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MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: JUNE 15, 1992
See the Register Index for Subsequent Rulemaking Activity.

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Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **September 16, 1992.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

On occasion, a proposing agency may extend the 30-day comment period to accommodate public hearings or to elicit greater public response to a proposed new rule or amendment. An extended comment deadline will be noted in the heading of a proposal or appear in a subsequent notice in the Register.

At the close of the period for comments, the proposing agency may thereafter adopt a proposal, without change, or with changes not in violation of the rulemaking procedures at N.J.A.C. 1:30-4.3. The adoption becomes effective upon publication in the Register of a notice of adoption, unless otherwise indicated in the adoption notice. Promulgation in the New Jersey Register establishes a new or amended rule as an official part of the New Jersey Administrative Code.

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NEW JERSEY REGISTER

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RULE PROPOSALS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW

Conduct of Administrative Law Judges

Proposed New Rules: N.J.A.C. 1:1-1.5 and 1:1 Appendix A

Proposed Amendment: N.J.A.C. 1:31-3.1

Authorized By: Jaynee LaVecchia, Director, Office of Administrative Law.

Authority: N.J.S.A. 52:14F-5(e), (f) and (g).

Proposal Number: PRN 1992-356.

Submit comments by September 16, 1992 to:

Jeff S. Masin, Deputy Director
Office of Administrative Law
Quakerbridge Plaza, Bldg. 9, CN 049
Quakerbridge Road
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed new rule, N.J.A.C. 1:1-1.5, provides that the conduct of Administrative Law Judges is governed by the Code of Judicial Conduct for Administrative Law Judges. That code is set forth as an appendix to N.J.A.C. 1:1. The proposed amendment to N.J.A.C. 1:31-3.1 specifies that conduct which constitutes a violation of the Code subjects an Administrative Law Judge to possible disciplinary action.

The Code of Judicial Conduct for Administrative Law Judges is based upon the Model Code of Judicial Conduct as adopted by the American Bar Association on August 7, 1990 and the New Jersey Code of Judicial Conduct. Administrative Law Judges (ALJs) have been advised since the establishment of this Office to look to the New Jersey Code of Judicial Conduct, as appropriate, for guidance on ethical conduct. The Code of Judicial Conduct for Administrative Law Judges is intended to provide specific guidance to Administrative Law Judges in establishing and maintaining high standards of judicial and personal conduct.

The proposed new rule and appendix make clear to both the Administrative Law Judges and to the public the standards by which the judges should be governed. The OAL has chosen to publish and codify these standards so that litigants, persons appearing at administrative hearings and the general public will have access to and be aware of the ethical regulations which should guide the conduct of ALJs.

The Code of Judicial Conduct for Administrative Law Judges consists of a set of canons which are authoritative, accompanied by commentary which by explanation and example provides guidance as to the purpose and meaning of the canons. The commentary is not intended as a statement of additional rules. There are five canons.

Canon I requires Administrative Law Judges to uphold the integrity and independence of the administrative judiciary. Canon II requires Administrative Law Judges to avoid impropriety and the appearance of impropriety. Family, social or other relationships shall not influence the judge's conduct nor shall the prestige of the office be used to advance private interests. Administrative Law Judges shall not hold membership in organizations that practice invidious discrimination.

Canon III requires an Administrative Law Judge to perform the duties of office impartially and diligently. ALJs shall be faithful to the law, maintain order and decorum in proceedings, be courteous to all individuals he or she deals with in an official capacity, perform without bias or prejudice and refrain from *ex parte* communications as to substantive matters concerning a pending proceeding. All judicial matters shall be handled promptly, efficiently and fairly and the judge shall abstain from public comment. ALJs are also required to diligently discharge assigned administrative responsibilities. Disqualification from any proceeding where the judge's impartiality might reasonably be questioned is required.

Canon IV provides that an Administrative Law Judge shall regulate extrajudicial activities to minimize the risk of conflict with judicial duties. A judge is permitted to speak, write, lecture, teach or participate in other activities concerning the law and may appear at public hearings or accept appointments to committees on that subject. Otherwise, participation at public hearings or on governmental committees is prohibited. The judge may participate in civic and charitable activities that do not reflect adversely on impartiality or interfere with the performance of judicial duties.

Finally, pursuant to Canon V, Administrative Law Judges shall refrain from political activity.

Social Impact

By providing appropriate ethical conduct standards for Administrative Law Judges, the rules assist judges in establishing and maintaining high standards of judicial and personal conduct. Advising the public of the standards furthers public confidence in the independence and impartiality of the administrative judiciary.

Economic Impact

No economic impact is anticipated from the proposed new rules and amendment. The financial restrictions imposed on Administrative Law Judges by the Code of Judicial Conduct promulgated by the New Jersey Supreme Court, applicable to ALJs pursuant to N.J.A.C. 1:31-3.1(a)4, are continued under the Code of Judicial Conduct for Administrative Law Judges.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed rule does not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules establish basic ethical conduct standards for administrative law judges.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

1:1-1.5 Conduct of Administrative Law Judges

The Code of Judicial Conduct for Administrative Law Judges, as incorporated herein by reference as Appendix A, shall govern the conduct of administrative law judges.

APPENDIX A
CODE OF JUDICIAL CONDUCT
FOR ADMINISTRATIVE LAW JUDGES

PREAMBLE

The Code of Judicial Conduct for Administrative Law Judges is intended to establish basic ethical conduct standards for administrative law judges. The Code is intended to govern the conduct of these administrative law judges and to provide guidance to assist judges in establishing and maintaining high standards of judicial and personal conduct. This Code is based upon the Model Code of Judicial Conduct as adopted by the ABA on August 7, 1990 and the New Jersey Code of Judicial Conduct.

The text of the Canons is authoritative. The Commentary, by explanation and example, provides guidance with respect to the purpose and meaning of the Canons. The Commentary is not intended as a statement of additional rules. When the test uses "shall" or "shall not," it is intended to impose binding obligations the violation of which can result in disciplinary action. When "should" or "should not" is used, the text is a statement of what is or is not appropriate conduct, but not as a binding rule under which a judge may be disciplined. When "may" is used, it denotes permissible discretion or, depending on the context, it refers to action that is not covered by specific proscriptions.

The Canons are rules of reason. They should be applied consistent with constitutional requirements, statutes, administrative rules, and decisional law and in the context of all relevant circumstances. The Code is to be construed so as not to impinge on the essential independence of judges in making judicial decisions. The Code is designed to provide guidance to administrative law judges and to provide a structure for regulating conduct.

CANON 1

AN ADMINISTRATIVE LAW JUDGE SHALL UPHOLD THE INTEGRITY AND INDEPENDENCE OF THE ADMINISTRATIVE JUDICIARY

An independent and honorable administrative judiciary is indispensable to justice in our society. An administrative law judge should participate in establishing, maintaining, and enforcing, high standards of conduct, and shall personally observe those standards so that the integrity and independence of the administrative judiciary will be preserved. The provisions of this Code are to be construed and applied to further that objective.

Commentary: Deference to the judgments and rulings of administrative proceedings depends upon public confidence in the integrity and independence of administrative law judges. The integrity and independence of administrative law judges depends in turn upon their acting without fear or favor. Although judges should be independent, they must comply with the law, including the provisions of this Code. Public confidence in the impartiality of the administrative judiciary is maintained by the adherence of each administrative law judge to this responsibility. Conversely, violation of this Code diminishes public confidence in the administrative judiciary and thereby does injury to the system of government under law.

CANON 2

AN ADMINISTRATIVE LAW JUDGE SHALL AVOID IMPROPRIETY AND THE APPEARANCE OF IMPROPRIETY IN ALL ACTIVITIES

A. An administrative law judge shall respect and comply with the law and at all times shall act in a manner that promotes public confidence in the integrity and impartiality of the administrative judiciary.

Commentary: Public confidence in the administrative judiciary is eroded by irresponsible or improper conduct by judges. An administrative law judge must avoid all impropriety and appearance of impropriety. An administrative law judge must expect to be the subject of constant public scrutiny. An administrative law judge must therefore expect, and accept restrictions on the administrative law judge's conduct that might be viewed as burdensome by the ordinary citizen, and should do so freely and willingly.

The prohibition against behaving with impropriety or the appearance of impropriety applies to both the professional and personal conduct of a judge. Because it is not practicable to list all prohibited acts, the proscription is necessarily cast in general terms that extend to conduct by administrative law judges that is harmful although not specifically mentioned in the Code. Actual improprieties under this standard include violations of law, court rules, or other specific provisions of this Code. The test for appearance of impropriety is whether the conduct would create in reasonable minds a perception that the administrative law judge's ability to carry out judicial responsibilities with integrity, impartiality, and competence is impaired.

See also Commentary under Canon 2C.

B. An administrative law judge shall not allow family, social, political, or other relationships to influence the judge's judicial conduct or judgment. An administrative law judge shall not lend the prestige of the office to advance the private interests of the administrative law judge or others; nor shall an administrative law judge convey or permit others to convey the impression that they are in a special position to influence the judge. An administrative law judge shall not testify voluntarily as a character witness.

Commentary: Maintaining the prestige of the administrative judiciary is essential to a system of government in which the administrative judiciary must to the maximum extent possible, function independently of the executive and legislative branches. Respect for the office facilitates the orderly conduct of legitimate administrative judicial functions. Administrative law judges should distinguish between proper and improper use of the prestige of office in all of their activities. For example, it would be improper for an administrative law judge to allude to his or her judgeship to gain a personal advantage such as deferential treatment when stopped by a police officer for a traffic offense. Similarly, official letterhead must not be used for conducting an administrative law judge's personal business.

An administrative law judge must avoid lending the prestige of the office for the advancement of the private interests of others. For example, a judge must not use the judge's judicial position to gain advantage in a civil suit involving a member of the judge's family.

Although an administrative law judge should be sensitive to possible abuse of the prestige of the office, an administrative law judge may, based on the judge's personal knowledge, serve as a reference or provide a letter of recommendation.

An administrative law judge must not testify voluntarily as a character witness because to do so may lend the prestige of the office in support of the party for whom the administrative law judge testifies. Moreover, when an administrative law judge testifies as a witness, a lawyer who regularly appears before the judge may be placed in the awkward position of cross-examining the judge. An administrative law judge may, however, testify when properly summoned. Except in unusual circumstances where the demands of justice require, an administrative law judge should discourage a party from requiring the judge to testify as a character witness.

C. An administrative law judge shall not hold membership in any organization that practices invidious discrimination as defined by Federal law and the New Jersey Law Against Discrimination.

Commentary: It is inappropriate for a judge to hold membership in any organization that practices invidious discrimination. Membership of an administrative law judge in an organization that practices invidious discrimination may give rise to perceptions that the judge's impartiality is impaired. Canon 2C refers to the current practices of the organization. Whether an organization practices invidious discrimination is often a complex question to which judges should be sensitive. The answer cannot be determined from a mere examination of an organization's current membership rolls, but rather depends on how the organization selects members and other relevant factors, such as, that the organization is dedicated to the preservation of religious, ethnic, or cultural values of legitimate common interest to its members, or that it is in fact and effect an intimate, purely private organization whose membership limitations could not be constitutionally prohibited. Absent such factors, an organization is generally said to discriminate invidiously if it arbitrarily excludes from membership on the basis of categories prohibited by Federal law or the New Jersey Law Against Discrimination persons who would otherwise be admitted to membership. See New York State Club Ass'n Inc. v. City of New York, 487 U.S. 1, 108 S.Ct. 2225, 101 L.Ed. 2d 1 (1988); Board of Directors of Rotary International v. Rotary Club of Duarte, 481 U.S. 537, 107 S.Ct. 1940, 95 L.Ed. 2d 474 (1987); Roberts v. United States Jaycees, 468 U.S. 609, 104 S.Ct. 3244, 82 L.Ed. 2d 462 (1984).

Although Canon 2C relates only to membership in organizations that invidiously discriminate, in addition, it would be a violation of Canon 2 and Canon 2A for an administrative law judge to arrange a meeting at a club that the judge knows practices invidious discrimination, or for the judge to regularly use such a club. Moreover, public manifestation by an administrative law judge of the judge's knowing approval of invidious discrimination on any basis gives the appearance of impropriety under Canon 2 and diminishes public confidence in the integrity and impartiality of the administrative judiciary, in violation of Canon 2A.

When a person who is an administrative law judge at the time this Code becomes effective learns that an organization to which the judge belongs engages in invidious discrimination that would preclude membership under Canon 2C or under Canon 2 and Canon 2A, the administrative law judge is permitted, in lieu of resigning, to make immediate efforts to have the organization discontinue its invidiously discriminatory practices, but the judge is required to suspend participation in any activities of the organization. If the organization fails to discontinue its invidiously discriminatory practices as promptly as possible, the administrative law judge is required to resign immediately from the organization.

CANON 3

AN ADMINISTRATIVE LAW JUDGE SHALL PERFORM THE DUTIES OF THE OFFICE IMPARTIALLY AND DILIGENTLY

The judicial duties of an administrative law judge take precedence over all other activities. Judicial duties include all the duties of the office prescribed by law. In the performance of these duties, the following standards apply.

A. Adjudicative responsibilities:

(1) An administrative law judge shall hear and decide matters assigned to the judge except those in which disqualification is required.

(2) An administrative law judge shall be faithful to the law and maintain professional competence in it. A judge shall be unswayed by partisan interests, public clamor, or fear of criticism.

(3) An administrative law judge shall maintain order and decorum in proceedings before the judge.

(4) An administrative law judge shall be patient, dignified, and courteous to litigants, witnesses, attorneys, representatives, and others with whom the judge deals in an official capacity, and shall require similar conduct of attorneys, representatives, staff members, and others subject to the judge's direction and control.

Commentary: The duty to hear all proceedings fairly and with patience is not inconsistent with the duty to dispose promptly of the business of the

judge. Judges can be efficient and businesslike while being patient and deliberate.

(5) An administrative law judge shall perform judicial duties without bias or prejudice. A judge shall not, in the performance of judicial duties, by words or conduct manifest bias or prejudice, including but not limited to bias or prejudice based upon race, sex, religion, national origin, disability, age, sexual orientation, or socioeconomic status, and shall not permit staff and others subject to the judge's direction and control to do so.

Commentary: A judge must refrain from speech, gestures, or other conduct that could reasonably be perceived as sexual harassment and must require the same standard of conduct of others subject to the judge's direction and control. Facial expression and body language, in addition to oral communication, can give to parties or lawyers in the proceeding, the media, and others an appearance of bias. A judge must be alert to avoid behavior that may be perceived as prejudice.

(6) An administrative law judge shall accord to all persons who are legally interested in a proceeding, or their representative, full right to be heard according to law, and except as authorized by law, neither initiate nor consider *ex parte* or other communications as to substantive matters concerning a pending or impending proceeding. On notice, a judge may obtain the advice of a disinterested expert on the law applicable to a proceeding before the judge, by *amicus curiae* or as otherwise authorized by law, if the judge affords the parties reasonable opportunity to respond. A judge may with the consent of the parties, confer separately with the parties and their lawyers in an effort to mediate or settle matters pending before the judge. A judge may initiate or consider any *ex parte* communications when expressly authorized by law to do so.

Commentary: The proscription against communications concerning a proceeding includes communications from lawyers, law teachers, and other persons who are not participants in the proceeding except as authorized by law, but does not preclude a judge from consulting with other judges or subordinate personnel whose function is to aid the judges in carrying out adjudicative responsibilities. To the extent reasonably possible, all parties or their lawyers shall be included in communications with a judge.

(7) An administrative law judge shall dispose of all judicial matters promptly, efficiently, and fairly.

Commentary: In disposing of matters promptly, efficiently, and fairly, a judge must demonstrate due regard for the rights of the parties to be heard and to have issues resolved without unnecessary cost or delay. Prompt disposition of the judge's business requires a judge to devote adequate time to his or her duties, to be punctual in attending hearings and expeditious in determining matters under submission, and to insist that other subordinate officials, litigants, and their representatives cooperate with the judge to that end.

(8) An administrative law judge shall abstain from public comment about a pending or impending proceeding in any court or tribunal and shall require similar abstention on the part of personnel subject to the judge's direction and control. This subsection does not prohibit judges from making public statements in the course of their official duties or from explaining for public information the hearing procedures of agencies.

Commentary: "Agency personnel" does not include the lawyers in a proceeding before a judge. The conduct of lawyers is governed by rules of professional conduct. This subsection is not intended to preclude participation in an association of judges merely because such association makes public comments about a pending or impending proceeding in the administrative process. The subsection is directed primarily at public comments by a judge concerning a proceeding before another judge.

(9) An administrative law judge shall not disclose or use, for any purpose unrelated to judicial duties, nonpublic information acquired in a judicial capacity.

B. Administrative responsibilities:

(1) An administrative law judge shall diligently discharge assigned administrative responsibilities, maintain professional competence in judicial administration, and facilitate the performance of the administrative responsibilities of other administrative law judges.

(2) An administrative law judge shall require staff and other persons subject to the judge's direction and control to observe the standards of fidelity and diligence that apply to the judge.

(3) An administrative law judge shall initiate appropriate disciplinary measures against a judge or a lawyer for unprofessional conduct of which the judge may become aware.

Commentary: Disciplinary measures may include reporting a lawyer's misconduct to an appropriate disciplinary body. Internal agency procedure which routes the complaint should be utilized; however, the judge remains responsible for initiation of the action.

C. Disqualification.

(1) An administrative law judge shall disqualify himself or herself in any proceeding in which the judge's impartiality might reasonably be questioned, including but not limited to instances where:

Commentary: By decisional law, the rule of necessity may supersede the rule of disqualification. For example, a judge might be the only judge available in a matter requiring immediate judicial action. The judge must disclose on the record the basis for possible disqualification and use reasonable efforts to transfer the matter to another judge as soon as practicable.

(a) the judge has a personal bias or prejudice concerning a party, or personal knowlege of disputed evidentiary facts concerning the proceeding;

(b) in private practice the judge served as a lawyer in the matter in controversy, or a lawyer with whom the judge previously practiced law served during such association as a lawyer concerning the matter, or the judge or such lawyer has been a witness concerning it;

Commentary: A lawyer in a governmental agency does not necessarily have an association with other lawyers employed by that agency within the meaning of this subsection; a judge formerly employed by a governmental agency, however, should disqualify himself or herself in a proceeding if the judge's impartiality might reasonably be questioned because of such association.

(c) the judge has served in governmental employment and in such capacity participated as counsel, advisor, or material witness concerning the proceeding or expressed an opinion concerning the merits of the particular case in controversy;

(d) the judge knows that he or she, individually or as a fiduciary, or his or her spouse or child residing in the judge's household, or any other member of the judge's family or a person treated by the judge as a member of the judge's family residing in the judge's household, has a more than *de minimis* financial interest in the subject matter in controversy or in a party to the proceeding, or any other more than *de minimis* interest that could be substantially affected by the outcome of the proceeding; generally, receiving service from a particular public utility is a *de minimis* interest;

(e) the judge or the judge's spouse, or a person within the third degree of relationship to either of them, or the spouse of such a person:

(i) is a party to the proceeding, or an officer, director, or trustee of a party;

(ii) is acting as, or is in the employ of or associated in the practice of law with, a lawyer or other representative in the proceeding;

Commentary: The fact that a lawyer in a proceeding is affiliated with a law firm with which a lawyer-relative of the judge is affiliated of itself disqualifies the judge.

