2. Under the Governor's Reorganization Plan No. 001-1996, this waiver was transferred to the Department of Health and Senior Services (DHSS). ECO was formerly known as the Assisted Living and Alternate Family Care (AL/AFC) waiver.

(a) ECO is a waiver program administered by DHSS, initiated to help eligible beneficiaries remain living in the community rather than in a nursing facility. (See N.J.A.C. 8:81 for DHSS rules regarding this program.)

END OF SUBCHAPTER 10

SUBCHAPTER 11. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:60-11.1 Introduction

(a) The New Jersey Medicaid and NJ KidCare programs adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this Subchapter are relevant to certain Medicaid and NJ KidCare Home Care services.

(b) These codes are used when requesting reimbursement for certain Home Care services and when a HCFA 1500 Claim Form is required.

10:60-11.2 HCPCS Codes

(a) PERSONAL CARE ASSISTANT SERVICES FOR MEDICAID, NJ KidCare--Plan A AND MODEL WAIVERS

HCPCS Code	Description	Maximum Rate
Z1600	Personal Care Assistant Service (Individual/hourly/weekday)	$14.50
Z1605	Personal Care Assistant Service (Group/hourly/weekday)	$11.00
Z1610	Initial Nursing Assessment Visit	$35.00
Z1611	Personal Care Assistant Service (Individual/ 1/2 hour/weekday)	$ 7.25
Z1612	Personal Care Assistant Service (Group/ 1/2 hour/weekday)	$ 5.50
Z1613	Nursing Reassessment Visit	$35.00
Z1614	Personal Care Assistant Service (Individual/hourly/weekend/holiday)	$16.00
Z1615	Personal Care Assistant Service (Individual/ 1/2 hour/weekend/holiday)	$ 8.50
Z1616	Personal Care Assistant Service (Group/hourly/weekend/holiday)	$12.00
Z1617	Personal Care Assistant Service (Group/ 1/2 hour/weekend/holiday)	$ 6.00

(b) PERSONAL CARE ASSISTANT SERVICES FOR THE MENTALLY ILL
(Applicable to clinics under contract to the Division of Mental Health Services of the Department of Human Services):

HCPCS	Maximum Fee Allowance

Code	Mod.	Description	S	$	NS
Z1600	ZI	Personal Care Assistant Services Individual, per hour		13.02	13.02
Z1605	ZI	Personal Care Assistant Service Group, per hour		10.23	10.23
Z1610	ZI	Personal Care Assistant Services Initial Nursing Assessment, per visit		35.00	35.00
Z1611	ZI	Personal Care Assistant Services Individual, per hour		6.51	6.51
Z1612	ZI	Personal Care Assistant Services Group, per half hour		5.12	5.12
Z1613	ZI	Nursing Reassessment Visit, per visit		35.00	35.00

(c) HCPCS CODES FOR MODEL WAIVERS AND AIDS COMMUNITY CARE ALTERNATIVES PROGRAM

HCPCS Code	Description
MODEL WAIVERS 1, 2 and 3	
Z1700	Case Management, per beneficiary/per month
MODEL WAIVER 3 and AIDS COMMUNITY CARE ALTERNATIVES PROGRAM	
Z1710	PDN-RN, Per Hour/Weekday
Z1715	PDN-LPN, Per Hour/Weekday
Z1720	PDN-RN, Per Hour/Weekend/Evening/Holiday
Z1725	PDN-LPN, Per Hour/Weekend/Evening/Holiday
Z1730	PDN-RN Specialty, Per Hour/Weekday
Z1735	PDN-LPN Specialty, Per Hour/Weekday
Z1740	PDN-RN Specialty, Per Hour/Weekend/Evening/Holiday
Z1745	PDN-LPN Specialty, Per Hour/Weekend/Evening/Holiday

(d) HCPCS CODES FOR AIDS COMMUNITY CARE ALTERNATIVES PROGRAM

HCPCS Code	Description
Z1800	Case Management, Per Beneficiary/Month
Z1801	Case Management, Initial Month (one time only, per beneficiary)
Z1810	Hospice, daily
Z1820	Personal Care Assistant Service, Per Hour/Weekday/Individual
Z1821	Personal Care Assistant Service, Per 1/2 Hour/Weekday/Individual
Z1822	Personal Care Assistant Service, Per Hour/Weekend/Holiday/Individual
Z1823	Personal Care Assistant Service, Per 1/2 Hour/Weekend/Holiday/Individual

Z1824 Personal Care Assistant Service, Per Hour/Weekday/Group
Z1825 Personal Care Assistant Service, Per 1/2 Hour/Weekday/Group
Z1826 Personal Care Assistant Service, Per Hour/Weekend/Holiday/Group
Z1827 Personal Care Assistant Service, Per 1/2 Hour/Weekend/Holiday/Group
Z1828 Initial Nursing Assessment Visit
Z1829 Nursing Reassessment Visit
Z1830 Methadone Treatment at Home provided only by narcotic and drug treatment centers
Z1831 Urinalysis for Drug Addiction at Home provided only by narcotic and drug treatment centers
Z1832 Psychotherapy, Full Session at Home provided only by narcotic and drug treatment centers
Z1833 Psychotherapy, Half Session at Home provided only by narcotic and drug treatment centers
Z1834 Family Therapy at Home provided only by narcotic and drug treatment centers
Z1835 Family Conference at Home provided only by narcotic and drug treatment centers
Z1850 Intensive Supervision for Children with AIDS in Foster Care Homes, per beneficiary, per month provided only by DYFS
Z1851 Specialized Group Foster Home Care for Children, daily
Z1852 Intensive Supervision for Children with ARC in Foster Care Homes, per beneficiary, per month provided only by DYFS
Z1853 Intensive Supervision for HIV-positive Children in Foster Care Homes, per beneficiary, per month provided only by DYFS
Z1860 Medical Day Care, daily

