

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 FamilyCare 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, Community Resources for People with Disabilities (CRPD), 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 Community Resources for People with Disabilities (CRPD), 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 DMAHS to provide private duty nursing services under the Community Resources for People with Disabilities (CRPD), ABC, ACCAP or EPSDT programs. 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.

“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 FamilyCare fee-for-service beneficiary’s residence and ends when the home health agency staff leaves the beneficiary’s residence.

Amended by R.1993 d.588, effective November 15, 1993.

See: 25 N.J.R. 2803(a), 25 N.J.R. 5167(a).

Amended by R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Amended by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

Amended by R.1997 d.277, effective July 7, 1997.

See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(a).

Added “Calendar work week”.

Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: 30 N.J.R. 3198(a), 30 N.J.R. 4377(a).

Substituted references to beneficiaries for references to recipients throughout; inserted “Field security cost”, “Non-routine supplies”, “Routine supplies”, “Unit” and “Visit”; in “Hospice service” and “Levels of care”, inserted references to NJ KidCare fee-for-service; in “On-site monitoring”, substituted a reference to this chapter for a reference to this manual; in “Personal care assistant”, substituted “Division-approved” for “Medicaid-approved” in 3; in “Preadmission screening (PAS)”, inserted a reference to NJ KidCare; and in “Quality

assurance”, substituted a reference to this chapter for a reference to this manual, and inserted a reference to NJ KidCare.

Amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

Rewrote the section.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted “Family Care” for “KidCare” and “Community Resources for People with Disabilities (CRPD)” for “Model Waiver 3” throughout; added definitions “DDD”, “DDS”, and “DMAHS”; deleted definitions “Division” and “Unit”; in definition “Home health agency”, inserted “the” preceding “Title” in 2; rewrote definitions, “Homemaker agency”, “Hospice service”, “On-site monitoring” and “Private duty nursing agency”; and substituted definition “Medical Assistance Customer Center” (MACC) for definition “Medicaid District Office” (MOD).

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, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the National Association for Home Care and Hospice.

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Amended by R.1994 d.623, effective December 19, 1994.

See: 26 N.J.R. 2840(a), 26 N.J.R. 5021(a).

Amended by R.1998 d.16, effective January 5, 1998.

See: 29 N.J.R. 4262(a), 30 N.J.R. 72(a).

In (b)1, amended date.

Amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (a)1i, substituted a reference to beneficiaries for a reference to recipients; and in (a)2i, changed N.J.A.C. reference.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

In (b), inserted "the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)", and substituted "National Association for Home Care and Hospice" for "Foundation for Hospice and Homecare"; and deleted (b)1.

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. There is no cost filing required. No retroactive settlement shall be made.

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: 30 N.J.R. 3198(a), 30 N.J.R. 4377(a).

In (a), added "For services rendered prior to January 1, 1999," at the beginning; and added (b).

Recodified from N.J.A.C. 10:60-1.9 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (b), amended N.J.A.C. references. Former N.J.A.C. 10:60-1.4, Covered home health services, recodified to N.J.A.C. 10:60-2.1.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

In (b), deleted "(d) and (f)" following N.J.A.C. reference.

10:60-1.5 Limitations on home care services

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), DDS or DMAHS retains the right to limit or deny the provision of home care services on a prospective basis.

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Amended by R.1997 d.277, effective July 7, 1997.

See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(a).

In (f), amended internal cite and added last sentence; and in (g), substituted "obtain prior authorization ... with N.J.A.C. 10:49-6.1" for "notify the Medicaid District Office (MDO), either in writing or by telephone" and amended "failure to comply" clause to conform.

Recodified from N.J.A.C. 10:60-1.12 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

Rewrote the section. Former N.J.A.C. 10:60-1.5, Certification of need for services, recodified to N.J.A.C. 10:60-2.2.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Section was "Limitations of home care services". Deleted designation (a), and substituted "DDS or DMAHS" for "the Division".

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)).

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Recodified from 10:60-1.13 by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

Recodified from N.J.A.C. 10:60-1.14 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (a), inserted references to NJ KidCare and changed P.L. reference in the introductory paragraph; and substituted references to beneficiaries for references to recipients throughout. Former N.J.A.C. 10:60-1.6, Plan of care, recodified to N.J.A.C. 10:60-2.3.