(iii) is known by the judge to have a more than *de minimis* interest that could be affected by the outcome of the proceeding;

(iv) is to the judge's knowledge likely to be a witness in the proceeding.

(2) A judge shall inform himself or herself about the judge's personal and fiduciary financial interests, and make a reasonable effort to inform himself or herself about the personal financial interests of his or her spouse and minor children residing in the judge's household.

(3) For the purposes of this Code the following words or phrases shall have the meaning indicated:

(a) The degree of relationship is calculated according to the common law;

Commentary: According to the common law, the third degree of relationship test would, for example, disqualify the judge if the judge's or his or her spouse's parent, grandparent, uncle or aunt, brother or sister, cousin, niece or her husband, or nephew or his wife were a party or lawyer in the proceeding.

(b) "fiduciary" includes such relationships as executor, administrator, trustee, and guardian;

(c) "financial interest" means ownership of a more than *de minimis* legal or equitable interest, or a relationship as director, advisor, or other active participant in the affairs of a party, except that:

(i) ownership in a mutual or common investment fund that holds securities is not a "financial interest" in such securities unless the judge participates in the management of the fund;

(ii) an office in an educational, religious, charitable, fraternal, or civic organization is not a "financial interest" in securities held by the organization;

(iii) the proprietary interest of a policy holder in a mutual insurance company, or a depositor in a mutual savings association, or a similar

proprietary interest, is a "financial interest" in the organization only if the outcome of the proceeding could substantially affect the value of the interest;

(iv) ownership of government securities is a "financial interest" in the issuer only if the outcome of the proceeding could substantially affect the value of the securities;

(v) ownership of one share of stock is more than a *de minimis* interest.

(d) "proceeding" includes prehearing or other stages of litigation.

CANON 4

AN ADMINISTRATIVE LAW JUDGE SHALL REGULATE EXTRA-JUDICIAL ACTIVITIES TO MINIMIZE THE RISK OF CONFLICT WITH JUDICIAL DUTIES

A. Extra-judicial activities in general:

An administrative law judge shall conduct all of the judge's extra-judicial activities so that they do not:

(1) cast reasonable doubt on the judge's capacity to act impartially as a judge;

(2) demean the judicial office; or

(3) interfere with the proper performance of judicial duties.

Commentary: Complete separation of a judge from extra-judicial activities is neither possible nor wise; a judge should not become isolated from the community in which the judge lives.

Expressions of bias or prejudice by a judge, even outside the judge's judicial activities, cast reasonable doubt on the judge's capacity to act impartially as a judge. Expressions which may do so include jokes or other remarks demeaning individuals on the basis of their race, sex, religion, national origin, disability, age, sexual orientation, or socioeconomic status.

B. Avocational activities:

An administrative law judge may speak, write, lecture, teach, and participate in other extra-judicial activities concerning the law, the legal system, the administration of justice, and non-legal subjects, subject to the requirements of this Code.

Commentary: As a judicial officer and person specially learned in the law, a judge is in a unique position to contribute to the improvement of the law, the legal system, and the administration of justice, including the revision of substantive and procedural law. To the extent that time permits, a judge is encouraged to do so, either independently or through a bar association, judicial conference, or other organization dedicated to the improvement of the law.

C. Governmental, civic, and charitable activities:

(1) An administrative law judge shall not appear at a public hearing before, or otherwise consult with, an executive or legislative body or official except on matters concerning the law, the legal system, or the administration of justice or except when acting *pro se* in a matter involving the judge or the judge's interest.

Commentary: The judge has a professional obligation to avoid improper influence.

(2) An administrative law judge shall not accept appointment to a governmental committee or commission or other governmental position that is concerned with issues of fact or policy on matters other than the improvement of the law, the legal system, or the administration of justice. A judge may, however, represent a country, state, or locality on ceremonial occasions or in connection with historical, educational, or cultural activities.

Commentary: Canon 4C(2) prohibits a judge from accepting any governmental position except one relating to the law, legal system, or administration of justice. The appropriateness of accepting extra-judicial assignments must be assessed in light of the demands on judicial resources created by crowded dockets and the need to protect the judge from involvement in extra-judicial matters that may prove to be controversial. Judges should not accept governmental appointments that are likely to interfere with the effectiveness and independence of the administrative judiciary.

(3) An administrative law judge may participate in civic and charitable activities that do not reflect adversely upon impartiality or interfere with the performance of judicial duties. A judge may serve as an officer, director, trustee, or non-legal advisor of an educational, religious, charitable, fraternal, or civic organization not conducted for the economic or political advantage of its members, subject to the following limitations:

(a) A judge shall not serve as an officer, director, trustee, or non-legal advisor if it is likely that the organization will be engaged in proceedings that would ordinarily come before the judge or will be regularly engaged in adversary proceedings in any court or tribunal.

Commentary: The changing nature of some organizations and of their relationship to the law makes it necessary for a judge to reexamine regularly the activities of each organization with which he or she is affiliated to determine if it is proper to continue his or her relationship with that organization.

(b) An administrative law judge as an officer, director, trustee or non-legal advisor, or as a member, or otherwise:

(i) may assist such an organization in planning fund-raising, but shall not personally participate in the solicitation of funds or other fund-raising activities; however, this shall not prohibit *de minimis* fundraising activities within the confines of the OAL and its employees for non-profit charitable organizations with which judges or their immediate families are associated;

(ii) may make recommendations to public and private fund-granting organizations on projects and programs concerning the law, the legal system, or the administration of justice;

(iii) shall not personally participate in membership solicitation if the solicitation might reasonably be perceived as coercive or, except as permitted in Canon 4C(3)(b)(i), if the membership solicitation is essentially a fund-raising mechanism;

(iv) shall not use or permit the use of the prestige of judicial office for fundraising or membership solicitation.

Commentary: An administrative law judge may solicit membership or endorse or encourage membership efforts for an organization devoted to the improvement of the law, the legal system, or the administration of justice or a nonprofit educational, religious, charitable, fraternal, or civic organization as long as the solicitation cannot reasonably be perceived as coercive and is not essentially a fund-raising mechanism. Solitication of funds for an organization and solicitation of memberships similarly involve the danger that the person solicited will feel obligated to respond favorably to the solicitor if the solicitor is in a position of influence or control. A judge must not engage in direct, individual solicitation of funds or memberships in person, in writing, or by telephone except in the following cases: (1) a judge may conduct de minimis fundraising activities within the confines of the OAL and its employees for non-profit charitable organizations with which judges or their immediate families are associated, (2) a judge may solicit other judges for membership in the organizations described above and other persons if neither those persons nor persons with whom they are affiliated are likely ever to appear before the Office of Administrative Law, and (3) a judge who is an officer of such an organization may send a general membership solicitation mailing over the judge's signature.

Use of an organization letterhead for membership solicitation does not violate Canon 4C(3)(b) provided the letterhead lists only the judge's name and office or other position in the organization, and if comparable designations are listed for other persons, the judge's judicial designation. In addition, a judge must also make reasonable efforts to ensure that the judge's staff, and others subject to the judge's direction and control do not solicit funds on the judge's behalf for any purpose, charitable or otherwise.

D. Financial activities:

(1) An administrative law judge shall not engage in financial and business dealings that:

(a) may reasonably be perceived to exploit the judge's judicial position, or

(b) involve the judge in transactions or continuing business relationships with lawyers or other persons likely to come before the Office of Administrative Law.

Commentary: A judge may avoid financial and business dealings that involve the judge in frequent transactions or continuing business relationships with persons likely to come either before the judge personally or before other judges in the Office of Administrative Law. In addition, a judge should discourage members of the judge's family from engaging in dealings that would reasonably appear to exploit the judge's judicial position or involve those family members in frequent transactions or continuing business relationships with persons likely to come before the judge. This rule is necessary to avoid creating an appearance of exploitation of office or favoritism and to minimize the potential for disqualification.

(2) An administrative law judge may, subject to the requirements of this Code, hold and manage investments of the judge and members of the judge's family, including real estate.

(3) An administrative law judge shall not serve as an officer, director, manager, advisor, or employee of any business entity.

(4) An administrative law judge shall manage the judge's investments and other financial interests to minimize the number of cases in which the judge is disqualified. As soon as the judge can do so without serious

financial detriment, the judge should divest himself or herself of investments and other financial interests that might require frequent disqualification.

(5) Neither an administrative law judge, nor a member of the judge's family or a person treated by the judge as a member of the judge's family residing in the judge's household shall accept a gift, bequest, favor, or loan from anyone except for:

Commentary: Because a gift, bequest, favor, or loan to a member of the judge's family residing in the judge's household might be viewed as intended to influence the judge, a judge must inform those family members of the relevant ethical constraints upon the judge in this regard and discourage those family members from violating them. A judge cannot, however, reasonably be expected to know or control all of the financial or business activities of all family members residing in the judge's household.

(a) a gift incident to a public testimonial, books, tapes, and other resource materials supplied by publishers on a complimentary basis for official use, or an invitation to the judge and the judge's spouse or guest to attend a bar-related function or an activity devoted to the improvement of the law, the legal system, or the administration of justice;

(b) a gift, award, or benefit incident to the business, profession, or other separate activity of a spouse or other family member of a judge residing in the judge's household, including gifts, awards, and benefits for the use of both the spouse or other family member and the judge (as spouse or family member), provided the gift, award, or benefit could not reasonably be perceived as intended to influence the judge in the performance of judicial duties;

(c) ordinary social hospitality;

(d) a gift from a relative or friend, for a special occasion, such as a wedding, anniversary, or birthday, if the gift is fairly commensurate with the occasion and the relationship;

Commentary: A gift to a judge, or to a member of the judge's family living in the judge's household, that is excessive in value raises questions about the judge's impartiality and the integrity of the judicial office and might require disqualification of the judge where disqualification would not otherwise be required.

(e) a gift, bequest, favor, or loan from a relative or close personal friend whose appearance or interest in a case would in any event require disqualification;

(f) a loan from a lending institution in its regular course of business on the same terms generally available to persons who are not administrative law judges;

(g) A scholarship or fellowship awarded on the same terms and based on the same criteria to other applicants; or

(h) any other gift, bequest, favor, or loan only if: the donor is not a party or other person who has come or is likely to come or whose interests have come or are likely to come before the judge.

Commentary: Canon 4D(5)(h) prohibits judges from accepting gifts, favors, bequests, or loans from lawyers or their firms if they have come or are likely to come before the judge; it also prohibits gifts, favors, bequests, or loans from clients of lawyers or their firms when the clients' interests have come or are likely to come before the judge.

(6) An administrative law judge is not required by this Code to disclose income, debts, or investments, except as provided in this Canon and Canon 3. The Director of the Office of Administrative Law is required to disclose such information pursuant to the New Jersey Conflicts of Interest Law, *N.J.S.A.* 52:13D-12.

E. Fiduciary activities:

(1) An administrative law judge shall not serve as executor, administrator, or other personal representative, trustee, guardian, attorney in fact, or other fiduciary, except for the estate, trust, or person of a member of the judge's family, and then only if such service will not interfere with the proper performance of judicial duties.

(2) An administrative law judge shall not serve as a fiduciary if it is likely that the judge as a fiduciary will be engaged in proceedings that would ordinarily come before the judge, or if the estate, trust, or ward becomes involved in adversary proceedings in the Office of Administrative Law.

(3) The same restrictions on financial activities that apply to a judge personally also apply to the judge while acting in a fiduciary capacity.

Commentary: The restrictions imposed by this Canon may conflict with the judge's obligation as a fiduciary. For example, a judge should resign as trustee if detriment to the trust would result from divestiture of holdings the retention of which would place the judge in violation of Canon 4D(4).

F. Practice of Law.

A full-time administrative law judge shall not practice law, with or without compensation.

Commentary: This prohibition refers to the practice of law in a representative capacity and not in a pro se capacity. A judge may act for himself or herself in all legal matters, including matters involving litigation and matters involving appearances before or other dealings with legislative and other governmental bodies. However, in so doing, a judge must not abuse the prestige of office to advance the interests of the judge or the judge's family.

This provision will not be interpreted to prohibit a judge from giving legal advice to and assisting in the drafting or reviewing of documents for a member of the judge's family, so long as the judge receives no compensation. A member of the judge's family denotes a spouse, child, grandchild, parent, grandparent, or other relative or person with whom the judge maintains a close familial relationship. A judge must not, however, act as an advocate or negotiator for a member of the judge's family in a legal matter.

G. Compensation and reimbursement.

An administrative law judge may receive compensation and reimbursement of expenses for the extra-judicial activities permitted by this Code to the extent permitted by law.

CANON 5

AN ADMINISTRATIVE LAW JUDGE SHALL REFRAIN FROM POLITICAL ACTIVITY

A. An administrative law judge shall not:

(1) act as a leader or hold an office in a political organization;

(2) publicly endorse or publicly oppose any candidate for public office;

(3) make speeches on behalf of a political organization;

(4) attend political functions or functions that are likely to be considered as being political in nature;

(5) solicit funds for, pay an assessment to, or make a contribution to a political organization or candidate, or purchase tickets for political party dinners or other functions; or

(6) otherwise engage in any political activity except as authorized under this Code.

Commentary: An administrative law judge retains the right to participate in the political process as a voter. Canon 5A(2) does not prohibit an administrative law judge from privately expressing his or her views on candidates for public office.

B. A candidate for reappointment to an administrative law judge position or an administrative law judge seeking another governmental office shall not engage in any political activity to secure the appointment except that such persons may:

(1) communicate with the appointing authority, including any selection or nominating commission or other agency designated to screen candidates;

(2) seek support or endorsement for the appointment from organizations that regularly make recommendations for reappointment or appointment to the office, and from individuals to the extent requested or required by those specified in Canon 5B(1); and

(3) provide to those specified in this Canon information as to his or her qualifications for the office.

C. An administrative law judge shall resign from office when the judge becomes a candidate either in a party primary or in a general election for an elective public office.

1:31-3.1 General causes for discipline

(a) The Director of the Office of Administrative Law may discipline an administrative law judge for:

1.-3. (No change.)

4. Any conduct which constitutes a violation of the OAL Office Policies for Administrative Law Judges or the [Code of Judicial Conduct, Appendix A to Part 1, Pressler, Current N.J. Court Rules (1991), as made applicable by Sec. IV(6) of the OAL Code of Ethics] **Code of Judicial Conduct for Administrative Law Judges**; or

5. (No change.)

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Secondary Mortgage Loan Act Rules

Proposed Amendments: N.J.A.C. 3:18-2.1, 4.1, 4.2, 5.1, 5.2, 7.4, 7.5, 8.2, 10.5 and 10.7

Proposed Repeals: N.J.A.C. 3:18-1, 3, 9 and 10.8

Proposed New Rules: N.J.A.C. 3:18-1, 3, 8.1, 9 and 11

Proposed Repeal and New Rule: N.J.A.C. 3:18-5.3

Authorized By: Jeff Connor, Commissioner, New Jersey Department of Banking.

Authority: N.J.S.A. 17:11A-54.

Proposal Number: PRN 1992-352.

Submit comments by September 16, 1992 to:

Robert M. Jaworski
Deputy Commissioner
Department of Banking
CN 040
Trenton, N.J. 08625

The agency proposal follows:

Summary

The Department of Banking (the "Department") proposes to substantially amend its rules concerning the Secondary Mortgage Loan Act, N.J.S.A. 17:11A-34 et seq., (the "Act"), to bring these rules in conformity with recent amendments to the Act. In addition, the proposed rules set forth many of the Department's policies regarding licensing, and make proposed changes in this area.

Consistent with the Act, the proposed rules require a person who engages in the secondary mortgage loan business in this State to be licensed. A person is engaged in the secondary mortgage loan business if such person advertises, solicits, negotiates, offers to make or makes a secondary mortgage loan. Similarly, a person is engaged in the secondary mortgage loan business if that person becomes the subsequent holder of a secondary mortgage loan. The rules define a secondary mortgage loan as a loan secured by residential real property which is subject to one or more prior liens.

The following are not considered secondary mortgage loans: (1) a loan to be repaid in 90 days or less; (2) a loan which is taken as security for a home repair contract; and (3) a loan which is the result of the private sale of a dwelling if title to the dwelling is in the name of the seller and the seller has resided in the dwelling for at least one year, if the buyer is purchasing said dwelling for his own residence and, as part of the purchase price, executes a secondary mortgage in favor of the seller. In addition, loans to corporations are exempted.

Consistent with the Act, the proposed new rules set forth several exceptions to the license requirements. For example a licensed real estate broker or salesman is not required to obtain a license to negotiate a secondary mortgage loan in the normal course of business as a real estate broker or salesman. A real estate broker or salesman receiving separate or additional compensation for originating, brokering or acquiring a secondary mortgage loan, in addition to the real estate sales commission, does not qualify for this exemption and must be licensed.

Similarly, an attorney authorized to practice law in New Jersey is not required to obtain a license to negotiate a secondary mortgage loan in the normal course of business as an attorney. An attorney who receives separate or additional compensation for originating, brokering or acquiring a secondary mortgage loan does not qualify for this exemption and must be licensed.

The proposed new rules also make reference to the exemption in the Act for a person who makes one or two secondary mortgage loans in this State during any calendar year which are at an interest rate which is not in excess of the usury rate in existence at the time the loan is made, and on which the borrower has not agreed to pay, directly or indirectly, any charge, cost, expense or fee whatsoever, other than interest. Further, the proposed new rules and amendments mirror the exemption in the Act for financial institutions, such as banks, savings banks, savings and loan associations, insurance companies and credit unions.

The rules currently require a licensee to preserve books and records for two years from the final entry. The proposed new rules specify that the assignment of a secondary mortgage loan, the denial of an application and the withdrawal of an application all constitute the final entry, and the licensee shall maintain the records for two years thereafter. In the case of an open end loan, a licensee shall preserve the books, accounts and records for at least two years after each entry.

The rules currently provide that a licensee may obtain approval of the Commissioner to maintain its records at either a licensed site located outside New Jersey or at an unlicensed location in New Jersey. Pursuant to the proposed amendments, a licensee may maintain its records at a licensed location inside the State. As an alternative, a licensee with the permission of the Department may keep its records at an unlicensed location in this State or at a licensed or unlicensed location outside this State. As a condition for approval, the licensee must enter into an agreement with the Department governing the maintenance and production of the records.

The proposed new rules next permit a licensee to make an open-end and closed-end loans at interest rates agreed to by the lender and the borrower. This does not permit the licensee to charge interest in excess of the criminal usury rate, which currently is 30 percent on loans to individuals. N.J.S.A. 2C:21-19.

The proposed new rules next specify the fees which a licensee may charge incident to a secondary mortgage loan. First, the rules permit a licensee to collect third party fees after they have been incurred by the licensee. The licensee may only collect these fees in the amount charged the licensee. Consistent with the Act, only the following fees may be recovered: fees for title examination, abstract of title, survey or title insurance, appraisal fees, credit report fees, and reasonable attorney's fees paid to an attorney authorized to practice law in New Jersey, if not otherwise prohibited.

