

CHAPTER 60

HOME CARE SERVICES

Authority

N.J.S.A. 30:4D-6b(2), 7, 7a, 7b and 7c; 30:4D-12, 30:34E; Federal Regulations 42 CFR 440.70, 170, 180, and 181, and Section §§ 1905(a) of the Social Security Act (42 U.S.C. §§ 1396(a)(7)).

Source and Effective Date

R.2001 d.14, effective December 7, 2000.
See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

Executive Order No. 66(1978) Expiration Date

Chapter 60, Home Care Services, expires on December 7, 2005.

Chapter Historical Note

Chapter 60, Home Health Services Manual, was adopted as R.1971 d.56, effective April 21, 1971. See: 3 N.J.R. 42(a), 3 N.J.R. 83(a).

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services Manual, was readopted as R.1985 d.488, effective August 27, 1985. See: 17 N.J.R. 28(a), 17 N.J.R. 2433(a).

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services Manual, was readopted as R.1990 d.458, effective August 15, 1990. See: 22 N.J.R. 1663(a), 22 N.J.R. 2966(c).

Subchapter 4, Home Care Expansion Program, was adopted as R.1990 d.466, effective September 17, 1990. See: 22 N.J.R. 597(a), 22 N.J.R. 2967(a).

Chapter 60, Home Care Services Manual, was repealed and Chapter 60, Home Care Services, was adopted as new rules by R.1991 d.65, effective February 19, 1991, operative March 1, 1991. See: 22 N.J.R. 3116(a), 23 N.J.R. 420(b).

Subchapter 2, Covered Home Care Services (Home Health Care Services and Personal Care Assistant Services), was repealed, Subchapter 3, Home and Community-Based Services Waiver Programs, was recodified as Subchapter 2, Home and Community-Based Services Waiver Programs, Subchapter 4, Home Care Extension Program, was recodified as Subchapter 3, Home Care Extension Program, Subchapter 5, HCFA Common Procedure Coding System (HCPCS), was recodified as Subchapter 4, HCFA Common Procedure Coding System (HCPCS), and Subchapter 6, Billing Procedures for Home Care Services, was repealed by R.1994 d.41, effective January 18, 1994. See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Subchapter 5, Traumatic Brain Injury Program, was adopted as new rules by R.1994 d.426, effective August 15, 1994. See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services, was readopted as R.1996 d.18, effective December 7, 1995. See: 27 N.J.R. 3667(a), 28 N.J.R. 184(a).

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services, was readopted as R.2001 d.14, effective December 7, 2000, and Subchapter 3, Home Care Expansion Program, was repealed and Subchapter 3, Personal Care Assistant (PCA) Services, was adopted as new rules, Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was recodified as Subchapter 11, HCFA Common Procedure Coding System (HCPCS), and Subchapter 4, Personal Care Assistant Services for the Mentally Ill, was adopted as new rules, Subchapter 5, Traumatic Brain Injury Program, was recodified as Subchapter 9, Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI Waiver), Subchapter 5, Private Duty Nursing (PDN) Services, was adopted as new rules, and Subchapter 8, Home and Community-Based Services Waiver for Medically Fragile Children

Under Division of Youth and Family Services Supervision (ABC Waiver), was adopted as new rules by R.2001 d.14, effective January 2, 2001. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 Purpose and scope

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

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

1. Home health services;
2. Personal care assistant services;
3. Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing (EPSDT/PDN) Services;
4. Home and Community-Based Services Waiver programs, which are administered by the Department of Human Services through 42 U.S.C. § 1915(c) waivers, as follows:

i. Home and Community-Based Services Waiver for Blind or Disabled Children and Adults (Model Waivers 1, 2, and 3);

ii. Home and Community-Based Services Waiver for Persons with AIDS and Children up to the age of 13 who are HIV Positive, known as AIDS Community Care Alternatives Program (ACCAP);

iii. Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI);

iv. Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (DDD-CCW) Individuals; and

v. Home and Community-Based Services Waiver Program for Medically Fragile Children under the Division of Youth and Family Services (DYFS) Supervision (ABC); and

5. Home and Community-Based Services Waiver programs (1915(c) waivers) administered by the Department of Health and Senior Services (DHSS):

i. Community Care Program for the Elderly and Disabled (CCPED); and

ii. Enhanced Community Options Waiver (ECO), which provides home and community-based services to aged or disabled adults.

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

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

(e) Requirements of the Home and Community-Based Services Waiver Programs are provided in N.J.A.C. 10:60-6, 7, 8 and 9.

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

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

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

SUBCHAPTER 4. PERSONAL CARE ASSISTANT SERVICES FOR THE MENTALLY ILL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 home-maker agency, private employment agency and temporary-help service agency approved by the Division.

