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 recipient with prescribed exercises which the recipient and the personal care assistant have been taught by appropriate personnel;

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

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

iv. Assisting the recipient 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 recipient can use equipment safely;

v. Assisting the recipient 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.

(d) 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 recipient, hours of service needed, and shall take into consideration the recipient'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 recipient'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 recipient.

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

(e) Recordkeeping for personal care assistant services shall include the following;

1. Clinical records and reports shall be maintained for each recipient, covering the medical, nursing, social and health related care in accordance with accepted professional standards. Such information must 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 recipient-specific plan of care;

iv. Signed and dated progress notes describing the recipient'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 recipient 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 2 above.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–1.11 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. 10:60–4) 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 Health Insurance Claim Form, 1500 N.J. (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 program 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.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–1.12 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 MDO staff may opt to limit or deny the provision of home care services on a prospective basis.

(b) Private duty nursing shall be a covered service only for those recipients covered under EPSDT, Model Waiver III and the AIDS Community Care Alternatives Program (ACCAP). Under Model Waiver III and ACCAP, when payment for private duty nursing services is being provided by another source (that is, insurance), the Division will 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 Model Waiver III and ACCAP. There must 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 recipient unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60–2.9(b)2 for exceptions to 16 hour maximum in a 24 hour period.)

(d) For personal care assistant services, Medicaid reimbursement shall not be made for services provided to Medicaid recipients in the following settings:

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

(e) 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 program.

(f) 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 (f)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 recipient;
2. If the recipient lives alone or has no caregiver, and is in need of medically necessary care to ensure his/her safety and well-being;
3. If the recipient 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 recipient'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.

(g) Additional hours under (f) above shall be medically indicated, as documented by the recipient's physician, and shall not be a companion service. The agency providing these increased services must obtain prior authorization from the Medicaid District Office (MDO) serving the recipient'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 recipients will be included by the MDO in the post-payment quality assurance reviews.

(h) Homemaker services provided under CCPED/HCEP shall be provided by certified homemaker-home health aides. Homemaker services provided by a parent to a minor child or by a spouse to a spouse shall not be covered services and shall not be reimbursed by the Division.

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.

10:60–1.13 Eligibility for early and periodic screening and diagnosis and treatment/private duty nursing services

(a) EPSDT eligible individuals under 21 years of age who are enrolled in the Medicaid program 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 the EPSDT program, in accordance with N.J.A.C. 10:49–5.3(a)2.

(b) An individual must exhibit a severity of illness that requires complex intervention by licensed nursing personnel, to be considered in need of EPSDT/PDN services. EPSDT/PDN services are only appropriate for such cases when the following requirements are complied with:

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 recipient;

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.

(c) The following criteria shall apply to EPSDT/PDN services:

1. Private duty nursing shall be provided for EPSDT-eligible Medicaid recipients in the community only and not in hospital inpatient or nursing facility settings.

2. The Medicaid District Office (MDO) shall determine and approve the total PDN hours for reimbursement, in accordance with (e) below. 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 of 16 hours per 24–hour period, shall take into account alternative sources of care available to the caregiver (for example, medical day care, or private duty nursing covered by private insurance).

4. In emergency situations, for example, when the sole caregiver has been hospitalized, the MDO may authorize, for a limited time, additional hours beyond the 16 hour limit.

(d) To qualify for payment of EPSDT/PDN services, the recipient shall be referred by a parent, primary physician, hospital discharge planner, special child health services case manager or current PDN provider. Requests for services shall be submitted to the Medicaid District Office (MDO) servicing the county where the child is currently located 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 must 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 Medicaid agency.

1. For individuals enrolled in a managed care program, the Physician Case Manager (PCM) will determine the need and approve the PDN services. For children enrolled in the Garden State Health Plan, the "Garden State Health Plan Authorization Form (GSHP–7)" form must be used.