In addition, a licensee is permitted to charge a late fee of up to five percent of the amount of payment in default. A licensee may not charge more than one late charge on any one payment in arrears. A licensee may also charge and collect a check collection charge in the amount charged to the licensee. Finally, pursuant to recent legislation, P.L.1992, c.20, approved June 12, 1992, a licensee may charge and receive no more than three discount points computed as a percentage of the amount of the loan. A licensee may not charge interest in advance of it being earned, except insofar as permitted discount points are considered interest.

It should be noted that licensees may make open-end loans only upon the same terms and conditions permitted to banks, savings banks and savings and loan associations. The rules of the Department regulating such loans, N.J.A.C. 3:1-14, do not permit interest in advance, and contain no exception for discount points. Pursuant to N.J.S.A. 46:10B-11.1, discount points are deemed to be interest charged on the loan. Accordingly, notwithstanding the recent legislation noted above, licensees may not charge discount points on open-end loans.

It is proposed that N.J.A.C. 3:18-3.5, which required reimbursement of specified fees, be repealed because it was based on Section 22 of the Act, a Section which has since been repealed.

It is proposed that N.J.A.C. 3:18-3.6, which required notice to the borrower of his right to be represented by an attorney, be repealed as redundant since the requirement is now set forth in the Act, N.J.S.A. 17:11A-47.

It is proposed that the 18 percent usury limitation previously contained in N.J.A.C. 3:18-9.1 be repealed because it is inconsistent with the Act which permits licensees to make loans at an annual percentage rate agreed to by the licensee and the borrower. N.J.S.A. 17:11A-44.7 and 44.8.

Consistent with N.J.S.A. 46:10B-2, the proposed new rules prohibit imposition of a prepayment penalty. In addition, a licensee may only compute interest using either the 365/365 method or the 360/360 method.

The proposed new rules, consistent with the Act, prohibit a licensee from requiring or accepting any collateral or security for a secondary mortgage loan other than a mortgage, indenture or any other similar interest in real property. A co-signature of a person other than the spouse or other person having an interest in the real property used as security for the loan constitutes prohibited collateral and security unless the co-signer is a joint borrower. A person not having an interest in the real property used as security for the loan is considered a joint borrower if: (1) the borrowers sign an affidavit affirming their agreement to be jointly liable and to share in the proceeds of the secondary mortgage loan; and (2) the licensee issues the proceeds check or checks in all

borrowers' names. If borrowers may access a line of credit by writing checks or otherwise, the second requirement will be satisfied if all borrowers have the authority to draw against the account.

The proposed new amendments also provide that a licensee may make available insurance covering direct or indirect damage or loss, so long as not for a term or an amount exceeding the loan, together with an amount needed to satisfy all prior liens on such property. A licensee may not compel a borrower to obtain this or any insurance from or through a particular insurance agent or broker. In addition, a licensee may not compel a borrower to purchase credit life or accident and health, or credit unemployment insurance.

The proposed new rules also provide that, before operating a branch office, a licensee shall obtain a branch office license from the Commissioner. A licensee may conduct its secondary mortgage loan business in the same office in which it conducts other licensed activities, unless otherwise prohibited. However, a licensee may not share office space with another person, including an affiliated corporation, unless the office and operations of the licensee are separate, apart and distinct from the offices and operations of the other person or persons. Other provisions previously contained in N.J.A.C. 3:18-10.8 have been moved to N.J.A.C. 3:18-8.1. These provisions have been revised to specifically require notice to the Commissioner before a licensee closes an office.

Current rules prohibit a licensee from engaging in the secondary mortgage loan business at a location which is utilized by a banking institution or savings and loan association, except under specified circumstances. This section is maintained, and the provision allowing for compliance within 60 days is repealed as obsolete.

One exception is carved out from the branch office licensing requirement consistent with a similar exception the Department proposed under the Mortgage Bankers and Brokers Act, N.J.S.A. 17:11B-1 et seq. The exception provides that a branch office of a licensee under the Act does not also constitute a branch office of another licensee merely because the first licensee distributes or receives applications of that other licensee at the branch office.

Proposed N.J.A.C. 3:18-9.1 mirrors repealed N.J.A.C. 3:18-1.1 and 1.2, by requiring a closing statement, and by requiring the licensee to provide the borrower with a copy of every paper he is called upon to sign. The rules, as amended, provide that where any disclosure is required pursuant to this chapter which is also required by Federal law, compliance with Federal law or regulation is deemed to be compliance with this subchapter.

Current rules base the required amount of the surety bond on the number of individual licensees employed. The more licensed individuals employed by the licensee, the higher the required bond. The Department proposes to amend this schedule to base the bond amount on the number of licensed offices, rather than the number of licensed individuals. In particular, the required bond pursuant to the proposed schedule would be $25,000 for a sole proprietorship with one licensed office, $35,000 for a licensee other than a sole proprietorship with one licensed office, $60,000 for a licensee with two to five licensed offices, $75,000 for a licensee with six to 10 licensed offices, $100,000 for a licensee with 11 to 15 licensed offices, and $125,000 for a licensee with 16 or more licensed offices. The Department views the number of branch offices as a better indicator of the amount of activity of a licensee, and therefore a more appropriate determinant for the amount of the bond.

Current rules prohibit a licensee from charging an attorney review fee if the fee is to be paid to the licensee, or an employee, partner, officer, director or stockholder of the licensee. In addition, current rules prohibit the following persons from receiving compensation from an attorney who is providing legal services incident to a secondary mortgage loan pursuant to N.J.S.A. 17:11A-46(g): (1) a licensee; (2) a person who is individually licensed under the Act; (3) an employee, partner, officer, director or stockholder of a licensee; or (4) any other person or organization directly or indirectly associated or affiliated with a licensee.

It is proposed that the term "stockholder" be defined to mean a person who, directly, indirectly or acting through one or more other persons owns, controls or has power to vote 10 percent or more of any class of voting securities, not 25 percent as currently defined. In addition, it is proposed that the persons who may not receive compensation from an attorney be defined as (1) a licensee; (2) an employee, partner, officer, director or stockholder of a licensee; and (3) any other person in which a licensee is an employee, partner, officer, director or stockholder.

The Act provides that licensees may assign, sell, or transfer secondary mortgage loans only to: (1) State or Federally-chartered banks, savings banks, or savings and loan associations having their principal places of business in New Jersey; (2) other secondary mortgage loan licensees; (3) the Federal National Mortgage Association; (4) the Federal Home Loan Mortgage Corporation; and (5) "other persons or entities as from time to time approved by the commissioner to facilitate and assure the steady flow of secondary mortgage funds into the State." N.J.S.A. 17:11A-46(h). To achieve the goal expressed in the last phrase, the Department proposes new rules which would establish procedures for registering persons located outside New Jersey as authorized assignees of secondary mortgage loans.

Pending promulgation of these rules, the Department granted provisional approval to allow for the sale of secondary mortgage loans by licensees to several persons outside New Jersey. It is proposed that this authority end on December 31, 1992, and that such sales may thereafter be made only to persons registered with the Department in accordance with procedures set forth in these proposed new rules.

If the secondary mortgage loans are to be sold without servicing rights, an applicant, which may be either the selling licensee or the person acquiring the loans, must submit the following to the Department: (1) a registration form requiring basic information about the person acquiring the loans, such as its name and address; (2) a statement from the person agreeing to submit itself to the jurisdiction of the Department for administrative actions; (3) a statement from the person designating the Commissioner as its registered agent to receive service of process in such an administrative action; (4) a statement from the person agreeing not to obtain servicing rights from a licensee of any secondary mortgage loan without first having been registered to receive servicing rights; and (5) the registration fee.

If the secondary mortgage loans are to be sold with servicing rights or the servicing rights are to be sold separately, and the person to whom they are to be sold is a chartered or licensed financial institution located outside New Jersey, such as a bank, savings bank, savings and loan association, credit union, or insurance company, a certificate of good standing from its primary regulator must also be filed with the Department. For other persons intending to obtain servicing rights, there must also be filed (1) a statement detailing the person's experience in dealing in transactions of the type for which approval is sought, including brief resumes of key personnel; (2) copies of balance sheets and earnings records for the last three calendar or fiscal years; and (3) a copy of the person's latest Annual Report to shareholders.

The proposed new rules require the Commissioner to file the registration within 60 days of its receipt by the Department. Registration shall become effective upon notification to the applicant. The Commissioner may refuse to register, revoke a registration or suspend a registration for any of the reasons set forth in N.J.S.A. 17:11A-39.1. That section provides that the Commissioner may revoke, suspend or refuse to renew a license for violation of the Act, a material misstatement on an application, a conviction of certain offenses, insolvency, a demonstration of unworthiness, incompetence, bad faith or dishonesty in the transaction of business as a licensee or for other conduct which is sufficient cause for denial of a license.

The registration is effective for a two-year biennial period ending on December 31 of even-numbered years. To renew a registration, an applicant must file the following: (1) a renewal registration form; (2) a statement from the person agreeing not to obtain from a licensee the servicing rights of any secondary mortgage loan without first becoming specifically registered to do so; (3) in the case of a person other than a chartered or licensed financial institution which files or has filed on its behalf an application for registration as an approved assignee of servicing rights, copies of balance sheets and earnings records for the last two calendar or fiscal years; (4) in the case of a chartered or licensed financial institution which files or has filed on its behalf an application for registration as an approved assignee of servicing rights, a certificate of good standing executed by its primary regulator; and (5) the required registration fee.

The biennial fee is set at $100.00, except it is $300.00 for the registration to receive secondary mortgage loans with servicing rights by other than a chartered or licensed financial institution. This fee is set to approximate the administrative cost involved with reviewing the registration and maintaining records of same. The fee is higher for other than financial institutions registering to receive servicing rights because such registrations require more review. The Department set the fee to approximate the per diem, per person, examination charge imposed by the Department. N.J.A.C. 3:1-6.6. When the registration materials require additional review, the Department may impose an additional per diem examination charge.

Social Impact

The licensing requirements set forth in these proposed rules and amendments, in general, merely codify existing requirements consistent with the Act. These provisions will have the beneficial social impact of allowing the Department to regulate licensees in a more effective manner. In particular, by codifying these requirements of the Act in the rules, the requirements will be further publicized to the industry, which should increase compliance.

The proposed rules also facilitate the process whereby out-of-State institutions become approved to receive assignment of secondary mortgage loans from licensees. It is hoped that these rules will have the beneficial social impact of increasing the flow of secondary mortgage funds into this State and thereby making this type of credit more available and less costly to consumers.

The proposed rules also require that a licensee may not share office space with another person unless the office and operations of the licensee are separate, apart and distinct from the offices and operations of the other person. This section is intended to prevent confusion on the part of consumers regarding the identity of the company with whom they are doing business.

Finally, the proposed rules change the surety bond requirements so that the surety bond requirement increases based on the number of branches the licensee maintains, rather than the number of licensed individuals employed. It is the view of the Department that the number of branch offices is a better indicator of the activity of the licensee. Those licensees with more branches and therefore more activity will need to obtain larger surety bonds, so that consumers will be protected to a larger degree.

Economic Impact

Licensees with more branches than licensed individuals may need to obtain higher surety bonds. Such a bond requires a premium payment, and may also require a licensee to grant a security interest in collateral owned by the licensee. This will have a negative economic impact on these licensees.

In addition, the proposed rules clarify the licensing requirements of the Act. To the extent that these provisions alert persons that they must obtain a license, and such persons become licensed for the first time, the proposed rules will impose on such persons for the first time the cost of licensing. Licensees are required to pay the Department a biennial license fee of $1,000. (N.J.A.C. 3:18-10.1.) In addition, licensees must reimburse the Department for the cost of examinations at the cost of $325.00 per diem per person. (N.J.A.C. 3:1-6.6(b).)

Finally, the proposed rules concerning registering of assignees impose biennial fees of $100.00 or $300.00. Pursuant to current procedures, the Department charges based on a per diem per person examination charge. This fee is typically more than $300.00. Accordingly, this will have a marginal positive economic impact on registrants.

Regulatory Flexibility Analysis

Virtually all licensees under the Act are small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. By clarifying the Act's licensing requirements, persons not previously clearly subject to licensure are now put on notice that they must be licensed. These persons, to become licensed, will need to file an application every other year, and will be subject to examination by the Department. The fees imposed for these services are set forth in the Economic Impact statement.

No differentiation is made in these licensing requirements based on business size because the Legislature has directed the Department in the Act to license all secondary mortgage lenders regardless of the size. Small licensees need the same supervision as larger licensees. Although the application fee and per diem examination charge are the same for all licensees, small businesses typically require fewer days of examination, so they are charged a proportionately lower examination charge. To this extent, differentiation in the fees is made based on business size.

The registration requirement for proposed assignees of secondary mortgage loans requires these persons to file with the Department. This is consistent with current practice. Most persons seeking to purchase these loans are larger financial institutions, and not small businesses. Further, the filing and fee requirements are less than what is currently required. Accordingly, the Department did not differentiate based on business size.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 3:18-1, 3 and 9.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. GENERAL PROVISIONS

3:18-1.1 Definitions

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

"Act" means the Secondary Mortgage Loan Act, N.J.S.A. 17:11A-34 et seq.

"Borrower" means an individual, association, joint venture, partnership, limited partnership, limited partnership association, or any other group of individuals however organized, except a corporation, who applies for a secondary mortage loan, whether such loan is granted, or who has obtained such a loan.

"Branch office" means any location where, in the regular course of business, secondary mortgage loan applications are distributed to or received from consumers, mortgage records are maintained, underwriting decisions are made, mortgage commitments are issued, or any fees or charges relating to the secondary mortgage loan are received from consumers. A location shall not be considered a branch office merely because any or all of the following activities are conducted at the location:

1. Consumers receive information concerning available loan products from a computer terminal;

2. Consumers are prequalified for a mortgage loan, so long as no additional fee is charged for this service; and

3. Advertising materials are distributed to consumers so long as the materials do not in any way resemble an application for a secondary mortgage loan.

"Closed-end loan" means a secondary mortgage loan pursuant to which the licensee advances to the borrower a specified amount of money and the borrower agrees to repay the principal and interest in substantially equal installments over a stated period of time.

"Commissioner" means the Commissioner of the New Jersey Department of Banking.

"Compensation" means and includes money, chattels, personal services or any other tangible or intangible thing of value.

"Department" means the New Jersey Department of Banking.

"Discount point" means an amount of money equal to one percent of the principal amount of the loan and payable only at closing.

"Financial institution" means a person that is duly licensed or chartered by a state or the Federal government to provide financial services to the public, and includes the following:

1. A state or Federal bank or savings bank;

2. A state or Federal savings and loan association;

3. An insurance company; and

4. A state or Federal credit union.

"Licensed office" means a principal office or a branch office.

"Licensee" means a person licensed in this State as a secondary mortgage loan lender, or a person required to be licensed.

"Open-end loan" means a secondary mortgage loan made by a licensee pursuant to a written agreement between the licensee and the borrower whereby:

1. The licensee may permit the borrower to obtain advances of money from the licensee from time to time or the licensee may advance money on behalf of the borrower from time to time as directed by the borrower;

2. The amount of each advance and permitted interest and charges are debited to the borrower's account and payments and other credits are credited to the same account;

3. Interest is computed on the unpaid principal balance or balances of the account from time to time; and

4. The borrower has the privilege of paying the account in full at any time or, if the account is not in default, in monthly installments of fixed or determinable amounts as provided in the agreement.

"Person" means an individual, association, joint venture, partnership, limited partnership, limited partnership association, corporation or any other group of individuals however organized.

"Secondary mortgage loan" means a loan made to a borrower which is secured in whole or part pursuant to a security agreement by any interest in real property which is subject to one or more prior mortgage liens and on which there is erected a structure containing one, two, three, four, five or six dwelling units, a portion of which structure may be used for nonresidential purposes. The following shall not constitute secondary mortgage loans:

1. A loan to be repaid in 90 days or less;

2. A loan in which the real property is taken as security for a home repair contract executed in accordance with N.J.S.A. 17:16C-62 et seq.; and

3. A loan which is the result of the private sale of a dwelling if title to the dwelling is in the name of the seller and the seller has resided in said dwelling for at least one year, if the buyer is purchasing said dwelling for his own residence and, as part of the purchase price, executes a secondary mortage in favor of the seller.

3:18-1.2 License requirement

(a) No person shall engage in the secondary mortgage loan business in this State without first obtaining a license. A person is engaged in the secondary mortgage loan business if such person:

1. Advertises, causes to be advertised, solicits, negotiates, offers to make or makes a secondary mortgage loan, whether directly or by any person acting for his benefit; or

2. Becomes the subsequent holder in this State of a promissory note or mortgage, indenture or any other similar instrument or document received in connection with a secondary mortgage loan.

3:18-1.3 Exceptions to license requirement

(a) A real estate broker or salesman licensed in New Jersey pursuant to Chapter 15 of Title 45 of the Revised Statutes is not required to obtain a license to negotiate a secondary mortgage loan in the normal course of business as a real estate broker or salesman. A real estate broker or salesman receiving separate or additional compensation for originating, brokering or acquiring a secondary mortgage loan, in addition to the real estate sales commission, shall be deemed to be engaged in the business of a licensee and must be licensed or employed by a licensee.

(b) An attorney authorized to practice law in New Jersey is not required to obtain a license to negotiate a secondary mortgage loan in the normal course of business as an attorney. An attorney who receives separate or additional compensation for originating, brokering or acquiring a mortgage loan shall not qualify for this exemption and must be licensed.

(c) A person who makes one or two secondary mortgage loans in this State during any calendar year which are at an interest rate which is not in excess of the usury rate in existence at the time the loan is made, and on which the borrower has not agreed to pay, directly or indirectly, any charge, cost, expense or fee whatsoever, other than said interest, shall not be required to obtain a license.

(d) Nothing contained in this chapter expands or restricts the powers otherwise conferred by law upon financial institutions to engage in the secondary mortgage loan business, and no financial institution in exercising any power otherwise so conferred upon it shall be subject to any provision of this chapter.

3:18-2.1 Preservation of records

(a) Every licensee shall preserve the books, accounts and records for at least two years after making the final entry on any secondary mortgage loan or application. The assignment or sale of a secondary mortgage loan shall constitute the final entry for the licensee assigning the secondary mortgage loan. The denial or withdrawal of an application shall constitute the final entry on any secondary mortgage loan application which is denied or withdrawn. In the case of an open-end loan, a licensee shall preserve the books, accounts and records for at least two years after each entry.

(b) A licensee may keep its secondary mortgage loan records at either: [a licensed site located in a state other than this State, or an unlicensed site located in this State, provided that, in either instance, the licensee secures the prior approval of the Department of Banking.]

1. A licensed branch office in this State; or

2. An unlicensed site in or out of this State, or a licensed branch office outside of this State, provided that, in either instance, the licensee secures the prior approval of the Department of Banking. The approval of the Department will be given only if the licensee enters into an agreement with the Department governing the maintenance and production of records at such site. The provisions of the agreement shall include, but shall not be limited to, the designation of the site where the records will be maintained, the fees and expenses chargeable by the Department for conducting the examinations, and the right of the Department to rescind the agreement.

SUBCHAPTER 3. MORTGAGE LOANS

3:18-3.1 Types of mortgage loans

(a) A licensee may make closed-end or open-end loans, and may charge, contract and receive thereon interest at an annual percentage rate agreed to by the licensee and the borrower.