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

10:60-5.2 Clinical records and personnel files

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

(b) Clinical records maintained at the agency shall contain at a minimum the following:

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

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

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

1. Diagnoses;
2. A physician treatment plan and interim orders;
3. A copy of the initial nursing assessment and six month reassessment;
4. A nursing care plan;
5. Signed and dated current nurse's notes describing the beneficiary's condition and documentation of all care rendered; and
6. A record of medication administered.

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

1. A completed application for employment;
2. Evidence of a personal interview;
3. Evidence of a current license to practice nursing;

4. Satisfactory employment references;
5. Evidence of a physical examination; and
6. Ongoing performance evaluation.

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

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

(a) EPSDT eligible individuals under 21 years of age who are enrolled in the Medicaid program, fee-for-service for all services, or who are enrolled in NJ KidCare-Plan A as a fee for service, 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.

2. For individuals who are getting EPSDT through HMO's, private duty nursing services are provided through the HMO and are not provided under this section.

(b) An individual must exhibit a severity of illness that requires complex continuous 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 satisfied:

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

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

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

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

2. The Division shall determine and approve the total PDN hours for reimbursement, in accordance with N.J.A.C. 10:60-5.5(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 of 16 hours per 24-hour period, shall take into account alternative sources of care available to the caregiver such as medical day care.

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

(b) Private duty nursing shall be a covered service only for those beneficiaries covered under EPSDT, Model Waiver 3, ABC and ACCAP. Under Model Waiver 3, ABC and ACCAP, when payment for private duty nursing services is being provided by another source (that is, insurance), the Division shall supplement payment up to a maximum of 16 hours per day, including services provided by the other sources, if medically necessary, and if cost of service provided by the Division is less than institutional care.

10:60-5.5 Basis for reimbursement for EPSDT/PDN

(a) To qualify for payment of EPSDT/PDN services, the beneficiary 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 Division using a "Request for EPSDT Private Duty Nursing Services (FD-389)" form. The Request shall be completed and signed by a physician and agreed to and signed by a parent or guardian. All sections of the Request shall be completed and a physician's case summary and current treatment plan shall be attached. Incomplete requests shall be returned to the referral source for completion prior to further action by the Division.

1. For individuals enrolled in a managed care program, the primary care physician (PCP) shall determine the need and approve the PDN services.

(b) Upon receipt of the fully completed Request (FD-389), the Division shall conduct an assessment of the need for PDN services, as well as the level (LPN or RN) and amount of service required. A letter notifying the family and the person who referred the individual of the decision following the assessment shall be issued by the Division. 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 on the form.

(c) 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 Division for the PDN services on the "Prior Authorization Request Form (FD-365)" which contains a pre-printed prior authorization (PA) num-

ber. Telephone requests for prior authorization (PA) can be accommodated in an emergency but shall be followed immediately by a written request.

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

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

1. This PA process does not apply to beneficiaries of PDN services in Model Waiver 3, ACCAP, or ABC.

10:60-5.6 Payment for EPSDT/PDN

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

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

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

10:60-5.7 Eligibility for home and community-based services waiver/private duty nursing (PDN) services

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

10:60-5.8 Limitation, duration and location of home and community-based services waiver/private duty nursing (waiver/PDN)

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

1. Use of a waiver/private duty nursing service outside the home for non-medical events shall not be approved by the Division. With Division approval, a private duty nurse may accompany a waiver beneficiary outside the home to obtain a Medicaid-reimbursable service.

2. Social situations and other non-medical events remain the responsibility of the primary caregiver. In addition, 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 Model Waiver 3, ABC, or ACCAP. Under Model Waiver 3, ABC and ACCAP, when payment for private duty nursing services is being provided by another source (that is, insurance), the Division shall supplement payment up to a maximum of 16 hours per day, including services provided by the other sources, if medically necessary, and if cost of service provided by the Division is less than institutional care.

(c) Private duty nursing services shall be limited to a maximum of 16 hours in a 24 hour period, per person in Model Waiver 3, ABC and ACCAP. There shall be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24 hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16 hour maximum in a 24 hour period.)

10:60-5.9 Basis for reimbursement for home and community-based services waiver/PDN

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

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

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

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

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

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

10:60-5.10 Prior authorization of home and community-based services waiver/PDN

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

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

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

SUBCHAPTER 6. HOME AND COMMUNITY-BASED SERVICES WAIVERS FOR BLIND OR DISABLED CHILDREN AND ADULTS (MODEL WAIVERS 1, 2, AND 3)

10:60-6.1 Purpose and scope

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

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