Repeal and New Rule, R.2001 d.294, effective August 20, 2001.

See: 32 N.J.R. 2687(b), 33 N.J.R. 2808(a).

10:60-1.7 Relationship of the home care provider with the Medical Assistance Customer Center (MACC) and the DHSS Long-Term Care Field Office (LTCFO)

(a) Preadmission screening (PAS) shall be required for all Medicaid-eligible or NJ FamilyCare-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 setting and shall be attached to the beneficiary's medical record upon admission to a nursing facility or when the beneficiary receives home care services. The HSDP provides data base history that reflects current or potential health problems and required services. For individuals deemed appropriate for a Home and Community-Based Services Waiver administered by the Department of Human Services, the PAS assessment and HSDP will be forwarded to the DDD for enrollment and issuance of the approval letter.

(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.

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Recodified from 10:60-1.14 by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

Recodified from N.J.A.C. 10:60-1.15 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (a), inserted "NJ KidCare—Plan A-eligible" in the first sentence, substituted "DHSS" for "MDO" in the second sentence, and substituted "LTCFO" for "MDO" in the third sentence; in (b), substituted reference to the DHSS for references to the MDO in the first and sixth sentences, added the last sentence, and substituted references to beneficiaries for references to recipients throughout. Former N.J.A.C. 10:60-1.7, Clinical records, recodified to N.J.A.C. 10:60-2.4.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Section was "Relationship of the home care provider with the Medicaid District Office (MDO) and the DHSS Long-Term Care Field Office (LTCFO)". In (a), substituted "FamilyCare" for "KidCare"; and rewrote (b).

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 DDS or DMAHS or its designated agent, using the CMS 485 form, that services have begun for the beneficiary. Providers shall use this form even when the Medicaid or NJ FamilyCare fee-for-service beneficiary is not a Medicare beneficiary. The CMS 485 form shall be submitted to the MACC that serves the county in which the beneficiary resides and shall be postmarked within five business days of initial assessment, reassessment, or termination. MACCs shall not accept faxed CMS 485 forms. If DDS or DMAHS discovers that a home health agency did not submit the documentation within the prescribed time frame, DDS or DMAHS shall recover any payments for services rendered from the sixth business day of initial assessment until a completed CMS 485 form is received by DDS or DMAHS. In cases when the beneficiary is eligible for both Medicare and Medicaid fee-for-service or NJ FamilyCare fee-for-service programs, the CMS 485 form shall be completed and submitted to the MACC within five business days of the date on which the Medicaid/NJ FamilyCare fee-for-service program becomes the primary payer.

1. The CMS 485 shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician authorizing the services, however, shall be kept on file in the agency, with the prescription, as necessary or appropriate, based on the service. Providers shall enter the Medicaid Eligibility Identification (MEI) Number or NJ FamilyCare Identification Number in block 1 when completing the CMS 485, 486 or 487 form. For the non-Medicare certified agency, the provider shall submit to the MACC an MACC 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 CMS 485 shall be submitted to the MACC 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 CMS 485 or 486 or 487 as the circumstances warrant to the MACC. Providers shall notify the MACC, using the CMS 485, when services have been terminated.

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

4. If DDS or DMAHS 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 DDS or DMAHS determines that the services provided were not in compliance, or should be reduced, DDS or DMAHS will 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 DDS' or DMAHS' determination, a fair hearing may be requested in accordance with procedures set forth in N.J.A.C. 10:60-1.10 and 10:49-9.14 and 10.

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

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

(b) The professional staff from the MACC 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 FamilyCare 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.

(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).

Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
Added (b).

Amended by R.2006 d.238, effective July 3, 2006.
See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

In (a) li, substituted "FamilyCare" for "KidCare" two times.

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 Centers for Medicare & Medicaid (CMS) Healthcare 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 CMS 1500 Claim Form is required.

Amended by R.2006 d.238, effective July 3, 2006.
See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

In (a), Substituted "Centers for Medicare & Medicaid (CMS) Healthcare" for "Health Care Financing Administration (HCFA)"; and in (b), substituted "CMS" for "HCFA".

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 DMAHS. 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, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the National Association for Home Care and Hospice.

(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 Community Resources for People with Disabilities (CRPD), ABC, ACCAP, as well as eligible EPSDT beneficiaries.