(b) Nothing contained in (a) above shall be construed to permit a licensee to charge a rate of interest in excess of that permitted by N.J.S.A. 2C:21-19.

3:18-3.2 Permitted charges

(a) A licensee may charge a borrower only the following fees incident to a secondary mortgage loan, in addition to interest:

1. Third party charges actually incurred by a licensee on behalf of a borrower incident to the processing of a secondary mortgage loan application or the closing of the loan. The licensee may collect third party charges only after they have been incurred by the licensee, and the licensee may not charge the borrower more than the amount the borrower is charged by the third party for the service. The licensee may not collect any third party charges except the following:

i. Fees for title examination, abstract of title, survey or title insurance;

ii. Appraisal fees;

iii. Credit report fees; and

iv. Reasonable attorney review fees paid to an attorney authorized to practice law in New Jersey, if not otherwise prohibited;

2. Charges for late payment by the borrower as may be provided in the note or loan agreement, provided that no late charge shall exceed five percent of the amount of payment in default. A licensee shall not charge more than one late charge on any one payment in arrears;

3. Check collection charges in the amount charged to the licensee; and

4. No more than three discount points.

(b) A licensee shall not charge interest in advance of it being earned, other than as discount points.

(c) Nothing contained in this section shall limit a licensee's ability to impose charges upon foreclosure.

3:18-3.3 Prepayment of secondary mortgage loan

A borrower may prepay a secondary mortgage loan at any time without penalty.

3:18-3.4 Method of computing interest

A licensee may only compute interest using the 365/365 method or the 360/360 method.

3:18-3.5 Collateral security

(a) A licensee shall not require or accept from a borrower any collateral or security for a secondary mortgage loan other than a mortgage, indenture or any other similar instrument or document which creates a lien upon any real property or an interest in real property including, but not limited to, shares of stock in a cooperative corporation.

(b) For purposes of this section, the co-signature of a person, other than a spouse or other person having an interest in the real property used as security for the loan, shall constitute prohibited collateral or security unless the co-signer is a joint borrower.

(c) A person not having an interest in the real property used as security for the loan shall be considered a joint borrower if:

1. The borrowers sign an affidavit affirming their agreement to be jointly liable and to share in the proceeds of the secondary mortgage loan; and

2. The licensee issues the proceeds check or checks in all borrowers' names. If borrowers may access a line of credit by writing checks or otherwise, this requirement will be satisfied if all borrowers have the authority to draw against the account.

3:18-4.1 Agent or broker and company licensed or authorized by the State of New Jersey

(a) When a licensee requires fire or [life] **casualty** insurance in connection with a secondary mortgage loan, such insurance shall be written by or through a duly licensed insurance agent or broker of the State of New Jersey, with an insurance company authorized to do business in this State.

(b) A licensee may make available insurance covering direct or indirect damage or loss, by fire or other perils, including those of extended coverage, to the property of the borrower all or part of which is the security for the loan, which insurance shall be for a term not to exceed the term of the loan and in an amount not to exceed the amount of the loan together with an amount needed to satisfy all prior liens on such property.

3:18-4.2 Designation of particular agent or broker

(a) No licensee shall require **a borrower**, as a condition to obtaining a secondary mortgage loan, [a borrower] to negotiate for or obtain a policy of insurance or renewal thereof, covering the property involved in the transaction, from or through a particularly designated insurance agent or broker.

(b) No licensee shall compel a borrower to purchase credit life or accident and health insurance, or credit involuntary unemployment insurance, in connection with a secondary mortage loan.

3:18-5.1 Affiliation between a licensee and its attorney prohibited

(a) [For the purpose of N.J.S.A. 17:11A-46h, a licensee is hereby prohibited from charging] **A licensee shall not charge** a borrower [a legal] **an attorney review** fee if the attorney to whom the fee is to be paid is [individually licensed under the Secondary Mortgage Loan Act or is] an employee, partner, officer, director or stockholder of the licensee.

(b) For purposes of this [regulation] **subchapter**, "stockholder" means and includes a person who directly, indirectly or acting through one or more other persons owns, controls or has power to vote [25] **10** percent or more of any class of voting securities of a corporate licensee.

3:18-5.2 Licensee's participation in legal fees prohibited

(a) [A licensee is hereby prohibited from receiving] **The following persons shall not receive** compensation from an attorney [for the preparation of documents or any other function performed by a licensee for and on behalf of an attorney] who is providing legal service [to the licensee] in accordance with N.J.S.A. [17:11A-46h.] **17:11A-46(g) for the preparation of documents or for any other services performed for and on behalf of the attorney:**

[(b) For the purpose of this regulation, "licensee" means and includes]

1. A licensee [as defined by N.J.S.A. 17:11A-35c];

[2. A person who is individually licensed under the Secondary Mortgage Loan Act;]

[3.]**2.** An employee, partner, officer, director or stockholder of a licensee; or

[4.]**3.** Any other person [or organization directly or indirectly associated or affiliated with a licensee] **in which a licensee is an employee, partner, officer, director or stockholder.**

3:18-5.3 Attorney's statement must be detailed

[For the purpose of N.J.S.A. 17:11A-46h, "statement" means an itemized listing of specific legal services performed by an attorney for and on behalf of a licensee.] **To obtain reimbursement from the borrower at closing for attorney review fees charged to the licensee in connection with a secondary mortgage loan, the licensee shall issue to the borrower at or before the closing of a secondary mortgage loan an itemized listing prepared by the attorney of the specific legal services performed by the attorney for and on behalf of the licensee and the charge to the licensee for each such service.**

3:18-7.4 Credit life, [and] accident and health, **and involuntary unemployment** insurance

Any licensee who advertises the availability of credit life or accident insurance, **or involuntary unemployment insurance,** shall specifically state that such insurance is optional.

3:18-7.5 Certain types of advertising prohibited

(a) The use of any of the following types of advertising shall be deemed to be misleading or deceptive, and as such in violation of N.J.S.A. [17:11A-46L(5)] **17:11A-46(k)(5)**:

1. and 2. (No change.)

3:18-8.1 Branch offices

(a) Before operating a branch office, a licensee shall obtain a branch office license from the Commissioner. A licensee shall apply to the Commissioner for permission to establish a branch office or offices on a form prescribed by the Commissioner. The application form requires basic information about the licensee and the proposed site, such as the name and address of the licensee and a description of the proposed branch office. An applicant shall submit with the application the required fees.

(b) A licensee may conduct its secondary mortgage loan business in the same office in which it conducts other licensed activities, unless otherwise prohibited. However, a licensee may not share office space with another person, including an affiliated corporation, unless the office and operations of the licensee are separate, apart and distinct from the offices and operations of the other person or persons. In addition, a licensee may not establish a branch office within an establishment which is primarily devoted to social or recreational activities, or which impairs the ability of the public to gain access to the licensee.

(c) Each licensee which maintains more than one office shall designate one office as the principal office. The designation of the principal office shall be filed with the Commissioner. Any change in the designation shall be filed within 10 days of the effective date of the change. The Commissioner shall endorse the change of address on the license.

(d) Each licensee shall submit any change of address for the principal office or any branch office or any change in the licensed supervisory individual within 10 days of the change. The Commissioner shall issue confirmation of the change in address. In addition, a licensee shall notify the Commissioner prior to closing a principal or branch office.

(e) Each licensee shall display the license so that it is easily observable by the general public. The address and name on the license must be the same as the address of the place of business and the name of the licensee where the license is on display.

(f) A branch office of a licensee under the Act does not also constitute a branch office of another licensee merely because the first licensee distributes or receives applications of that other licensee at the branch office.

3:18-[8.1]**8.2** Banking institution or savings and loan association location prohibited

[(a)] A licensee is prohibited from engaging in the secondary mortgage loan business at a location which is utilized by a banking institution or savings and loan association as a main branch or any other office, except that no licensee shall be prohibited from engaging in the secondary mortgage loan business at a location utilized by a banking institution, or savings and loan association, where the office and operations of the licensee are separate, apart and distinct from the offices and operations of the banking institution or the savings and loan association, and when employees of the banking institution or savings and loan association are not employed by or soliciting for the licensee.

[(b) In the event a licensee is presently engaged in the secondary mortgage loan business at any such location or locations, the licensee shall have 60 days, unless extended by the commissioner for good

cause shown, to relocate its offices, subject to the approval of the commissioner, otherwise said license(s) shall be surrendered to the commissioner for cancellation.]

SUBCHAPTER 9. DISCLOSURE OF TERMS

3:18-9.1 Required disclosures

(a) At or before the time a secondary mortgage loan is made, the licensee shall deliver a closing statement to the borrower setting forth the net proceeds of the loan, itemized fees incurred or disbursed, interest charges, full amount of the loan and the terms by which the loan is to be repaid.

(b) The licensee shall provide the borrower with a copy of every paper he is called upon to sign.

3:18-9.2 Compliance with Federal law

Where any disclosure is required pursuant to this subchapter which is also required by any Federal law or regulation, compliance with such Federal law or regulation shall be deemed to be compliance with this subchapter.

3:18-10.5 Bonds

(a) No license will be issued unless and until the applicant has posted with the Department of Banking a bond in the amount required by this subchapter in a form prescribed by the Commissioner by a surety company authorized to do business in the State of New Jersey. **A person employed by a licensee which already has an adequate surety bond, as defined by this section, does not need to obtain an additional surety bond to become licensed.**

[(b) The minimum amount of the bond posted shall be:

1. For a sole proprietorship: $25,000;
2. For a corporate or non-corporate entity plus one individual licensee: $35,000;
3. For a corporate or non-corporate entity plus two to five individual licensees: $60,000;
4. For a corporate or non-corporate entity plus six to 10 individual licensees: $75,000;
5. For a corporate or non-corporate entity plus 11 to 15 individual licensees: $100,000;
6. For a corporate or non-corporate entity plus 16 or more individual licensees: $125,000.]

(b) Every licensee shall obtain and maintain a surety bond in the following minimum amounts:

1. For a sole proprietorship with one licensed office: $25,000;

2. For a licensee other than a sole proprietorship with one licensed office: $35,000;

3. For a licensee with two to five licensed offices: $60,000;

4. For a licensee with six to ten licensed offices: $75,000;

5. For a licensee with 11 to 15 licensed offices: $100,000;

6. For a licensee with 16 or more licensed offices: $125,000.

(c)-(h) (No change.)

3:18-10.7 Replacement of license

If a natural person upon whom a corporation, partnership, association, or other entity relies for its license pursuant to N.J.S.A. 17:11A-36(b), **or a natural person otherwise supervising an office or offices pursuant to N.J.A.C. 3:18-8.1,** discontinues his **or her** affiliation or employment with such entity for any reason whatsoever, the entity may continue to operate under its license for a period of 90 days or for such other extended period as the Commissioner determines necessary for the entity to replace that natural person with another licensed natural person; provided, that the entity so notifies the Department of Banking within 10 days [of the date upon which] **following** that natural [person] **person's** [disassociates or leaves the employ of the entity] **discontinuance of affiliation or employment with the licensed entity**.

3:18-10.8 [Office requirements] **(Reserved)**

[(a) Each licensee which maintains more than one office must designate one office as the principal office. The designation of the principal office must be filed with the Commissioner of Banking. Any change in the designation must be filed within 10 days of the effective date of the change. The Commissioner shall endorse the change of address on the license.

(b) A licensee shall apply to the Commissioner for permission to establish a branch office or offices on a form prescribed by the Commissioner together with the required fees.

(c) Each licensee must submit any change of address for the principal office of any branch office or any change in the licensed supervisory individual within 10 days of the change. The Commissioner shall issue confirmation of the change in address.

(d) Unless the Commissioner determines within 30 days of receipt of a completed branch application that the office is located within an establishment which is exclusively devoted to social or recreational activities or is inconsistent with the ability of the public to gain access to the licensee, a license shall be issued.

(e) Each licensee shall display the license so that it is easily observable by the general public. The address and name on the license must be the same as the address of the place of business and name of licensee where the license is on display.]

SUBCHAPTER 11. ASSIGNMENT OF SECONDARY MORTGAGE LOANS

3:18-11.1 Definitions

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

"Applicant" means an applicant to become registered, or a licensee seeking to register a person, to receive the assignment, sale or transfer of secondary mortgage loans from a licensee.

"Banking institution" means a New Jersey chartered bank, a New Jersey chartered savings bank, a New Jersey chartered savings and loan association, a national banking association having its principal office in this State or a Federal association having its principal office in this State.

"Biennial period" means a two-year period beginning on January 1 of each odd-numbered year and ending on December 31 of the succeeding even-numbered year.

"Registrant" means a person that is registered under this subchapter to receive the assignment, sale or transfer of secondary mortgage loans from a licensee.

"Servicing rights" includes the right to receive payments directly from borrowers and to administer secondary mortgage loan accounts.

3:18-11.2 Restraints on assignments

(a) A licensee shall not assign, sell or transfer a secondary mortgage loan to a person other than the following:

1. A banking institution;

2. A person licensed under the Act;

3. The Federal National Mortgage Association;

4. The Federal Home Loan Mortgage Corporation; or

5. Any other person located outside New Jersey that is registered with the Department to acquire secondary mortgage loans.

(b) A licensee shall not assign, sell or transfer the servicing rights of a secondary mortgage loan to a registrant unless that registrant is specifically registered with the Department to acquire servicing rights.

3:18-11.3 Procedure for registration

(a) To register to acquire secondary mortgage loans from a licensee without servicing rights, an applicant shall submit the following to the Department:

1. A registration form requiring basic information about the proposed registrant, such as its name and address;

2. A statement that the person acquiring the loans irrevocably submits itself to the jurisdiction of the Department for any administrative action brought by the Department in connection with any secondary mortgage loan secured by New Jersey real property which it purchases from a licensee under the Act;

3. A statement that the person acquiring the loans, and its successors and assigns, irrevocably designates the Commissioner as its registered agent to receive service of process in an administrative action brought by the Department regarding any matter to which jurisdiction has been submitted pursuant to (a)2 above;

4. A statement that the person acquiring the loans agrees not to obtain the servicing rights of any secondary mortgage loan from a licensee without first having been registered to receive servicing rights; and

5. The required registration fee.

(b) To register to acquire secondary mortgage loans from a licensee with servicing rights, or to acquire servicing rights separately, an applicant shall submit, in addition to the items set forth in (a)1, 2 and 3 above, the following to the Department:

1. In the case of a chartered or licensed financial institution, a certificate of good standing executed by the institution's primary regulator;

2. In the case of an applicant other than a chartered or licensed financial institution, the following items;

i. A statement detailing the applicant's experience in dealing in transactions of the type for which approval is sought, including brief resumes of key personnel;

ii. Copies of balance sheets and earnings records for the last three calendar or fiscal years; and

iii. A copy of the person's latest Annual Report to Shareholders; and

3. The required registration fee.

(c) Any person that received provisional approval from the Department to acquire secondary mortgage loans prior to adoption of this subchapter must file a registration form with the Department before the beginning of the next biennial period. All such provisional approvals shall expire on December 31, 1992.

3:18-11.4 Review of registration filings

(a) The Commissioner shall file the registration within 60 days of its receipt by the Department. The registration shall become effective when the applicant receives notification of the filing of the registration from the Department.

(b) The Commissioner may refuse to register, revoke a registration or suspend a registration for any of the reasons set forth in N.J.S.A. 17:11A-39.1. An opportunity for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and N.J.S.A. 52:14F-1 et seq., and the Uniform Administrative Rules of Practice, N.J.A.C. 1:1, shall be provided prior to such refusal to register, revocation or suspension.

3:18-11.5 Renewal of registration

(a) Registration shall be effective for the remainder of the biennial period.

(b) To renew a registration, an applicant for renewal shall file the following with the Department:

1. A renewal registration form requiring basic information about the registrant, such as its name and address;

2. A statement that the applicant agrees not to obtain the servicing rights of any secondary mortgage loan from a licensee without first having been registered to receive servicing rights;

3. In the case of a person other than a chartered or licensed financial institution for which registration is sought to receive servicing rights, copies of balance sheets and earnings records for the last two calendar or fiscal years;

4. In the case of a chartered or licensed financial institution for which registration is sought to receive servicing rights, a certificate of good standing executed by the institution's primary regulator; and

5. The required registration fee.

3:18-11.6 Registration fees

(a) The Department shall charge the following biennial fees to register or renew a registration pursuant to this subchapter:

1. The filing of a registration to receive secondary mortgage loans without servicing rights..... $100.00

2. The filing of a registration by a chartered or licensed financial institution to receive secondary mortgage loans with servicing rights..... $100.00

3. The filing of a registration to receive secondary mortgage loans with servicing rights by other than a chartered or licensed financial institution..... $300.00

(b) When the initial registration is issued in the second year of the biennial period, the registration fee shall be an amount equal to one-half of the registration fee set forth in (a) above.

(c) The Department may charge an additional per diem examination charge pursuant to N.J.A.C. 3:1-6.6 to review a registration when the registration materials require additional review.

COMMUNITY AFFAIRS

(a)

DIVISION OF LOCAL GOVERNMENT SERVICES

Tax Collection Procedures
Unbudgeted School Aid
Proposed Repeal: N.J.A.C. 5:30-8.2
Proposed Amendments: N.J.A.C. 5:33-1.2 and 1.3
Proposed New Rules: N.J.A.C. 5:33-1.5, 1.6, 1.7 and 1.8

Authorized By: Local Finance Board, Joseph Iannaconi, Jr., Vice-Chairman.

Authority: N.J.S.A. 52:27BB-32.

Proposal Number: PRN 1992-368.

Submit comments by September 16, 1992 to:

Marc Pfeiffer, Manager
Office of Administration and Local Government Research
Division of Local Government Services
CN 803
Trenton, New Jersey 08625-0803

The agency proposal follows:

Summary

This proposal addresses several matters related to practices of municipal tax collectors in regard to tax billing and receipting. The proposal stems from P.L. 1990, c.69 (N.J.S.A. 17:16F-5 et seq.), a law relating to the regulation of mortgage escrow account transactions. Several minor technical changes to existing rules are also proposed.

N.J.A.C. 5:33-1.2 is amended to make technical corrections to a statutory citation and to delete the definitions at this section and recodify them in a new, discreet section N.J.A.C. 5:33-1.5. At N.J.A.C. 5:33-1.3 language has been changed to make clear a standard form is to be used.

New rules N.J.A.C. 5:33-1.5 through 1.8 are proposed to establish formal procedures regarding tax bill processing, payment of property taxes, payment of taxes paid through escrow accounts, and to provide a means to inform the public and industry about tax collection practices.

The proposed new rules establish formal procedures regarding use of the original and replacement property tax bills to accommodate payments by individual taxpayers and payments through mortgage escrow account and property tax servicing organizations. The procedures allow payment to be made on bills prepared by mortgage industry tax processors, as long as they meet specified technical requirements as to size and content. Tax collectors will be required to accept payment for taxes by the presentation of a proper "stub," and cannot require the presentation of a full tax bill.

The proposed new rules establish criteria when individually printed replacement tax bills may be used by a tax processing organization. The criteria provide maximum flexibility for local tax collectors to permit consideration of local needs and conditions.