(e) Upon receipt of the fully completed Request (FD–389), the Medicaid Regional Staff Nurse (RSN) will 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 RSN's assessment will be issued by the MDO on the "Medicaid District Office Authorization/Approval/Denial Form (FD–390)." The number of hours approved, the level of services, and the length of time of the approval (up to a maximum of six months) will be noted on the form.

(f) If the prospective PDN provider has not yet been selected at the time of the assessment and approval of the need for PDN services, the PDN agency, when selected, shall submit a request to the MDO 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.

(g) If the PDN provider has already been selected, the MDO staff, working in conjunction with a hospital discharge planner, will create an active PA record for the individual. This will allow for immediate PDN service provision and billing at the time of the individual's hospital discharge.

(h) Requests for continuation, or modification of PDN services during the treatment period, shall be submitted by the PDN agency, in writing, to the MDO 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, in accordance with N.J.A.C. 10:60–1.13(c).

1. Although the requirement for prior authorization (PA) applies to EPSDT/PDN and Garden State Health Plan (GSHP) recipients, the PA process does not apply to recipients of PDN services in Model Waiver III, the AIDS Community Care Alternatives Program (ACCAP), or the ABC Program for Medically Fragile Children.

(i) Claims for payment for PDN services shall be submitted on the Health Insurance Claim Form (HCFA 1500). The PA number from the "Medicaid District Office Authorization/Approval/ Denial Form (FD–390)" 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 proce-

dure 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. 10:60–4.2(e).

2. The prior authorization (PA) and billing processes also applies to PDN providers servicing children enrolled in the Garden State Health Plan. For services provided to these individuals, the PDN provider must also include the PA number from the "Garden State Health Plan Authorization Form (GSHP–7)" on the HCFA 1500 claim form.

(j) EPSDT-PDN providers shall submit to the MDO, every two months, comprehensive clinical summaries reflecting recipients' medical status and need for ongoing services. The MDO staff will review the submitted clinical data and may conduct on-site home visits before reauthorizing PDN services. In addition, MDO staff will perform Home Care Quality Assurance Reviews of these individuals. In accordance with N.J.A.C. 10:60–1.17, the Bureau of Home and Community Services will continue on-site monitoring of private duty nursing agencies to review compliance with personnel (N.J.A.C. 10:60–1.16(b) through (g), recordkeeping (N.J.A.C. 10:60–1.16(j)) and service requirements (N.J.A.C. 10:60–1.16(h)).

New Rule, 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).

Case Notes

Severely disabled child qualified for private-duty nursing care under federal assistance program implemented to avoid expensive institutionalization. S.R. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 63.

10:60–1.14 Advance directives

(a) All home health, private duty nursing, hospice and personal care agencies participating in the New Jersey Medicaid program shall comply with the provisions of the Federal Patient Self Determination Act (P.L. 101–508) 1902(w) of the Social Security Act, 42 U.S.C. 1396a, and shall notify Medicaid recipients about their rights under P.L. 1991, c.201 to make decisions concerning their medical care and their right to formulate an advance directive.

1. Such agencies shall:

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

ii. Provide the New Jersey Department of Health (DOH) statement of New Jersey law, "Your Right to Make Health Care Decisions in New Jersey", to recipients upon initial visit for home health or personal care services, regarding their rights to make decisions concerning their medical care available from the DOH. Such rights include the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive for their health care;

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

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

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

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

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

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

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).

10:60–1.15 Relationship of the home care provider with the Medicaid District Office (MDO)

(a) Preadmission screening (PAS) shall be required for all Medicaid-eligible individuals and other individuals applying for nursing facility (NF) services and/or the Home and Community–Based Services Waiver programs. MDO professional staff shall 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 MDO 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) shall be completed by the MDO 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 recipient's medical record upon admission to a nursing facility or when the recipient receives services from home care agencies. The HSDP may be updated as required to reflect changes in the recipient'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. The MDOs shall provide HSDPs for individuals who have been assessed in a community setting during the PAS process.