Amended by R.2006 d.238, effective July 3, 2006.
See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

In (a), substituted "DMAHS" for "the Division" and added the last sentence; and in (b) substituted "Community Resources for People with Disabilities (CRPD)" for "Model Waiver 3".

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

(a) To be considered for EPSDT/PDN services, the beneficiary shall be under 21 years of age, enrolled in the Medicaid/NJ FamilyCare fee-for-service program and referred by a parent, primary physician, hospital discharge planner, Special Child Health Services case manager, Division of Developmental Disabilities (DDD), Division of Disability Services (DDS), Division of Youth and Family Services (DYFS), Division of Mental Health Services (DMHS) 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, incorporated herein by reference (see Appendix C). The Request shall be completed and signed by the referring physician and agreed to and signed by a parent or guardian. All sections of the Request shall be completed and a current comprehensive medical history and current treatment plan, completed by the referring physician, shall be attached. The comprehensive medical history, current treatment plan and other documents submitted with the request shall reflect the current medical status of the individual and shall document the need for ongoing (not intermittent) complex skilled nursing interventions by a licensed nurse. Incomplete requests shall be returned to the referral source for completion prior to further action by DMAHS.

(b) Upon receipt of the fully completed Request (FD-389), a DMAHS 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 DMAHS. 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 DMAHS 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 DMAHS 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.

Recodified from N.J.A.C. 10:60-5.5 and amended by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Rewrote the section. Former N.J.A.C. 10:60-5.2, Clinical records and personnel files, recodified to N.J.A.C. 10:60-5.6.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted "DMAHS" for "the Division" throughout; rewrote (a); and in (b), substituted "a DMAHS" for "the Division's" in (b).

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. "Complexity" 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 adult primary caregiver agrees to be trained or has been trained in the care of the individual and agrees to receive additional training for new procedures and treatments, if directed to do so by a State agency;

3. The primary caregiver agrees to provide a minimum of eight hours of hands-on care to the individual during every 24-hour period; and

4. The home environment can accommodate the required equipment and licensed PDN personnel.

Amended by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Rewrote the section.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Added new (c)2, recodified former (c)2 and (c)3 as present (c)3 and (c)4; in present (c)3 substituted "during every" for "in any".

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. DMAHS 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, DMAHS 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 of 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 the Division of Development Disabilities – Community Care Waiver (CCW-DDD), 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.

Amended by R.2003 d.103, effective March 3, 2003.
See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Rewrote the section.

Amended by R.2004 d.92, effective March 1, 2004.
See: 35 N.J.R. 4424(a), 36 N.J.R. 1206(b).

In (a), amended the N.J.A.C. reference in 2 and inserted “PDN” preceding “care available to the caregiver” in 3.

Amended by R.2006 d.238, effective July 3, 2006.
See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted “DMAHS” for “the Division” throughout; in (a)2, substituted a period for a semi-colon; in (a)4, substituted “16-hour” for “16 hour”; in (b)1, inserted “of”; and rewrote (f).

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 time frame for reassessment.

(f) A nursing reassessment 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.

New Rule, R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Former N.J.A.C. 10:60-5.5, Basis for reimbursement for EPSDT/PDN, recodified to N.J.A.C. 10:60-5.2.

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 DMAHS staff to the private duty nursing agency to review compliance with personnel, recordkeeping and service delivery requirements.

Recodified from N.J.A.C. 10:60-5.2 by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Former N.J.A.C. 10:60-5.6, Payment for EPSDT/PDN, recodified to N.J.A.C. 10:60-5.7.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted "DMAHS" for "Division" in (f).

10:60-5.7 Payment for EPSDT/PDN

(a) Claims for payment for PDN services shall be submitted on the CMS 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 DMAHS in accordance with N.J.A.C. 10:60-11.2(e).

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

Recodified from N.J.A.C. 10:60-5.6 by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Former N.J.A.C. 10:60-5.7, Eligibility for home and community-based services waiver/private duty nursing (PDN) services, recodified to N.J.A.C. 10:60-5.8.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted "DMAHS" for "Division" and "the Division" throughout; and in (a), substituted "CMS" for "HCFA".

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 DMAHS/DDS/DDD 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 Community Resources for People with Disabilities (CRPD).