As part of the rules, the Division of Local Government Services is required to annually publish information about individual municipal tax office procedures in the New Jersey Register. This is to assist the public and industry in their transactions with tax collectors.

In order to maintain only currently applicable rules in the Code, the Board is also repealing, through this proposal, N.J.A.C. 5:30-8.2, concerning 1977 unbudgeted school aid, as it is obsolete.

Social Impact

Adoption of the proposed amendments and new rules should standardize and speed up the administration of tax payments and make it easier for those making payments under current industry practices. The impact on the public and industry is negligible, as most of the burden will be on tax collectors, and many collectors already meet the standards and practices in the rules. Those who will have to change their systems

to meet provisions of the rules will also find improvements in their operations as a result of the changes. The amendments and rules have been reviewed by industry and tax collectors organizations and they have concurred with its content.

Economic Impact

The proposed amendments and new rules should have a positive economic impact on institutions regulated by the Division. In particular, administrative improvements in use of replacement bills will offset any initial outlays for new forms and procedures. The initial outlay is of undeterminable cost and will be incurred by banks, savings and loan associations, and organizations servicing mortgage escrow accounts. There will be minimal cost to local government, as these changes in documentation and tax office procedures are also improvements.

Regulatory Flexibility Analysis

Most of the institutions affected by these proposed rules are small businesses, as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed rules take small servicers into account by providing options on how information can be reported. The rules also permit large companies to take advantage of sophisticated automation capabilities to meet the same goals. Thus the rules meet the requirements for less expensive administrative procedures for small businesses by providing compliance options in these rules.

Full text of the proposed repeal may be found in the New Jersey Administrative Code in N.J.A.C. 5:30-8.2.

Full text of the proposal follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]):

5:33-1.1 Bank collection of tax payments

(a) Any municipality adopting a resolution to contract for services in connection with [this Act] **N.J.S.A. 54:4-122.9** shall, prior to awarding the contract, receive approval of the Director of the Division of Local Government Services of the contract. Such contract shall include detailed procedures to be used in implementing procedures to receive and deposit funds, forwarding of back-up materials to the collector, holding of funds, audit trails and all other information required for evaluation of the proposed system.

(b) (No change.)

(c) Any municipality which has contracted with a bank, savings bank or trust company under [this Act] **N.J.S.A. 54:4-122.9** shall notify all taxpayers at least once annually that such a service has been contracted. Notification must be made by mail to all taxpayers at least 30 days prior to the next payment due, payable and subject to possible receipt by such bank, savings bank or trust company agent, following the designation of such agent.

[(d) The following words, when used in this subchapter, have the following meaning.

"Current" payment means any payment which is not yet due and payable, or any payment which became due and payable within the tenth calendar day prior to its receipt, provided that the municipality has adopted a resolution allowing "that no interest shall be charged if payment of any installment is made within the tenth calendar day following the date upon which the same became payable" in accordance with provisions of N.J.S.A. 54:4-67.

"Delinquent" payment means any payment which is not current (as defined above), plus any payments for accounts on which a municipality held Tax Title Lien exists.]

5:33-1.3 Form of tax collection record

[Use of this form of tax collection record] **Tax collectors shall use a standard from** for posting preliminary and final taxes [is required by municipal taxing districts in the State of New Jersey.] Sample copies can be obtained from:

Division of Local Government Services
Department of Community Affairs
CN 803
Trenton, NJ 08625

5:33-1.5 Definitions

The words and terms used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.

"Current" payment means any payment which is not yet due and payable, or any payment which became due and payable within the tenth calendar day prior to its receipt, provided that the municipality has adopted a resolution allowing "that no interest shall be charged if payment of any installment is made within the tenth calendar day following the date upon which the same became payable" in accordance with provisions of N.J.S.A. 54:4-67.

"Delinquent" payment means any payment which is not current (as defined above), plus any payments for accounts on which a Tax Title Lien exists.

"Property identification information" means the information necessary to identify a specific parcel of land and includes the following elements: name of municipality, county, block number, lot number, qualification code, property address or location, name and mailing address of the property owner.

"Replacement bill" shall mean a property tax bill made or generated by a mortgagee, servicing organization, or tax processing organization to serve as a replacement to an original tax bill and used in accordance with this subchapter.

"Tax bill" shall mean the original form issued by the tax collector with the appropriate itemization and payment information for local property taxes as required by N.J.S.A. 54:4-64, 65 and 66. It shall include the information section itemizing the taxes due, and payment stubs containing property identification information and amount due for each of the quarters.

"Tax collector" shall mean the properly designated tax collector of the taxing district in which the mortgagor's property is located.

5:33-1.6 Payment of property tax bills

(a) Payment of property tax bills shall be made by presenting the stub from either an original or duplicate tax bill, or through the use of a replacement bill as described in N.J.A.C. 5:33-1.7. The original or duplicate tax bill itself does not need to be presented for payment when a payment stub showing the required information is used.

(b) When a receipt for payment sent through the mail is requested, the payor must provide the bill, stub, and a self-addressed stamped envelope for the return of the receipt.

(c) Notwithstanding any provision herein to the contrary, at the option of the local tax collector, computer printouts or other electronically generated data formats containing property identification and payment amounts will be accepted for processing in lieu of individual tax bills. Notice to the public of tax collector options shall be provided pursuant to N.J.A.C. 5:33-1.8.

5:33-1.7 Use of replacement bills

(a) Replacement bills must contain property identification information, the amount of tax due, and indication of which quarterly installment is being paid for each parcel. It may be an individually printed bill with a stub, a printed listing of many bills, or many bills transferred via magnetic media or transmitted through electronic means. If printed individually, it must contain a stub that is at least six square inches in size and include the information detailed above.

(b) Individually printed replacement tax bills may be used under the following conditions:

1. For the first payment on the tax bill if the tax collector is unable to, or fails to, issue or mail an original or duplicate tax bill 15 calendar days prior to the statutory due date for that payment, or a later date set by the governing body at which time the full interest penalty for late payments shall begin to accrue, whichever is later;

2. For other quarters if a formal request for a duplicate or original tax bill is not fulfilled within 15 calendar days from the time the tax collector receives the request; or

3. For other quarters when specifically permitted by the tax collector.

(c) The tax collector may permit non-individually printed replacement bills to be used for payment periods other than the first payment period. Such determination shall be made solely by the tax collector and shall be published annually by the Director as provided in N.J.A.C. 5:33-1.8.

(d) When a payment is made with a replacement bill, if not previously forwarded, the tax collector shall forward the original

bill or a duplicate tax bill, without charge, when the original tax bill was not properly issued by the tax collector. The tax collector shall send the original or duplicate tax bill, as the case may be, to the payor so the subsequent tax payments can be paid in a timely manner.

5:33-1.8 Annual publication of municipal practices

(a) Each year the Director shall survey each tax collector and, prior to June 14, publish, as a public notice in the New Jersey Register, a listing of the following tax collection practices for each municipality:

1. Duplicate bill fee;

2. Acceptable format(s) of replacement bills;

3. Use of printouts or electronic media for tax payment information;

4. Payment quarters when replacement bills may be used; and

5. Office and facsimile machine telephone numbers.

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

ENVIRONMENTAL REGULATION

Ninety-Day Construction Permits
Freshwater Wetlands Protection Act Rules
Coastal Permit Program Rules
Fees

Proposed Amendments: N.J.A.C. 7:1C-1.5, 1.6 and 1.7; 7:7-1.7; and 7:7A-16.1

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1D-9, 13:1D-29 et seq., specifically 13:1D-33, 13:9B-1 et seq., specifically 13:9B-9 and 13:9B-17, and 13:18A-1 et seq.

DEPE Docket Number: 22-92-06.

Proposal Number: PRN 1992-279.

A **public hearing** concerning this proposal will be held on Wednesday, September 2, 1992 at 9:30 A.M. at:

New Jersey Department of Environmental Protection and Energy
First Floor Hearing Room
401 East State Street
Trenton, New Jersey 08625

Submit written comments by September 16, 1992 to:

Samuel A. Wolfe, Esq.
Administrative Practice Officer
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Environmental Protection and Energy (Department) is proposing amendments to N.J.A.C. 7:1C-1.5 governing fees for the filing and review of applications for construction permits pursuant to the Waterfront Development Act, N.J.S.A. 12:5-3, the Wetlands Act of 1970, N.J.S.A. 13:9A-1 et seq., the Coastal Area Facility Review Act (CAFRA), N.J.S.A. 13:19-1 et seq., and the Flood Hazard Area Control Act, N.J.S.A. 58:16A-50 et seq., (for Stream Encroachment Permits). N.J.S.A. 13:1D-33 requires that the proceeds of these fees be deposited in an "Environmental Services Fund," and provides that the Department is to receive annual appropriations from that fund sufficient to defray in full the costs incurred in the processing and review of applications for such construction permits.

However, the revenues collected under the existing fee schedule set forth in N.J.A.C. 7:1C-1.5 are insufficient to support that appropriation. During fiscal year 1990-1991, CAFRA permit fees accounted for only 12 percent of program costs, waterfront development permit fees for 40 percent of program costs, coastal wetlands permit fees for 20 percent of program costs, and stream encroachment program fees for 75 percent of program costs. These programs have been supported, in part, by other funding sources.

The three major sources of additional funding are: the Federal Coastal Zone Management Grant (CZM), State appropriations, and fines and penalties collected under the Flood Hazard Area Control Act. The CZM grant requires the State of New Jersey to have a regulatory program associated with coastal zone management. Three of the 90-day permit programs (Waterfront Development, CAFRA, and Coastal Wetlands) make up New Jersey's coastal management program. For this reason only these programs are eligible for Federal coastal zone management funds. Of the $2 million awarded to the State of New Jersey, more than 50 percent or $1,134,000 was used to help offset the costs associated with these three fee programs. The remaining Federal funds were used for administration of planning grants to municipalities for public access plans, and contracts awarded to outside vendors for monitoring of beach erosion and development of management practices for control of stormwater runoff.

The fee programs also received $556,000 in funding from Direct State Service (DSS) or State appropriations. This appropriation will likely be reduced as the State budget process is requiring the fee programs support their own costs. A number of the positions currently funded from this appropriation will most likely have to be funded directly from fee accounts in the future.

Fines and penalties from the Flood Hazard Area Control Act (Stream Encroachment Program) are deposited into the fee account. These funds are used to supplement permit revenue.

Even with supplements from these additional funding sources, permit revenues do not cover the program costs.

Because the fee revenues no longer cover the Department's costs of processing construction permit applications, the Department is proposing amendments to N.J.A.C. 7:1C-1.5, to increase the fees for the filing and review of construction permit applications provided therein, The Department expects that these increased fees will generate revenues sufficient to fund the cost of these processing and review activities. In establishing the specific fees in a manner which satisfies the statutory requirement that the fees be reasonable, the Department's intent is to have the specific fee bear a reasonable relationship to the overall construction project costs. If a project requires more than one permit, and the permit applications are submitted and processed simultaneously, the permit fee will be equal to the sum of the following: the single highest permit fee for the Land Use Regulation permits required and 75 percent of the sum of the permit fees for all other permits required for the project, because the separate permit applications will be reviewed simultaneously and will reduce review costs. This proposal would also amend the Coastal Permit Program Rules at N.J.A.C. 7:7-1.7 and the Freshwater Wetlands Protection Act Rules at N.J.A.C. 7:7A-16.1 to be consistent with this provision.

The Department is also proposing a new N.J.A.C. 7:1C-1.5(i), which provides for an annual review and adjustment of the fees set forth in N.J.A.C. 7:1C-1.5 (other than treatment works approval fees, for which the rules already provide an annual adjustment procedure). The Department will revise these fees each year, based upon projected changes in the Department's total costs in performing activities for which fees are charged, and projected changes in the volume of those activities. The proposed amendment provides the Commissioner with the ability to implement the annual revision through the publication of an annual report. The report will set forth any revised fees, and describe the changes in the Department's costs and in the volume of its activities upon which the revisions will be based.

Several factors may increase or decrease the Department's projected costs, such as changes in the time the Department requires to perform activities, changes in the average level of compensation of Department employees working in the 90 day construction permit programs, and changes in the amount of funding available from sources other than these fees. In projecting the volume of its activities, the Department will consider several factors. The most important factor will be the volume experienced in previous years. The projected volume also will reflect economic trends such as increasing or decreasing construction activity.

Under the proposed amendments, the fees within each 90-day permit program will increase or decrease by the same percentage. The purpose of this method is to maintain the relative proportions of the fees established in the proposed new rule. As discussed above, these fees

are intended to bear a reasonable relationship to the overall construction costs of a project; the Department believes that maintaining a constant proportion among the fees will preserve that result.

Under the proposed amendment, the Department will adjust the fees through the following method:

1. Project the total amount of money required to fund each 90-day permit program in the coming year;
2. Subtract the total amount projected to be available from non-fee sources, such as appropriations or Federal Grants;
3. The remainder is the fee revenue necessary for the coming year;
4. Divide the fee revenue necessary for the coming year by the fee revenue which was necessary for the current year. The result is a fee factor which is unadjusted to reflect the expected volume of permit applications;
5. Divide the volume of permit applications the Department received in the current year by the volume it expects to receive in the coming year. Multiply this result by the unadjusted fee factor described in 4 above. This result is the fee adjustment factor; and
6. Multiply every fee for the permit program by the fee adjustment factor.

An example of this adjustment calculation follows:

Assume that the total cost of the waterfront development permit program is $10,000 this year, and will increase to $11,000 in the coming year; that the Department receives Federal grants and appropriations of $5,000 this year, but that this amount will be cut to $3,500 in the coming year; and that the Department received seven waterfront development permit applications this year, and expects to receive 10 applications in the coming year.

Applying these assumptions, the fee revenue necessary for the coming year is:

$$\$11,000 - \$3,500 = \$7,500.$$

The fee revenue necessary for the current year was:

$$\$10,000 - \$5,000 = \$5,000$$

Dividing these two figures (Step 4 in the above description) provides an unadjusted fee factor of:

$$\frac{\$7,500}{\$5,000} = 1.5$$

Divide the volume of permit applications received this year by the projected volume for the coming year:

$$\frac{7}{10} = .7$$

Multiply this number by the unadjusted fee factor:

$$.7 \times 1.5 = 1.05$$

Therefore, all waterfront development permit fees for the current year would be adjusted for the coming year by multiplying them by 1.05.

The proposed amendments also provide that the Department will not perform this annual adjustment in any calendar year in which it promulgates amendments to these fee rules. Publishing the annual report and performing this fee adjustment would be redundant, because in promulgating amendments the Department would consider the same factors reflected in this adjustment.

As discussed in the Economic Impact statement below, while the higher fees on the fee schedule are associated with activities requiring greater amounts of Department staff time, the fees are not directly proportional to the time required. To avoid the possibility that a fee for a particular application could significantly exceed the Department's costs, the Department is proposing a procedure for an applicant to obtain a partial rebate of a fee submitted as part of a Waterfront Development, CAFRA, or Coastal Wetlands application. Under proposed N.J.A.C. 7:1C-1.5(k), an applicant could request a partial rebate for fees greater than $7,000; if the Department's timekeeping records show that the fee exceeds its actual costs incurred in connection with a permit by more than 25 percent and by more than $2,000, the applicant would receive a rebate in the amount of the difference between the assessed fee and the Department's costs.

As a result of these requirements, only those applicants whose fees materially exceed the Department's permit processing costs will be eligible for partial rebates. The eligibility requirements limit the Department's costs of processing rebate requests by simplifying and streamlining the processing of rebate requests; without the eligibility requirements, the Department's costs in processing rebate requests would be likely to outweigh any benefit resulting from the availability of the rebate. The Department would need to defray the cost of processing rebate requests through either increased fees or other sources of funding, but believes that the eligibility requirements will ensure that the rebate procedure does not result in significant additional costs.

The exact eligibility requirements are based upon the Department's projections of its costs to process rebate requests. If the Department's experience in implementing the fee rebate provision establish that its costs are materially different from what it has projected, the eligibility criteria will be amended.

N.J.A.C. 7:1C-1.5(l) establishes the time for filing a request for a fee rebate. The applicant must file the request within 20 days after the final disposition of a permit decision, whether that disposition is through a decision on appeal or through the expiration of the time allotted to file an appeal. The amendment provides that the applicant cannot request a rebate before that final disposition, because until that time the Department cannot determine whether its total cost will be less than the fee.

The rebate provision replaces an existing provision of N.J.A.C. 7:1C-1.5(a)1, which provides a maximum fee of $10,000 for waterfront development permits, except for unusually large-scale or complex projects. The premise underlying the $10,000 maximum was that once a project reached a certain size, further increases in its size would not materially increase the Department's cost in processing the permit. However, the Department's experience in processing Waterfront Development permit applications has shown that this is not the case. While increases in the construction cost of a large project may not always lead to a directly proportional increase in the Department's review costs, these costs generally do continue to increase, since the projects often include more land and have more potential environmental and other impacts. Nonetheless, the new rebate provision described above will continue to ensure that fees do not materially exceed the Department's costs.

The Department is also proposing amendments to N.J.A.C. 7:1C-1.7. The proposed change in N.J.A.C. 7:1C-1.7 clarifies the procedural requirements for projects that are also regulated under the New Jersey Pinelands Protection Act. As proposed, any application subject to these rules for development in the Pinelands Area would not be deemed complete for filing unless the applicant has in his or her possession a certificate of filing from the Pinelands Commission.

Social Impact

The increase in fees under the proposed amendments will have a positive social impact. The Department expects that the proposed increases will generate sufficient revenue to enable the Department to maintain staffing levels. As a result, the Department will be able to preserve its ability to process and review applications for construction permits in a timely manner.

The Department expects that the provision for annual review of its fees under the proposed amendments will have a positive social impact because the annual review of the 90 day construction permit programs' fees should increase the accountability of all levels of the Department's management for efficiency in the performance of the activities for which these fees are assessed.

The Department expects that the provision for a partial rebate of a fee under the proposed amendments will have a positive social impact. This provision will help avoid unfair fee assessments and provide a rebate in those cases where the fee materially exceeds the Department's permit processing costs.

Economic Impact

The Department expects that the proposed fee increases will result in an increase for construction permits for the first year in which the fees are charged. Specifically, based upon the Department's analysis of permit activities during the fiscal year ending June 30, 1991, the Department expects that the proposed fee increases will generate an additional $290,000 attributable to the CAFRA program (for total revenues of $365,000), $250,000 attributable to the Waterfront Development program (for total revenues of $900,000), $7,600 attributable to the Coastal Wetlands program (for total revenues of $12,100), and $330,000 attributable to the Stream Encroachment program (for total permit revenue of $1,550,000). The proposed fees will cover a larger portion of the Department's costs in performing the activities for which fees are charged under N.J.A.C. 7:1C-1.5, but will not cover all such costs.

The only significant change with the Waterfront Development fees occurred in 1981 when the fee rate was changed from one-half of one percent of the construction cost to one percent of the construction cost. The fees for CAFRA and Wetlands have remained essentially the same since the programs' inception in the early 1970's. The CAFRA fees were adjusted once in 1981 when the base fee for residential facilities was

increased from $1,000 to $1,500. The wetlands permit fees have remained the same for the last two decades.