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 recipient with prescribed exercises which the recipient and the personal care assistant have been taught by appropriate personnel;

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

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

iv. Assisting the recipient 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 recipient can use equipment safely;

v. Assisting the recipient 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.

(d) 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 recipient, hours of service needed, and shall take into consideration the recipient'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 recipient'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 recipient.

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

(e) Recordkeeping for personal care assistant services shall include the following;

1. Clinical records and reports shall be maintained for each recipient, covering the medical, nursing, social and health related care in accordance with accepted professional standards. Such information must 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 recipient-specific plan of care;

iv. Signed and dated progress notes describing the recipient'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 recipient 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 2 above.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–1.11 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. 10:60–4) 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 Health Insurance Claim Form, 1500 N.J. (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 program 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.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–1.12 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 MDO staff may opt to limit or deny the provision of home care services on a prospective basis.

(b) Private duty nursing shall be a covered service only for those recipients covered under EPSDT, Model Waiver III and the AIDS Community Care Alternatives Program (ACCAP). Under Model Waiver III and ACCAP, when payment for private duty nursing services is being provided by another source (that is, insurance), the Division will 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 Model Waiver III and ACCAP. There must 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 recipient unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60–2.9(b)2 for exceptions to 16 hour maximum in a 24 hour period.)

(d) For personal care assistant services, Medicaid reimbursement shall not be made for services provided to Medicaid recipients in the following settings:

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

(e) 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 program.

(f) 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 (f)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 recipient;
2. If the recipient lives alone or has no caregiver, and is in need of medically necessary care to ensure his/her safety and well-being;
3. If the recipient 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 recipient'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.

(g) Additional hours under (f) above shall be medically indicated, as documented by the recipient's physician, and shall not be a companion service. The agency providing these increased services must obtain prior authorization from the Medicaid District Office (MDO) serving the recipient'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 recipients will be included by the MDO in the post-payment quality assurance reviews.

(h) Homemaker services provided under CCPED/HCEP shall be provided by certified homemaker-home health aides. Homemaker services provided by a parent to a minor child or by a spouse to a spouse shall not be covered services and shall not be reimbursed by the Division.

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.

10:60–1.13 Eligibility for early and periodic screening and diagnosis and treatment/private duty nursing services

(a) EPSDT eligible individuals under 21 years of age who are enrolled in the Medicaid program 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 the EPSDT program, in accordance with N.J.A.C. 10:49–5.3(a)2.

(b) An individual must exhibit a severity of illness that requires complex intervention by licensed nursing personnel, to be considered in need of EPSDT/PDN services. EPSDT/PDN services are only appropriate for such cases when the following requirements are complied with:

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 recipient;

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.

(c) The following criteria shall apply to EPSDT/PDN services:

1. Private duty nursing shall be provided for EPSDT-eligible Medicaid recipients in the community only and not in hospital inpatient or nursing facility settings.

2. The Medicaid District Office (MDO) shall determine and approve the total PDN hours for reimbursement, in accordance with (e) below. 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 of 16 hours per 24–hour period, shall take into account alternative sources of care available to the caregiver (for example, medical day care, or private duty nursing covered by private insurance).

4. In emergency situations, for example, when the sole caregiver has been hospitalized, the MDO may authorize, for a limited time, additional hours beyond the 16 hour limit.

(d) To qualify for payment of EPSDT/PDN services, the recipient shall be referred by a parent, primary physician, hospital discharge planner, special child health services case manager or current PDN provider. Requests for services shall be submitted to the Medicaid District Office (MDO) servicing the county where the child is currently located 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 must 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 Medicaid agency.

1. For individuals enrolled in a managed care program, the Physician Case Manager (PCM) will determine the need and approve the PDN services. For children enrolled in the Garden State Health Plan, the "Garden State Health Plan Authorization Form (GSHP–7)" form must be used.

(e) Upon receipt of the fully completed Request (FD–389), the Medicaid Regional Staff Nurse (RSN) will 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 RSN's assessment will be issued by the MDO on the "Medicaid District Office Authorization/Approval/Denial Form (FD–390)." The number of hours approved, the level of services, and the length of time of the approval (up to a maximum of six months) will be noted on the form.