(e) HCPCS CODES FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT/PRIVATE DUTY NURSING:

HCPCS Code	Description	Maximum Rate
Z1710WT	PDN-RN, EPSDT, Per Hour	$30.00
Z1730WT	PDN-RN, EPSDT, Enhanced, Per Hour	$35.00
Z1735WT	PDN-LPN, EPSDT, Per Hour	$25.00

(f) HCPCS CODES FOR TRAUMATIC BRAIN INJURY PROGRAM:

HCPCS Code	Description	Maximum Rate
Y7433	TBI-Case Management, Initial (First Month)	$200.00
Y7434	TBI-Case Management, Continuing (Subsequent Month)	$125.00

Y7435 TBI-Community Residential Services (Level I Supervision) 2-4 hours $99.00
Y7436 TBI-Community Residential Services (Level II Supervision) over 4-8 hours $115.00
Y7437 TBI-Community Residential Services (Level III Supervision) over 8 hours $147.00
Y7438 TBI-Structured Day Program (Full Day) $87.00
Y7439 TBI-Structured Day Program (Half Day) $44.00
Y7443 TBI-Supported Day Program (Per Hour) $30.00
Y7444 TBI-Personal Care Assistant Services (Weekdays, per hour) $14.00
Y7445 TBI-Personal Care Assistant Services (Weekends, and Holidays, Per Hour) $17.00
Y7446 TBI-Companion Services (Per Hour) $11.00
Y7448 TBI-Night Supervision (8 hours) $112.00
Y7449 TBI-Chore Services (Per hour) $10.00
Y7453 TBI-Respite Inpatient Variable NF Rate or per day for non-NF $100.00
Y7454 TBI-Personal Care Assistant Services RN Initial Nursing Assessment $35.00
Y7455 TBI-Personal Care Assistant Services, RN Reassessment $35.00
Y7456 TBI-Respite 8 hour day $88.00
Y7457 TBI-Respite 8 hour night $104.00
Y7458 TBI-Respite greater than 8 hour to 12 hour day $128.00
Y7459 TBI-Respite greater than 8 hour to 12 hour night $144.00
Y7463 TBI-Respite greater than 12 hour to 24 hour day $160.00
Y7554 TBI-Physical Therapy (Per Visit $73.00
Y7555 TBI-Occupational Therapy (Per Visit) $73.00
Y7556 TBI-Speech Therapy (Per Visit) 73.00
Y7557 TBI-Cognitive Therapy (Per Visit) $73.00
Y7558 TBI-Counseling (Behavior) (Per Hour) $65.00
Y7559 TBI-Counseling (Individual/Family) (Per Hour) $65.00
Y7563 TBI-Counseling (Addiction) (Per Hour) $65.00
Y7564 TBI-Behavior Program (Assessment) (Per Hour) $75.00
Y7565 TBI-Behavior Program (Psychologist) (Continuing) (Per Hour) $75.00

Y7566 TBI-Behavior Program (Continuing) (Per Hour) $35.00
Y7567 TBI-Transportation (Per Trip) $.25 per mile
Y7568 TBI-Environmental Modification (Per Service or Item) $1,000.00

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation
PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

APPENDIX B
Current through July 16, 2001; 33 N.J. Reg. No. 14

RANCHO SCALE

Level	Response	Patient Function
I	No response	Patient is completely unresponsive to any stimulus.
II	Generalized response	Patient reacts to the environment, but not as a specific response to the stimulus--responses are often the same despite change of stimuli. The earliest response is often gross movement to deep pain.
III	Localized response	Patient reacts in a specific manner to the stimulus, but may inconsistently turn head to sound, withdraw an extremity to pain, squeeze fingers placed in the hand, or respond to family members more than others.
IV	Confused, agitated	Patient is in a heightened state of activity, but is still severely detached from the

		surroundings. Internal confusion and very limited ability to learn is combined with short attention span and easy fatigue. The patient is unable to cooperate and may be aggressive, combative, or incoherent.
V	Confused, inappropriate/ nonagitated	Patient appears alert and is able to respond to simple commands. Responses are best with familiar routines, people, and structured situations. Distractibility and short attention span lead to difficulty learning new tasks and agitation in response to frustrations. If physically mobile, there may be wandering. Much external structure is needed. Initiation and memory are limited.
VI	Confused, appropriate	Patient shows goal-directed behavior, but still is dependent on external structure and direction. Simple directions are followed consistently and there is carry-over of relearned skills (like dressing), yet new learning progresses very slowly with little carry-over. Orientation is better and there is no longer inappropriate wandering.
VII	Automatic, appropriate	Patient appears appropriate and oriented with familiar settings such as home and hospital, but is confused and often helpless in unfamiliar surroundings. The daily routine can be managed with minimal confusion as long as there are no changes. There is little recall of what has just been done. There is only a superficial understanding of the disability, with lack of insight into the significance of the remaining deficits. Judgment is impaired with inability to plan ahead. New learning is slow and minimal supervision is needed. Driving is unsafe; supervision is needed for safety in the community or in school and workshop settings.
VIII	Purposeful, appropriate	Patient may not function as well as before the injury, but is able to function

independently in home and community skills, including driving. Alert, oriented, and able to integrate past and present events. Vocational rehabilitation is indicated. Difficulties dealing with stressful or unexpected situations can arise, as there may be a decrease in abstract reasoning, judgment, intellectual ability, and tolerance of stress relative to premorbid capabilities.