The Waterfront Development, CAFRA and Coastal Wetlands proposed fee increases will not be sufficient to cover the program costs. These programs will still need to rely upon outside funding sources to support their activities to reduce the permit fee for small scale residential projects. The Department expects that the revenues from increased fees will cover the costs associated with the Stream Encroachment program.

In determining the fee increases under the proposed amendments, the Department analyzed its time-keeping records and permitting data for the fiscal year ending June 30, 1991 to determine the total cost of processing and reviewing permit applications for each of the construction permit programs. For each program, the Department compared this total cost against the total revenues actually collected from fees charged during that fiscal year, and the funds collected from other sources, to determine the amount by which total costs exceeded total revenues. This excess represents the amount of additional revenue needed to be collected from fees under each program.

To calculate the specific fee increases under each program, the Department apportioned the necessary additional revenue among the activities within each program for which fees are charged under N.J.A.C. 7:1C-1.5, based upon several factors. These factors included:

i. The estimated portion of staff time spent in performing each type of activity during the fiscal year ending June 30, 1990;

ii. The amount which would not be a disproportionately large portion of the total construction cost of a project;

iii. The amount of revenues which the increased fees would be expected to generate, based upon the number and types of applications which the Department received during the fiscal year ending June 30, 1990; and

iv. The amount of funds which the Department expects to receive from other sources which can be applied to defray the costs of reviewing and issuing permits.

By applying this method of analysis, the Department determined the amount of each proposed fee. While the higher fees on the fee schedule are associated with activities requiring greater amounts of Department staff time, the fees are not directly proportional to the time required. As discussed in the Summary above, to avoid the possibility that a fee for a particular application could significantly exceed the Department's costs, the Department is proposing a procedure for an applicant to obtain a partial rebate of a fee. The Department believes this provision will have a positive economic impact for those applicants eligible for a rebate, although the exact benefit cannot be determined as it will depend on the circumstances of each particular application. There is no fee assessed by the Department on a person requesting a rebate, and essentially no cost aside from the nominal cost of making the request; therefore, there will be no negative economic impact on those persons seeking a rebate.

The proposed minimum fees for various projects in all four of the programs are closer to the actual costs for the Department to process the smaller projects within each program than the existing fees. While this method was also used to calculate a minimum fee for larger projects, the fees for larger projects are assessed for their additional review needs based upon either a percentage of the construction cost or the number of review elements, that is, dwelling units, acreage, or other specified items tied directly to the project.

The economic impact of the procedure for annual review of the Department's fees will depend upon the results of each year's review. Various factors may increase or decrease the fees including, but not limited to, changes in the time the Department requires to perform activities, changes in the average level of compensation of Department employees working in the 90 day construction permit programs and availability of funding from other sources. As a result, the Department cannot determine the economic impact of this portion of the proposed amendments at this time. However, as discussed in the Summary above, the Department believes that the adjustment method will prevent a fee for a given construction project from becoming disproportionate to the construction cost of the project.

The change in application requirements at N.J.A.C. 7:1C-1.7 sets forth the coordination procedure for the review of a project which requires approvals from both the Department and the Pinelands Commission. This procedure will bring these two separate review processes together by ensuring that the reviews will commence within a relatively short time of each other, thus reducing review time. A concurrent review will also facilitate a more coordinated review between the two agencies and thus enhancing efficiency and consistency.

Environmental Impact

The proposed amendments reflect the Department's intention to manage these permit programs as effectively and efficiently as possible. Under the proposed amendments, the Department will be able to retain the level of staff support necessary to administer these permit programs in a judicious and timely fashion. These programs steer developments away from naturally hazardous and sensitive areas, protect estuarine and marine environments from adverse impacts, and promote resource conservation and designs sensitive to the environment. Thus, to the extent that fees collected and permits reviewed pursuant to these amendments improve the efficiency and maintain the capabilities of the Department, the environment will benefit.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has determined that these proposed amendments will not impose additional reporting, recordkeeping or other technical compliance requirements on small businesses, nor will compliance result in additional capital costs. However, the proposed amendments would apply to all applicants for a coastal construction permit or stream encroachment permit. The Department estimates that of the approximately 3,000 applicants affected by the amendments, 2,400 are likely to fall within the "small businesses" category as defined in the New Jersey Regulatory Flexibility Act and will continue to be affected. Most applicants will have to submit a higher application fee in order to comply with these amendments.

The application fees are necessary to support the processing and review of construction permits. In an attempt to balance the need to protect the environment against the economic impact, the Department has determined that to charge reasonable fees for the filing and review of construction permit applications while minimizing the impact of the rule based upon the size of the businesses affected (rather than permit processing and review costs and overall project costs) would not provide sufficient revenue to administer these programs and would, therefore, endanger the environment, public health and public safety. Thus, no exception from coverage is provided.

While large businesses may avail themselves of the rebate provision more frequently, it is available to any small business who meets the eligibility requirements. The applicant seeking a fee rebate will incur no additional charge or application fee, aside from a letter requesting a review of the fee charged.

Moreover, the change in the application requirements makes no substantive change, but rather clarifies the application of the Pinelands Protection Act. Therefore, the changes impose no discernible increase in the compliance requirements imposed on small businesses.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:1C-1.5 Fees

(a) Fees shall be charged for the review of any application for a construction permit in accordance with the following schedule:

1. Waterfront development **permits**:

i. The fee for any work **requiring a General Permit or** consisting solely of capital repairs or reconstruction with all work taking place above the mean high water elevation on piles or other support structures or taking place landward of the mean high water line or the identical structural replacement of piles or other supports in the same location shall be $250.00. **Regulated activities eligible for a General Permit include, but are not limited to, the following: minor reconstruction or maintenance of currently serviceable legal existing structures in all navigable waters, minor construction of new bulkheads in man-made tidal lagoons and minor maintenance dredging in man-made tidal lagoons.**

[ii. The fee for any work taking place landward of the mean high water line and qualifying as a CAFRA facility as defined in N.J.A.C. 7:7-2.1 shall be set forth as in (a)3 below.]

[iii.]**ii.** The **permit** fee for any [work] **waterfront development** taking place landward of the mean high water line and not qualifying as a CAFRA facility, **based on size and use,** as defined in N.J.A.C. 7:7-2.1 shall be [$250.00] **as follows:**

(1) The fee for Residential Facilities shall be $500.00 for the first [four] residential dwelling [units] **unit** plus [$50.00] **$125.00** for each additional dwelling unit[, and shall be $500.00];

(2) The fee for Non-Residential Facilities shall be $700.00 plus **one**-half of one percent of the **non-residential** construction cost, up to a maximum of [$1500 for all Non-Residential developments] **$4,000; and**

(3) The fee for mixed Residential and Non-Residential Facilities shall be the sum of the Residential and Non-Residential Facilities fees as calculated under (a)1ii(1) and (2) above.

[iv. For] **iii. The permit fee for** all other waterfront [development projects with work] **developments** taking place waterward of the mean high water line [the fee] shall be [one percent of the construction cost, or a minimum of $100.00. The maximum fee charged pursuant to this subsection shall be $10,000, except for unusually large scale or complex projects where the Division of Coastal Resources determines, after consultation with the applicant, that additional fees are necessary for a proper review of the application.] **as follows:**

(1) The permit fee for residential site improvements, including without limitation: shore stabilization structures (bulkheads, riprap) piers and docks, walkways, boat ramps, mooring piles, and other water related structures and activities associated with a private residential unit or duplex, shall be $250.00 plus one-half of one percent of the construction cost above $10,000.

(2) The permit fee for all other activities requiring a waterfront development permit shall be based on the following schedule:

Construction Costs	Fees
$0 to $50,000	**$1,450 V ½ of one percent of construction costs**
$50,001 to $100,000	**$1,700 + one percent of construction costs above $50,000**
$100,001 to $200,000	**$2,200 + 1¼ percent of construction costs above $100,000**
$200,001 to $350,000	**$3,450 + 1½ percent of construction costs above $200,000**
greater than $350,000	**$5,700 + one percent of construction costs above $350,000**

2. Wetlands permits: [i.] The fee for a Type A **or Type B** permit (N.J.A.C. 7:7-2.2) shall be [one half of] one percent of the construction costs, or a minimum of [$100.00] **$500.00**.

[ii. The fee for a Type B permit (N.J.A.C. 7:7-2.2) shall be one half of one percent of the construction cost, or a minimum of three hundred dollars $300.00.]

3. CAFRA permits:

i. The fee for Residential Facilities shall be [$1000.00] **$3,000** plus [$10.00]:

(1) $50.00 per dwelling unit **for the first 300 units;**

(2) $40.00 per dwelling unit for units 301 to 600; and

(3) $30.00 per dwelling unit for all units in excess of 600.

ii. The fee for Non-Residential [and Mixed-Use facilities] **Facilities** shall be [$1,500.00] **$3,500** plus [$10.00] **$500.00** per acre [to be developed] **included in the site plan.**

iii. The fee for mixed Residential and Non-Residential Facilities shall be $3,500 plus $500.00 per acre included in the site plan plus a per unit fee calculated in accordance with (a)3i above.

4. Stream encroachment **permits**:

i. As used in this paragraph, the following terms shall have the following meanings:

(1)-(2) (No change.)

(3) "Major stream encroachment project" means a project that requires hydrologic and/or hydraulic review to determine the impact on flood carrying capacity of the stream or review of stormwater detention basin(s) for compliance with Stormwater Management Regulations, [(]N.J.A.C. 7:8[)], or involves fill or structures necessitating review for compliance with **the** 20 percent "net fill" limitation specified in N.J.A.C. 7:13[-4.7(d)]. In addition, developments involving more than one acre in **a** flood plain for commercial use and [subdivision of] **developments or subdivisions involving** more than [ten] **10** acres [for residential development] shall also be classified as major projects.

ii. For **each project element of** minor stream encroachment projects, the fee shall be [$150.00] **$300.00 for each project element that is to be reviewed,** except that no fee shall be charged for such projects in a drainage area of less than 320 acres which has been approved by the appropriate municipal or county engineer, or a professional engineer for State agency projects, and the certification of such approval has been submitted to and acknowledged by the Department. [An additional $200.00 shall be charged for minor stream encroachment projects of special concern (see N.J.A.C. 7:13-5.2.).] **Each individual stream encroachment shall constitute a project element.**

iii. (No change.)

iv. For each project element of major projects, the fee shall be [$1,500] **$2,000** for each project element that is to be reviewed. These project elements shall include, but not be limited to, the following: bridges, culverts, small dams, channel [modification] **modifications**, stream enclosures, stormwater detention basins, fill, structures[,] and retaining walls more than four feet high, channel realignment[,] and channel relocation. The fee for major **stream encroachment** projects [such as culverts or bridges] shall include channel work for a distance of 300 feet upstream and downstream **except as provided below at (a)4vi.**

v. For major **stream encroachment** projects outside the channel but within the 100 year flood plain and requiring the establishment of an encroachment line, the fee shall be [$1,500] **$2,000** for each 1,000 [feet]-**foot** reach of the channel or portion thereof.

vi. For major **stream encroachment** projects that consist of **an** individual driveway [culverts] **culvert or fill** for [residential dwellings] **one single family residence**, the fee shall be $1,000 for [each project] **the culvert and $400.00 for the fill.**

vii. [No] **Except as provided at (a)4vi above, an** additional fee shall **not** be charged for projects involving [fill associated with the development of a single family residential lot or for] fill associated with bridges and culverts.

5. (No change.)

(b) (No change.)

[(c) Each request for a approval of a major modification of the approved project must be accompanied with a fee equal to one half of the total permit fee attributable to that portion of the project to be modified subject to a minimum fee of $100.00. For the purposes of this section, a major modification is one which will result in a significant change in scale, use, design or impact of the project as approved.]

(c) The Department shall assess a single permit fee for a project which requires more than one of the following permits, if the permit applications are submitted and processed simultaneously: CAFRA permits; waterfront development permits; coastal wetlands permits; stream encroachment permits; or freshwater wetlands permits (including individual permits, general permits, and transition area waivers) issued under N.J.A.C. 7:7A. The permit fee for the project is equal to the sum of the following:

1. The single highest permit fee for the above listed permits required for the project; and

2. Seventy-five percent of the sum of the permit fees for all other permits required for the project.

(d) For the purposes of this section, a major modification is one which will result in a significant change in the scale, use, design or impact of the project as approved. A minor modification is one which will not result in a significant change in the scale, use, design or impact of the project as approved.

1. The fee for a request for an approval of a major modification of the approved project shall be the greater of;

i. One-half of the total permit fee attributable to that portion of the approved project to be modified; or

ii. One-quarter of the total permit fee attributable to the entire approved project.

2. The fee for a request for an approval of a minor modification of a CAFRA project or a waterfront development project qualifying as a CAFRA facility based on size and use as defined in N.J.A.C. 7:7-2.1 shall be $200.00 and shall be $75.00 for all other waterfront development, coastal wetlands and stream encroachment projects.

Recodify existing (d)-(f) as (e)-(g) (No change in text.)

(h) The Department shall annually adjust the fees for each activity provided in this section for waterfront development permits, coastal wetlands permits, CAFRA permits and stream encroachment permits. For each such permit program, the Department shall calculate a fee adjustment factor annually, and multiply each fee within that program by that fee adjustment factor. The Department shall calculate the fee adjustment factor by taking the following steps:

1. Project the total amount of money required to fund each 90-day permit program in the coming year. This projection shall be based upon the following data:

i. The number and type of Department staff required to perform each activity for which fees are charged;

ii. The total salaries of those staff members;

iii. The cost of fringe benefits for those staff members, calculated as a percentage of salaries, which percentage is set by the New Jersey Department of the Treasury based upon costs associated with pensions, health benefits, workers' compensation, disability benefits, unused sick leave, and the employer's share of FICA;

iv. Indirect costs attributable to those staff members. "Indirect costs" means costs incurred for a common or joint purpose, benefiting more than one cost objective, and not readily assignable to the cost objective specifically benefited without effort disproportionate to the results achieved. Indirect costs shall be calculated at the rate negotiated annually between the Department and the United States Environmental Protection Agency, multiplied by the total of salaries and fringe benefits;

v. Operating expenses (including, without limitation, expenses for postage, telephone, travel, supplies and data system management) attributable to those staff members; and

vi. The budgeted annual cost of legal services rendered by the Department of Law and Public Safety, Division of Law, in connection with each of the permit programs listed in the introductory language of (h) above.

2. Project the total amount to be available from sources other than fees, such as State appropriations or Federal grants;

3. Subtract the amount in (h)2 above from the amount in (h)1 above. The remainder is the fee revenue necessary for the coming year;

4. Divide the fee revenue necessary for the coming year by the fee revenue which was necessary for the current year;

5. Divide the volume of permit applications the Department received in the current year by the volume it expects to receive in the coming year. In projecting the expected volume of permit applications, the Department shall consider the following factors:

i. The volume of permit applications received in previous years;

ii. Based on (h)5i above, any trends toward an increasing or decreasing volume of permit applications;

iii. Information indicating a trend toward increasing or decreasing construction activity in various areas of the State; and

iv. Other data concerning economic trends reasonably likely to influence the volume of permit applications; and

6. Multiply the number provided in (h)5 above by the number provided in (h)4 above. This result is the fee adjustment factor.

(i) Each year, the Department shall prepare an Annual Ninety-Day Construction Permit Fee Schedule Report. Promptly after completing the report, the Department shall publish in the New Jersey Register a notice of administrative change, pursuant to N.J.A.C. 1:30-2.7(c), setting forth the adjusted fees and the operative date thereof. The notice shall state that the report is available, and directed interested persons to contact the Department for a copy of the report. The Department shall provide a copy of the report to each person requesting a copy.

(j) The Department will not make the adjustment of fees provided in (h) above or prepare the report described in (i) above for any one-year period ending June 30, if in that period the Department proposes or promulgates amendments to any fees for waterfront development permits, wetlands permits, CAFRA permits or stream encroachment permits.

(k) An applicant who has paid a fee calculated under (a)1, 2, or 3 above of more than $7,000 may request a rebate of part of that fee, at the time provided in (l) below. The Department shall refund to the applicant the amount by which that fee exceeds the Department's actual costs incurred in connection with the review of the Waterfront Development, coastal wetlands, or CAFRA application (including, without limitation, costs incurred in processing and reviewing the application and in addressing any appeal of the permit decision), as shown by Department timekeeping records, if:

1. The Department's timekeeping records show that the fee exceeds the Department's actual costs incurred in connection with the application by more than 25 percent; and

2. The Department's timekeeping records show that the fee exceeds the Department's actual costs incurred in connection with the application by more than $2,000.

(l) An applicant requesting a rebate under (j) above shall make the request in writing, to:

Administrator
Land Use Regulation Program
Department of Environmental Protection & Energy
CN 401
Trenton, NJ 08625

The request shall be received by the Department within 20 days after the applicable date in (l)1 or (l)2 below, but not before such applicable date:

1. If neither the applicant nor any other person appeals the Department's decision to approve, condition or disapprove the permit application, the last day on which such an appeal could have been timely filed (without considering any extensions of such time which may be available under any other provision of this title); or

2. If the applicant or another person has appealed the Department's decision to approve, condition or disapprove the permit application, the date as of which any disposition of such appeal can no longer be further appealed.

7:1C-1.6 DEPE Bulletin

(a) The Department shall publish in the "DEPE Bulletin", a report of the receipt of each new application and each agency action on applications currently before it. This publication will be distributed free of charge to all municipalities, counties, and other interested persons. Publication in the "DEPE Bulletin" constitutes constructive notice to all interested persons of Department actions on construction permits.

(b) (No change.)

7:1C-1.7 Review of application

(a)-(c) (No change.)

(d) Except as provided in N.J.A.C. 7:50-4.1, an application subject to these rules for development of any land within the Pinelands Area as defined in N.J.S.A. 13:18A-11 is not complete unless and until the applicant has in his or her possession a Certificate of Filing, a Certificate of Compliance or an Approval Resolution from the Pinelands Commission for the proposed development of that land. Pursuant to N.J.S.A. 13:18A-10(c), no approval shall be granted for an application subject to these rules for any development in the Pinelands Area unless that development conforms to all applicable provisions of the Pinelands Comprehensive Management Plan (N.J.A.C. 7:50).

7:7-1.7 Procedure where more than one permit is required

(a) (No change.)

(b) The fee to be submitted for such an application shall be [the highest of any of the required permit fees provided for in] **calculated in accordance with** N.J.A.C. 7:1C-1.5(c).

7:7A-16.1 Payment of fees

(a)-(c) (No change.)

(d) The Department shall assess a single permit fee for a project which requires a permit under this chapter (including individual permits, general permits, and transition area waivers) and one or more of the following permits: CAFRA permit issued pursuant to the Coastal Area Facility Review Act, N.J.S.A. 13:19-1; waterfront development permit issued pursuant to the Waterfront Development Act, N.J.S.A. 12:5-3; coastal wetlands permit issued pursuant to the Wetlands Act of 1970, N.J.S.A. 13:9A-1; or stream encroachment

permit pursuant to the Flood Hazard Area Control Act, N.J.S.A. 58:16A-50. The permit fee for the project is equal to the sum of the following:

1. The single highest permit fee for the above listed permits required for the project; and

2. Seventy-five percent of the sum of the permit fees for all other permits required for the project.

(a)

DIVISION OF FISH, GAME AND WILDLIFE
FISH AND GAME COUNCIL
1992-93 Game Code
Hunting Prohibition
Parker Creek and Oceanport Creek, Monmouth County
Proposed Amendment: N.J.A.C. 7:25-5.13

Authorized By: Fish and Game Council, Cole Gibbs, Chairman.
Authority: N.J.S.A. 13:1B-29 et seq.
DEPE Docket Number: 32-92-07.
Proposal Number: PRN 1992-364.