(f) If the prospective PDN provider has not yet been selected at the time of the assessment and approval of the need for PDN services, the PDN agency, when selected, shall submit a request to the MDO 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.

(g) If the PDN provider has already been selected, the MDO staff, working in conjunction with a hospital discharge planner, will create an active PA record for the individual. This will allow for immediate PDN service provision and billing at the time of the individual's hospital discharge.

(h) Requests for continuation, or modification of PDN services during the treatment period, shall be submitted by the PDN agency, in writing, to the MDO 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, in accordance with N.J.A.C. 10:60–1.13(c).

1. Although the requirement for prior authorization (PA) applies to EPSDT/PDN and Garden State Health Plan (GSHP) recipients, the PA process does not apply to recipients of PDN services in Model Waiver III, the AIDS Community Care Alternatives Program (ACCAP), or the ABC Program for Medically Fragile Children.

(i) Claims for payment for PDN services shall be submitted on the Health Insurance Claim Form (HCFA 1500). The PA number from the "Medicaid District Office Authorization/Approval/ Denial Form (FD–390)" 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 proce-

dure 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. 10:60–4.2(e).

2. The prior authorization (PA) and billing processes also applies to PDN providers servicing children enrolled in the Garden State Health Plan. For services provided to these individuals, the PDN provider must also include the PA number from the "Garden State Health Plan Authorization Form (GSHP–7)" on the HCFA 1500 claim form.

(j) EPSDT-PDN providers shall submit to the MDO, every two months, comprehensive clinical summaries reflecting recipients' medical status and need for ongoing services. The MDO staff will review the submitted clinical data and may conduct on-site home visits before reauthorizing PDN services. In addition, MDO staff will perform Home Care Quality Assurance Reviews of these individuals. In accordance with N.J.A.C. 10:60–1.17, the Bureau of Home and Community Services will continue on-site monitoring of private duty nursing agencies to review compliance with personnel (N.J.A.C. 10:60–1.16(b) through (g), recordkeeping (N.J.A.C. 10:60–1.16(j)) and service requirements (N.J.A.C. 10:60–1.16(h)).

New Rule, 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).

Case Notes

Family must provide on-site nursing services to offset Medicaid's private duty nursing program. J.D. v. Division of Medical Assistance & Health Services, 97 N.J.A.R.2d (DMA) 19.

Severely disabled child qualified for private-duty nursing care under federal assistance program implemented to avoid expensive institutionalization. S.R. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 63.

10:60–1.14 Advance directives

(a) All home health, private duty nursing, hospice and personal care agencies participating in the New Jersey Medicaid program shall comply with the provisions of the Federal Patient Self Determination Act (P.L. 101–508) 1902(w) of the Social Security Act, 42 U.S.C. 1396a, and shall notify Medicaid recipients about their rights under P.L. 1991, c.201 to make decisions concerning their medical care and their right to formulate an advance directive.

1. Such agencies shall:

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

ii. Provide the New Jersey Department of Health (DOH) statement of New Jersey law, "Your Right to Make Health Care Decisions in New Jersey", to recipients upon initial visit for home health or personal care services, regarding their rights to make decisions concerning their medical care available from the DOH. Such rights include the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive for their health care;

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

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

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

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

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

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

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).

10:60–1.15 Relationship of the home care provider with the Medicaid District Office (MDO)

(a) Preadmission screening (PAS) shall be required for all Medicaid-eligible individuals and other individuals applying for nursing facility (NF) services and/or the Home and Community–Based Services Waiver programs. MDO professional staff shall 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 MDO 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) shall be completed by the MDO 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 recipient's medical record upon admission to a nursing facility or when the recipient receives services from home care agencies. The HSDP may be updated as required to reflect changes in the recipient'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. The MDOs shall provide HSDPs for individuals who have been assessed in a community setting during the PAS process.