Recodified from N.J.A.C. 10:60-5.7 by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Former N.J.A.C. 10:60-5.8, Limitation, duration and location of home and community-based services waiver/private duty nursing (waiver/PDN) services, recodified to N.J.A.C. 10:60-5.9.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted "DMAHS/DDS/DDD" for "the Division" and "Community Resources for People with Disabilities (CRPD)" for "Model Waiver 3".

10:60-5.9 Limitation, duration and location of home and 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 DMAHS/DDD/DDS 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 (CRPD), ABC, or ACCAP. Under CRPD, ABC and ACCAP, when payment for private duty nursing services is being provided or paid for by another source (that is, insurance), DDS or DMAHS shall supplement payment up to a maximum of 16 hours per day, including services provided or paid for 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, including services provided or paid for by other sources, in a 24-hour period, per person in CRPD, 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.)

Recodified from N.J.A.C. 10:60-5.8 by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Former N.J.A.C. 10:60-5.9, Basis for reimbursement for home and community-based services waiver/PDN, recodified to N.J.A.C. 10:60-5.10.

Amended by R.2004 d.92, effective March 1, 2004.

See: 35 N.J.R. 4424(a), 36 N.J.R. 1206(b).

Rewrote (a); in (b) and (c), substituted references to CRPD/PDN for references to Model Waiver 3.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

In (a)1, substituted "DMAHS/DDD/DDS" for "the Division"; and in (b), substituted "Community Resources for People with Disabilities (CRPD)," for the first occurrence of "CRPD/PDN", "CRPD," for the second occurrence of "CRPD/PDN" and "DDS or DMAHS" for "the Division" and inserted "or paid for" following "provided" two times; and in (c), inserted "including services provided or paid for by other sources" and substituted "CRPD," for "CRPD/PDN".

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 CMS 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 CMS 1500 Claim Form even though the actual payment may be different.

(c) Home health services are billed on the UB-92 CMS-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.

Recodified from N.J.A.C. 10:60-5.9 by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Former N.J.A.C. 10:60-5.10, Prior authorization of home and community-based services waiver/PDN, recodified to N.J.A.C. 10:60-5.11.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted "CMS" for "HCFA" throughout.

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 Office 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.

Recodified from N.J.A.C. 10:60-5.10 by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Substituted "Office" for "Bureau" in (a).

SUBCHAPTER 6. HOME AND COMMUNITY-BASED SERVICES WAIVERS FOR BLIND OR DISABLED CHILDREN AND ADULTS COMMUNITY RESOURCES FOR PEOPLE WITH DISABILITIES (CRPD) WAIVER PROGRAM

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 an approved, Federally renewable Model Waiver, the Community Resources for People with Disabilities (CRPD) Waiver, which 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.

Recodified from N.J.A.C. 10:60-2.7 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

Substituted references to beneficiaries for references to recipients throughout.

Amended by R.2006 d.238, effective July 3, 2006.

See: 38 N.J.R. 1136(a), 38 N.J.R. 2810(a).

Rewrote (b).

10:60-6.2 Eligibility for Community Resources for People with Disabilities (CRPD) Waiver Program

(a) Program eligibility criteria for the Community Resources for People with Disabilities (CRPD) Waiver Program is as follows:

1. Beneficiaries shall be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria. Beneficiaries eligible to receive PDN services under the former Model Waiver 3 program, who continue to be in need of private duty nursing services, shall remain eligible for those services as a CRPD waiver eligible beneficiary.

2. For the Community Resources for People with Disabilities (CRPD) Waiver Program, 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. The Community Resources for People with Disabilities (CRPD) Waiver Program, 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. The Community Resources for People with Disabilities (CRPD) Waiver Program 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 FamilyCare-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 FamilyCare-Plan A card shall be issued to the CRPD Waiver beneficiary by the county board of social services for the beneficiary applying for CRPD and also for the beneficiary applying for CRPD who is not categorically eligible for Medicaid or NJ FamilyCare-Plan A in the community. The county board of social services may issue a temporary MEI card.

1. A CRPD Waiver beneficiary who is categorically eligible for Medicaid or NJ FamilyCare-Plan A shall continue to receive a MEI Card or NJ FamilyCare-Plan A Card in the same manner as before his or her participation. The Medical Assistance Customer Center may issue a temporary MEI Card.

Amended by R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Recodified from N.J.A.C. 10:60-2.8 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).