Public comments concerning the proposed amendment will be accepted at the **monthly meeting** of the Fish and Game Council to be held on:

Tuesday, September 8, 1992 at 10 A.M.
Conservation Center
Assunpink Wildlife Management Area
Robbinsville, New Jersey

Submit written comments by September 16, 1992 to:

Robert McDowell, Director
Division of Fish, Game and Wildlife
Department of Environmental Protection and Energy
CN 400
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment to the 1992-93 Game Code prohibits the hunting of all game birds and mammals, including waterfowl, on those portions of Parker Creek and Oceanport Creek in Monmouth County, including the shores thereof, southwest or upstream of the Conrail R.R. bridge.

Social Impact

The prohibition of hunting in this relatively small area will have only a minimal adverse social impact, in that only a few individuals (six to 10) utilize this area for hunting, primarily for waterfowl. However, the elimination of firearm hunting in this area will eliminate the potential for conflict between residents and hunters in this heavily developed residential area. The reduction of conflict serves to improve the quality of recreational hunting over the entire resource.

Economic Impact

No significant adverse economic impact on the local economy is anticipated as a result of this action.

Environmental Impact

No significant environmental impacts will result from this change.

Regulatory Flexibility Analysis

This proposed amendment to the 1992-93 Game Code imposes restrictions on sportsmen and sportswomen engaged in recreational hunting. The requirements are not, therefore, imposed upon small business, as the term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 5. 1992-93 GAME CODE

7:25-5.13 Migratory birds
(a)-(q) (No change.)

(r) Parker Creek and Oceanport Creek: There shall be no open firearm season for hunting any game bird or mammal including waterfowl on Parker Creek and Oceanport Creek, Monmouth County, or the shores thereof, southwest or upstream of the Conrail R.R. bridge.

[(r)](s) (No change in text.)

(b)

DIVISION OF RESPONSIBLE PARTY SITE REMEDIATION
Environmental Cleanup Responsibility Act Rules
Proposed Readoption: N.J.A.C. 7:26B

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.
Authority: N.J.S.A. 13:1D-1 et seq., 13:1K-6 et seq., particularly 13:1K-10 and 58:10-23.11 et seq.
DEPE Docket Number: 26-92-07.
Proposal Number: PRN 1992-369.

Submit written comments by September 16, 1992 to:

Samuel A. Wolfe, Esq.
Administrative Practice Officer
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to the requirements and criteria of Executive Order No. 66(1978), N.J.A.C. 7:26B expires on December 21, 1992. As required by the Executive Order, the Department of Environmental Protection and Energy (Department) has reviewed these rules and has determined them to be necessary, reasonable, and proper for the purpose for which they were originally promulgated. The Department proposes to readopt these rules without change.

The Environmental Cleanup Responsibility Act (Act) and the rules promulgated pursuant thereto have since December 31, 1983 provided an effective means of mitigating the inherent danger to the citizens, property and natural resources of the State posed by the generation, manufacture, refining, transportation, treatment, storage, handling and disposing of hazardous substances or wastes by industrial establishments. The Act and these rules require an environmental audit and remediation, or the execution of an agreement for such remediation, by owners and operators of industrial establishments as a pre-condition for the sale, transfer or termination of operations at these facilities.

A business is covered by the Act in these rules if it meets the following three criteria. First, the business must have a Standard Industrial Classification (SIC) major group number listed in the Act. SIC numbers are set forth in a manual prepared by the Federal Office of Management and Budget. Second, the business must have engaged in operations on or after December 31, 1983 that involve the generation, manufacture, refining, transportation, treatment, storage, handling or disposal of hazardous substances or wastes on the site of the industrial establishment. Third, there must be either a closing, terminating or transferring of the property or the business operations.

If all three criteria are present, the owner or operator of the industrial establishment must submit either a cleanup plan or a negative declaration to the DEPE for approval, or enter into an ECRA Administrative Consent Order, prior to the closing, terminating or transferring of the industrial establishment. A cleanup plan details the measures necessary to detoxify the site of the industrial establishment including buildings and equipment. A negative declaration is a statement by the owner or operator, subject to the approval of the DEPE, that there has been no discharge of hazardous substances or wastes on the site or that any discharge has been remediated to the cleanup standards established by the Department.

The Department has been developing amendments to N.J.A.C. 7:26B it would like to propose. These amendments are designed to clarify and streamline the ECRA process without compromising the level of environmental protection provided by the ECRA program. The Department, however, has decided to postpone proposing these amendments for three reasons: (1) the Legislature has indicated to the Department

that it intends to significantly amend the Act in the current session; (2) the Department is waiting to evaluate the comments on recently proposed site remediation rules, prior to substantially modifying the technical requirements of the ECRA rules; and (3) the Department is presently evaluating comments to the March 2, 1992 proposed amendments to the ECRA rules to be consistent with the Appellate Division's decision *In Re: Adoption of N.J.A.C. 7:26B.*

As noted in the preceding paragraph, the Legislature is presently considering amendments to ECRA and is scheduled to enact these amendments in the current session. The Governor and the Legislature have indicated to the Department that these amendments may redefine the scope of ECRA, provide grants and loans to aid cleanup, change the financial mechanism for guaranteeing cleanups and allow limited sales of property subject to the Act (see Bill recently released June 10, 1992). Consequently, the Department has determined that it is appropriate to readopt these rules without change to allow the Department to continue to implement the Act and postpone proposing any amendments to the rules until the Legislature has acted.

Another reason the Department has determined to propose these ECRA rules without change at this time is because of a decision from the New Jersey Appellate Division *In Re: Adoption of N.J.A.C. 7:26B,* 250 *N.J. Super.* 189 (App. Div. 1991), the Department refers the public to the Department's proposed amendments to the ECRA rules published in the New Jersey Register on March 2, 1992 at 24 N.J.R. 720(a). In that proposal, the Department amended the ECRA rules to be consistent with the Appellate Division's holdings. Upon adoption, those amendments will then become part of the overall ECRA rules the Department is seeking to readopt here.

In addition, the Department has decided to postpone proposing any amendments to the ECRA rules at this time in order to ensure consistency between the ECRA rules and the recently proposed rules for Cleanup Standards of Contaminated Sites (Cleanup Standards) N.J.A.C. 7:26D, 24 N.J.R. 373(a), Procedures for Department Oversight of the Remediation for Contaminated Sites (Oversight Rules), N.J.A.C. 7:26C, 24 N.J.R. 1281(b), and Technical Requirements for Site Remediation (Technical Rules), 24 N.J.R. 1695(a). Together these three rules will ensure that sites are investigated in accordance with minimum technical standards and that the same remedial processes and cleanup levels will apply regardless of the party conducting the work or the lead regulatory program overseeing the work. The Cleanup Standards will provide clearly articulated, predictable levels to which contaminated sites must be remediated in order to adequately protect human health and the environment. The Oversight Rules will define when and how a party may participate in remediation activities and the degree of Department oversight of those activities. The Technical Rules will provide detailed requirements of how investigations and cleanups are to be conducted by establishing the technical requirements for remediation. Concurrent with the Department's proposal of the Oversight Rules, the Department proposed repeals and new rules at N.J.A.C. 7:26B-7. This subchapter pertains to the ECRA Administrative Consent Order requirements. The Department will also be required to amend the ECRA rules, particularly Subchapters 1, 3, 4, and 5, in order to make the ECRA rules consistent with the Cleanup Standards, Technical Rules and Oversight Rules. However, the Department has determined that, in order to ensure clarity and predictability in the manner in which the ECRA rules will interact with these new rules, it is necessary to review the public comment to these new rules and formulate appropriate regulatory responses prior to modifying the ECRA rules. The Department is still receiving public comment on these three rule proposals.

In sum, although the Department has identified revisions it would like to propose to the ECRA rules, it is proposing to readopt the chapter, without change to allow the Department to continue to implement the Act while the Legislature considers amendments to the Act and the Department completes ongoing related rulemaking which has broad impact to the remediation of all contaminated sites in New Jersey. The Department is developing, and intends to propose, amendments to N.J.A.C. 7:26B in the near future.

A summary of the text of N.J.A.C. 7:26B follows:

General Information

Subchapter 1 includes the scope and construction of the chapter proposed for readoption. N.J.A.C. 7:26B-1.3 contains definitions relevant to this chapter. N.J.A.C. 7:26B-1.5 describes with specificity the applicability of ECRA to owners and operators by providing examples of closing, terminating, and transferring operations of an industrial establishment subject to the Act. N.J.A.C. 7:26B-1.6 identifies the specific event in connection with an applicable transaction requiring the owner or operator of an industrial establishment to submit an Initial Notice to the Department. N.J.A.C. 7:26B-1.8 lists those facilities and transactions not subject to the Act, including those SIC numbers the Department has determined pose no threat to the health and safety of the public or the environment or are adequately regulated by the Department through other programs. N.J.A.C. 7:26B-1.9 sets forth the procedure by which owners and operators can apply to the Department for a determination concerning the applicability of the Act to their transaction. N.J.A.C. 7:26B-1.10 establishes a fee schedule to cover the costs of administering the program. N.J.A.C. 7:26B-1.12 provides for right of entry and inspection, and N.J.A.C. 7:26B-1.13 specifies the form of certification and execution required on key submissions to the Department under the Act and this chapter.

Exemption Procedures

Subchapter 2 establishes the procedure by which a person may petition the Department to exempt a subgroup, or class of operations within a subgroup of the Standard Industrial Classification (SIC) major groups. The purpose of this provision is to allow for exemptions from the Act of those classes or subgroups of industrial establishments whose operations do not pose a threat to public health or the environment.

Initial Notice Submissions

Subchapter 3 describes the initial notice filing procedures. N.J.A.C. 7:26B-3.1 provides for a pre-notice filing conference upon request of the owner or operator to discuss compliance with the Act and this chapter. N.J.A.C. 7:26B-3.2 presents a two-step process for the submission of information to the Department once ECRA is triggered. The first step is the submission of the General Information Submission (GIS), and the second step is the submission of a detailed Site Evaluation Submission (SES). N.J.A.C. 7:26B-3.3 recommends a process for landlord-tenant compliance with the initial notice requirements. N.J.A.C. 7:26B-3.4 sets forth the procedure for withdrawing from the ECRA process and N.J.A.C. 7:26B-3.5 provides for the Department's inspection and records review.

Approval, Implementation, and Submittal of Results from the Sampling Plan

Subchapter 4 sets forth the procedures for sampling plan implementation as well as the preparation and submission of sampling results to the Department.

Criteria for Negative Declaration and Cleanup Plan Approval and Deferral of Cleanup

Subchapter 5 requires the owner or operator to submit either a negative declaration or a cleanup plan. The rules set forth the criteria for approval by the Department and the requirements for implementation of proposed cleanup plans and proposed negative declarations. Pursuant to N.J.A.C. 7:26B-5.4, the negative declaration is valid for a period not to exceed 60 days, and only to the extent the information submitted remains unchanged. The owner or operator may request one extension of the negative declaration for a period of 60 days. The proposed amendments scheduled for adoption by December 21, 1992 will amend this subchapter to make the negative declaration valid for 120 days and eliminate the need for the extension request. N.J.A.C. 7:26B-5.8 provides the procedural requirements for a deferral of implementation of a cleanup plan.

Financial Assurance

Subchapter 6 contains the general requirements that require the owner or operator to provide and maintain financial security in the form of a letter of credit, surety bond, performance bond, fully funded trust or self bonding. The Wording of Instruments Document provides the required language for each type of acceptable financial assurance instrument and is located in Appendix A of this chapter.

Administrative Consent Orders

Subchapter 7 provides an administrative procedure to allow a closing, terminating or transferring of an industrial establishment pursuant to an Administrative Consent Order (ACO) to proceed prior to the approval of a proposed negative declaration or cleanup plan.

Protection of Confidential Information

Subchapter 8 provides a detailed confidentiality procedure for those owners or operators who desire confidential treatment for any information submitted pursuant to the Act or this chapter.

Violations and Penalty Provisions

Subchapter 9 provides the Department's position regarding penalty settlement offers by establishing a schedule of penalty amounts based on the type of violation and time out of compliance.

DeMinimus Standards

Subchapter 10 establishes criteria and procedures by which an industrial establishment may be exempt from the Act because the operations involve amounts of hazardous substances posing no danger to the public health and the environment.

ECRA Cleanup Standards

Subchapter 11 continues to provide that minimum standards for the remediation of sites shall be established on a case-by-case basis.

Limited Conveyance

Subchapter 13 allows owners to convey as much as 20 percent of their real property without the owner conducting a complete review of the industrial establishment pursuant to the Act.

Social Impact

The proposed readoption of N.J.A.C. 7:26B will allow the Department to continue in full force and effect the successful program pursuant to the Act, requiring adequate preparation and subsequent implementation of acceptable cleanup procedures as a precondition to the closing, terminating, or transferring of industrial establishments in New Jersey. The readoption of these rules will continue this important and innovative program and further minimize the exposure of the citizens, property and natural resources of the State to the inherent dangers from operations which involve the generation, manufacture, refining, transportation, treatment, storage, handling, or disposal of hazardous substances and wastes.

Economic Impact

The proposed readoption of these rules will not increase or decrease the cost of regulatory compliance. The proposed readoption will continue to impose economic burdens on the owners and operators of industrial establishments subject to the Act who are seeking to transfer ownership of the business or property or cease operations on site. The cost compliance with these rules varies depending on the size of the facility, the complexity of the investigation, and the extent of the remediation required at the site. These costs can include Department fees, consultant and laboratory technical costs, attorney fees, costs associated with obtaining financial assurance, and those costs associated with the delay of a transaction which may result from the need to comply with ECRA. However, the Legislature intended that the owner or operator of industrial establishments should incur these expenses as a precondition to closure of sale rather than the citizens and taxpayers of New Jersey at some later date.

Since the original adoption of N.J.A.C. 7:26B, the Department has taken steps to decrease case processing times and thereby alleviate some of the economic burdens imposed by the Act. In addition, as evidenced by the proposed Cleanup Standards, Oversight Rules and Technical Rules, the Department will be able to provide more guidance and predictability to the regulated community for its remediation work. As a result, the Department anticipates that on the average it will take less time for the regulated community to obtain a cleanup plan approval or negative declaration approval from the Department, and less time to remediate.

Environmental Impact

The readoption of these rules will have a positive environmental impact by continuing, without interruption, the regulatory framework necessary to implement the benefits of the Act. As a result of the Act and these rules, over 1,600 sites in the State have been remediated. The ECRA rules have had a major positive environmental impact for the citizens, property, and natural resources of New Jersey. The rules have provided the Department with an important, effective remedial tool to significantly reduce the occurrence of future contaminated site problems throughout the State.

Regulatory Flexibility Analysis

N.J.A.C. 7:26B applies to any owner or operator of an "industrial establishment" who plans to "close, terminate or transfer" the operations of the industrial establishment, unless the operation or transaction is exempted from ECRA under N.J.A.C. 7:26B-1.8. Based upon experience in administering ECRA, the Department estimates that approximately 1,000 industrial establishments become subject to ECRA each year, and that approximately 500 of these establishments are owned or operated by "small businesses" as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. In addition, the Department recognizes that in practice a larger number of persons will elect to obtain an applicability determination from the Department pursuant to N.J.A.C. 7:26B-1.9, even though they are not subject to ECRA. The Department cannot estimate how many of these persons are "small businesses," because it lacks the data to support such an estimate.

The Department has determined that it can reduce ECRA-related fees for small businesses without any effect on the environment, public health or public safety. Accordingly, the fee schedule in N.J.A.C. 7:26B-1.10(c) provides reduced fees for small businesses. However, there is no reduced fee for an applicability determination, for the reasons discussed below.

To comply with the requirements for obtaining an applicability determination, the small business must submit a completed applicability determination form and a $200.00 fee. The cost of completing the applicability determination form will vary, increasing with the complexity of the operations of the industrial establishment and with the complexity of the transaction for which the determination is sought. In addition, a person seeking an applicability determination will frequently obtain professional services from an attorney, though there is no requirement for such services. There are no initial capital costs for compliance. The rules for obtaining an applicability determination are not designed to minimize any adverse economic impact upon small businesses, for two reasons. First, the information the Department requires to make the applicability determination does not vary depending upon the size of the business affected. Second, it would be impracticable to assess a lower fee for small businesses; to determine that an applicant was a small business would require a significant increase in the complexity of the applicability determination form, thereby significantly increasing the cost to the applicant of completing the form and the cost to the Department to review it.

The Department has structured the General Information Submission (GIS) required under N.J.A.C. 7:26B-3.2(b) in a manner intended to minimize the cost of completing it, for all persons required to do so. For this reason, the Department has not established reduced GIS reporting requirements for small businesses. Generally, the person preparing the GIS will obtain professional services from an attorney and/or an environmental consultant, though there is no requirement for such services. There are no initial capital costs associated with compliance.

The cost of preparing the Site Evaluation Submission (SES) increases with the complexity of the information relevant to the site required under N.J.A.C. 7:26B-3.2(c). The cost will be significantly reduced if no sampling plan need be developed and implemented in accordance with N.J.A.C. 7:26B-3.2(d). The services of an environmental consultant are generally necessary in order to complete the SES, especially if a sampling plan is required. There are no initial capital costs for compliance. The requirements for this submission are not designed to minimize any adverse economic impact upon small businesses, because the same information is needed to initiate the ECRA process regardless of the size of the business affected.

As discussed in the economic impact statement above, the cost of compliance with N.J.A.C. 7:26B varies depending on the size of the facility, the complexity of the investigation, and the extent of remediation required at the site. The compliance requirements may include preparing a sampling plan, obtaining Department approval of the plan, and implementing it; preparing and obtaining approval of a negative declaration submission; preparing a cleanup plan, obtaining Department approval of the plan, and implementing it. A person complying with these requirements generally needs the assistance of an environmental consultant, and frequently obtains professional services from an attorney as well. In addition, the small business may be subject to other provisions which impose compliance requirements, including applying for and entering into an administrative consent order; posting financial assurance; making confidentiality claims for information believed to be trade secrets or proprietary information; and obtaining a de minimus quantity exemption or certificate of limited conveyance. A person complying with these requirements generally will obtain professional services from an attorney,

and may seek assistance from an environmental consultant as well. Compliance with the requirements described in this paragraph requires no initial capital costs.

The requirements described in the preceding paragraph are not designed to minimize any adverse economic impact upon small businesses. To minimize the impact of these requirements on small businesses would endanger the environment, public health, and public safety, because there is no necessary correlation between the size of the business and the extent of the environmental problems that may exist at a site or at other sites to which environmental contamination may have migrated.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 7:26B.

(a)

DIVISION OF ENVIRONMENTAL SAFETY, HEALTH, AND ANALYTICAL PROGRAMS

Pesticide Control Code

Proposed Readoption with Amendments: N.J.A.C. 7:30

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1D-1 et seq. and 13:1F-1 et seq., particularly 13:1F-4.

DEPE Docket Number: 31-92-07.

Proposal Number: PRN 1992-353.

A **public hearing** concerning this proposed readoption will be held on Thursday, September 17, 1992, at 10:00 A.M. at:

Main Conference Room
Pesticide Control Program
380 Scotch Road
CN 411
West Trenton, NJ 08625

Submit written comments by October 1, 1992, to:

Samuel Wolfe, Esq.
Office of Legal Affairs
New Jersey Department of Environmental Protection and Energy
CN 402
Trenton, NJ 08625

The agency proposal follows:

Summary

Pursuant to the requirements and criteria of Executive Order No. 66(1978), the Pesticide Control Code, N.J.A.C. 7:30, (Code) expires on December 4, 1992. The Department of Environmental Protection and Energy (Department) has reviewed the Code and has determined that it is necessary, reasonable, and proper for the purposes for which it was originally promulgated.

The Department proposes to readopt the Code with minor changes. The Department finds that with these minor changes the Code, which covers the registration of pesticides, the registration of dealers and applicators, and the regulation of pesticide use, continues to be necessary to protect the citizens, economy and environment of the State.

The Code as originally adopted on January 18, 1974 was based, in part, on U.S. Environmental Protection Agency (EPA) regulations under the Federal Insecticide, Fungicide and Rodenticide Act, 7 U.S.C, Sections 136 et seq. (FIFRA). EPA enforcement was turned over to New Jersey under an agreement, over a period of years (1975-1980). Currently there are no Federal pesticide inspectors in New Jersey, and the entire task is handled by the Department's inspectors. The Department is required to enforce the requirements of FIFRA at a minimum, and may regulate the sale or use of pesticides as long as it does not permit any sale or use prohibited by FIFRA. In particular, the list of restricted pesticides, the applicator's registration requirements, and the termiticide use regulations are examples of more stringent regulation than that required by EPA.

The Code proposed for readoption consists of the following 10 subchapters:

Subchapter 1. Pesticide Product Registration and General Requirements: This subchapter contains the scope of the Code and requires all pesticide products held, used, distributed, sold or offered for sale in the state to be registered with the Pesticide Control Program (Program). This requirement is in addition to registration with the EPA. This subchapter enables the PCP to better control and monitor the pesticides currently being used in New Jersey. Copies of product labels are submitted to the Department in the registration process and are often used to aid in inspections and investigations. Product registration fees support much of the program, including investigation and response to misuse or accidental releases into the environment. In addition, this subchapter contains requirements for emergency exemption registrations, experimental uses and general requirements.

Subchapter 2. Prohibited and Restricted Use Pesticide List: This subchapter identifies prohibited pesticides and lists the pesticides currently classified as restricted use in New Jersey. This list contains pesticides which are currently classified as general use by EPA, but are restricted in New Jersey. These pesticides can only be purchased or used by certified and registered pesticide applicators, or by a person under their direct supervision. Thus, pesticides which have a greater potential for causing harm than the general use pesticides, can be kept out of the hands of untrained persons.

Subchapter 3. Pesticide Dealers: This subchapter requires the certification and registration of persons who sell restricted use pesticides. It insures that the sale of restricted use pesticides is performed only by trained and certified dealers.

Subchapter 4. Pesticide Dealer Businesses: This subchapter requires businesses that sell restricted use pesticides to register each outlet with the Program, and to have a responsible dealer employed at each outlet. It requires recordkeeping and restricts the sale of restricted use pesticides only to registered pesticide applicators.

Subchapter 5. Pesticide Operators: This subchapter requires the registration of persons who apply pesticides under the supervision of a certified, registered applicator. It requires that these pesticide operators receive training which will enable them to apply pesticides safely and properly.

Subchapter 6. Commercial Pesticide Applicators: This subchapter requires the certification and registration of persons who use or supervise the use of pesticides in a way which does not meet the definition of a private pesticide applicator. It requires that applicators take both general and specialized examinations in order to become certified. These examinations are more detailed and specialized than those given for private applicators. This insures that only properly trained and certified personnel apply pesticides commercially.

Subchapter 7. Pesticide Applicator Businesses: This subchapter requires that pesticide applicator businesses register each location and name under which they operate. It also requires that these businesses employ registered applicators who are certified in each category in which the business conducts applications. Proper recordkeeping, pesticide storage, and service vehicle requirements are mandated. These requirements are vital in regulating the pest control industry and in maintaining high standards of service and safety.

Subchapter 8. Private Pesticide Applicators: This subchapter requires the certification and registration of persons who use or supervise the use of restricted use pesticides for the purpose of producing any agricultural commodity. General and specialized certification exams are required. Recordkeeping, service vehicle, and storage requirements are mandated. Requiring that private pesticide applicators, who apply restricted pesticides, receive training in such areas as pesticide handling, safety, regulations, labeling information, harvest intervals and other related topics, insures that pesticides are applied to agricultural commodities safely and properly.

Subchapter 9. Pesticide Exposure Management: This subchapter deals with topics such as community or area wide applications, pesticide storage, container labelling, pesticide disposal, application and safety equipment, notification, farmworker safety, and reporting of pesticide spills. This subchapter is extremely important in that it regulates exposure of the public to pesticides, along with storage and disposal, and emphasizes safety. The Department proposes to amend the current requirement at N.J.A.C. 7:30-9.13(i), which requires farm owners or lessees to post pesticide treatment warnings for workers when the reentry time for the treated area is 24 hours or more. The proposed new subsection (i) requires farm owners or lessees to post for their workers information for all pesticide applications. The contents of the notice are specified in the proposed subsection.

Subchapter 10. Pesticide Use: This subchapter regulates pesticide use and application, pesticide contamination clean-up and other related

topics. It also regulates aerial and termite control applications. It is more restrictive than many of the Federal labels on products used for these purposes. These restrictions have helped to insure the safe and proper use of pesticides in these areas.

Subchapter 11. Emergency Containment and Disposal of Pesticides: This subchapter requires containment of any pesticide contamination resulting from an emergency situation and Department approval of any disposal plan for such a pesticide. This subchapter was adopted by the Department as an emergency rule in 1971 in response to the passage of the Pesticide Control Act of 1971. It was adopted as part of the general rules which governed the Department, as N.J.A.C. 7:1-2, and in 1990 was recodified without change as N.J.A.C. 7:30-11 in order to include it, more appropriately, as part of the Department's Pesticide Control Code.

The Pesticide Control Council (Council) was consulted about the upcoming expiration of the Code and at their July 13, 1992 meeting, the Council, after discussion, voted to recommend that the Department readopt the Code as proposed. The Council felt that the Code is essential to protect worker and public health, and the environment. This vote is reflected in the minutes of that meeting.

Social Impact

The positive social impacts of the Code have been significant. Public Health has been protected from exposure to toxic substances, including carcinogens. Prior to Federal and State regulation, numerous instances of inadvertent harm due to misapplication were documented. This led to the passage of FIFRA and the Pesticide Control Act of 1971, N.J.S.A. 13:1F-1 et seq. Recent changes to the Code in 1983, 1985, and early 1987 have further defined the correct use of termiticides and other pesticides, and brought the restricted use list into conformance with current scientific data.

The entire population of New Jersey has benefitted from the Code regulating pesticides in New Jersey. Drift from aerial applications, contamination of homes with termiticides, and dumping of pesticides have all been reduced in New Jersey. Many pesticides have been taken out of the hands of untrained homeowners and tenants, for their own protection. Approximately 6,900 registered commercial applicators, 3,000 certified private applicators and 250 certified dealers have successfully completed the State testing program, which is recognized as a national model. In addition, approximately 3,000 operators have been trained by their responsible applicators and registered with the State.

The training program, Department press releases, and the New Jersey Bell yellow pages notification alerting consumers to the regulatory requirements have helped to make the public more safety conscious.

The interested public's reaction to the Code has generally been favorable. Chemical manufacturers, applicators, environmentalists and consumers have differed on specific substances and provisions in the existing rules, but there is general acknowledgement that there is a need for pesticide regulation. The existence of the Code has successfully focused the attention of all parties on the importance of using scientific data as the basis for pesticide regulation. It is anticipated that the Code will continue to be the focus of public debate over what constitutes an acceptable health risk concerning pesticides.

FIFRA states in part that the States shall have primary enforcement responsibility for pesticide use violations, but only if that State has adopted adequate pesticide regulations, and adequate procedures for enforcing such regulations. If the Code were not readopted, New Jersey would face Federal intervention. In addition, the public and the environment would be needlessly exposed to risk from improper pesticide use.

Economic Impact

The Code has had a positive economic impact by reducing the costs attributed to health problems posed by improper pesticide use. There has also been a decrease in the number of contamination cases requiring expensive clean-up. Proper use of pesticides enables farmers to protect their crops from damage due to agricultural pests, while the public is protected from harmful residues in food. The residents of the State and their property are also protected from harmful, destructive, and disease carrying pests through the proper use of pesticides. All of these positive impacts would be threatened if the Code were not readopted.

Pursuant to 7 U.S.C. Section 136g, approximately $400,000 in grants is available to the Department from EPA for pesticide monitoring and conducting inspections for the administration of FIFRA. Under EPA Enforcement Grant No. E002149-10, and the Department's authority under N.J.S.A. 13:1F-9, the following activities are conducted:

1. Cooperative pesticide enforcement agreements;
2. Use/misuse inspections, both agricultural and nonagricultural;
3. Monitoring of New Jersey's State certification program;
4. Pesticide producing establishment inspections;
5. Export inspections;
6. Experimental use permits;
7. Incident investigations;
8. Market place inspections;
9. Sample collection; and
10. Sample analysis.

Approximately $3,000,000 in operating expenses for the Program is generated through the Code by registration fees for pesticide products, applicator and applicator business registration fees, dealer and dealer business registration fees, operator registration fees, and permit fees. Collection of these fees makes the pesticide program almost self-sufficient. Registration fees for all the regulated persons and businesses were increased in 1988, but are still moderate. The fees are listed as follows:

Examination fee—$10.00
Certified pesticide dealer—$75.00
Dealer businesses—$150.00
Commercial pesticide operator—$30.00
Commercial pesticide applicator—$75.00
Commercial applicator business—$150.00
Private pesticide applicator—$0
Private pesticide operator—$0
Permits—Aquatic—$75.00
Mosquito/Fly—$5.00
Products—$200.00

Due to the large number of registrants, the Department has been able to keep these fees moderate. Therefore, the economic impact of these fees is minimal on the individual registrant.

Environmental Impact

The proposed readoption of the Code will have the positive environmental impact of continuing the regulatory framework necessary to implement the benefits of the Pesticide Control Act of 1971. In the past, the Code has significantly reduced the threat to public health and the environment from the misapplication and misuse of these inherently dangerous substances.

For example, since implementation of the Code on termiticide use, effective November 4, 1985, there has been a significant reduction in the number of homes contaminated, and in the number of clean-ups subsequently ordered (1985—40 clean-ups, 1986—20, 1990—six, 1991—four).

Training and licensing under the continuing registration program have been successful in reducing environmental hazards by making the applicator industry more aware of potential harm to the environment. There has likewise been an increased pubic awareness of the need to use pesticides more carefully.

The code has reassured the public that pesticide applications will be performed properly and only by trained applicators, and that clean-ups, where necessary, will be conducted promptly and effectively.

The Code has resulted in the Department's acquiring better knowledge of the applicators who are operating, and what pesticides are being used. Applicators appear to be far better organized as to procedures, records, and storage, based on inspections conducted by the Department since 1976. Environmental monitoring also takes place. For example, random collections of fruits and vegetables from New Jersey farms in 1991 indicated only one violative pesticide residue in all the samples which were collected. This gives New Jersey consumers confidence in Garden State products.

Regulatory Flexibility Analysis

The rules proposed for readoption would apply to 1,981 applicator businesses, 257 certified dealers, 164 dealer businesses, 2,294 private applicators, 6,882 commercial certified applicators and 2,899 pesticide operators registered with the Pesticide Control Program. Virtually all of the above fall under the definition of a small business as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. One exception to the above are the pesticide manufacturers, who register their pesticide products in New Jersey. The revised pesticide application notice requirements at proposed N.J.A.C. 7:30-9.13(i) must be complied with by farm owners or their lessees, the majority of whom are small businesses. In order to comply with these rules the small businesses will have to comply with the recordkeeping, reporting, and other requirements set forth in the Summary above. In so doing it is unlikely that

the small businesses will need any type of professional services to comply. The Department has estimated that there are no initial capital costs resulting from compliance and that the annual costs of compliance are minimal. In developing this Code, the Department has balanced the need to protect the environment against the economic impact of the proposed Code and has determined that exemption from coverage under the Code would endanger public health and the environment through the increased possibility of improper pesticide handling and use. Therefore, no exemption from coverage is provided. While no exception is provided, the highest fee is paid by the pesticide product manufacturers, which are generally larger businesses.

Full text of the proposed readoption appears in the New Jersey Administrative Code at N.J.A.C. 7:30.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:30-9.13 Farm worker safety

(a)-(h) (No change.)

[(i) Workers who might reasonably be anticipated to enter a field being treated or which has been treated with a pesticide having a reentry time of 24 hours or more shall be warned by the posting of a sign on a bulletin board at the point(s) where the workers assemble for instructions. The bulletin board shall be visible and available to farm workers at this assembly point.

1. Posted warnings shall clearly designate the treated field and the reentry time for such field.]

(i) No person shall apply pesticides on a farm without complying with the following provisions:

1. The following application information shall be posted at a central location, or at various assembly points throughout the farm, or at any other location to ensure that the information is visible and accessible to all farmworkers employed by the farm:

i. The crop;

ii. The brand or trade name, and common chemical name for the pesticide(s) applied to that crop;

iii. The date and time for safe reentry by farmworkers;

iv. The date of application; and

v. The location of application, to be shown on the map required in (i)3 below.

2. The posted information shall have the following column headings printed in English and in the native language(s) understood by farmworkers employed by the farm:

i. Crop;

ii. Name of Pesticide;

iii. Safe Reentry Time;

iv. Application Date;

v. Application Location.

3. A map of the farm shall be posted at the same location as the written information designated in (i)1 and 2 above and shall be used to clearly designate the fields treated with pesticides.

4. The Department will develop and make available an example format for proper posting of written information. This example will be made available through agriculture-related organizations including the New Jersey Department of Agriculture, Rutgers Cooperative Extension, and the New Jersey Farm Bureau, and from the Department by mail at the following address:

Pesticide Control Program
Farmworker Information
CN 411
Trenton, N.J. 08625

In lieu of the example format developed by the Department, a farm owner or lessee may use a different format if it conforms to the requirements of this subsection.

5. The posted information and map required in this subsection shall be updated at the time of application.

(j)-(l) (No change.)

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Hospice Services Manual
General Provisions, Provider and Recipient Requirements, Basis of Payment, Appendices
Medicaid Only Manual
Eligibility Standards
Proposed New Rules: N.J.A.C. 10:53A
Proposed Amendment: N.J.A.C. 10:71-5.6

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-3i(1) through (7); N.J.S.A. 30:4D-6(b)(20); N.J.S.A. 30:4D-7, 7a, b and c; 1814(i) of the Social Security Act, 42 U.S.C. 1395f(i); 1905(o) of the Social Security Act, 42 U.S.C. 1396d.

Agency Control Number: 92-P-5.

Proposal Number: PRN 1992-339.

Submit comments by September 16, 1992 to:

Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance
and Health Services
CN-712
Trenton, NJ 08625-0712

The agency proposal follows:

Summary

The Division of Medical Assistance and Health Services is proposing as new rules at N.J.A.C. 10:53A a new Hospice Services Manual, specifying rules governing hospice services to terminally ill persons who are eligible for Medicaid hospice care. These hospice services are provided by approved Medicaid hospice providers and physicians, and are reimbursed by the Division of Medical Assistance and Health Services.

The term "Medicare" refers to Title XVIII of the Social Security Act. The term "Medicaid" refers to Title XIX of the Social Security Act.

Hospice emphasizes supportive and palliative care, rather than curative care, and includes services such as bereavement counseling and pain control. Individuals who elect to receive hospice benefits may revoke that decision, and may later, if they so desire, resume care through the hospice program in a subsequent benefit period. It must be emphasized that hospice coverage is available to all qualified applicants regardless of whether they reside in the community or in a nursing facility.

The standards for eligibility for recipients specify that the individual meet both medical and financial criteria.

Medical criteria:

The applicant for hospice care shall have been diagnosed to have a terminal illness. A terminal illness is defined as having a medical prognosis of a life expectancy of six months or less, as certified or recertified in writing by a licensed physician (M.D. or D.O.).

Financial criteria:

The hospice program is available for recipients determined eligible under the categorical assistance or optional categorical assistance financial eligibility criteria. The hospice program is available to those recipients who meet the medical criteria, and who elect hospice care.

There is also a group of applicants who may have their financial eligiblity for hospice benefits established under the institutional standards, commonly referred to as the "Medicaid Cap." These standards for income and resources are found in the Medicaid Only Manual, N.J.A.C. 10:71-5.6(c). The higher income standard will be used for participants in the hospice program who are not otherwise eligible, regardless of whether they live in the community or in a nursing facility (NF).

In addition to satisfying medical and financial criteria, the person shall have signed the Election of Hospice Benefit Statement. Participation in hospice is strictly voluntary. The choice to participate belongs to the individual patient. The patient may revoke his or her participation in hospice at any time "without a showing of cause." The patient may also

request a modification of the hospice program with respect to which a previous election was made (see 1905(o)(2) of the Social Security Act, codified as 42 U.S.C. 1396d.) Individuals who elect hospice care waive their rights to Medicaid services related to the curative intent for treatment of the terminal illness.

Providers of hospice services who wish to enroll as Medicaid hospice providers must: (1) be certified for Medicare (Title XVIII) participation with the Health Care Financing Administration (HCFA) as a hospice provider and (2) submit the following documentation to the Paramax/Unisys Corporation according to N.J.A.C. 10:53A-2.1(a)2i: a provider application, a copy of the Medicare certification, an ownership and controlling interest statement and the Medicaid provider agreement.

All hospices participating in the New Jersey Medicaid Program are required to comply with the provisions of the Federal Patient Self Determination Act, 42 U.S.C. 1395cc (P.L. 101-508, sec. 4206), and the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq. (P.L. 1991, c.201).

Four per diem rates have been established for reimbursement of hospice providers: routine home care, continuous home care, inpatient respite care and general inpatient care. The per diem rates include payment for nursing care, physical therapy, occupational therapy, speech-language pathology services, medical social services, homemaker/home health aide services, durable medical equipment and supplies, drugs and biologicals, nutritional supplements, and counseling.

When the patient is receiving hospice room and board within a nursing facility, an additional reimbursement (computed as a percentage of the nursing facility daily rate) is made to the hospice. If the hospice is providing room and board services to a Medicaid recipient residing in a nursing facility, the nursing facility must be a Medicaid approved nursing facility. The hospice must have a written contract with the nursing facility whereby the hospice takes full responsibility for the professional management of the recipient's hospice services, while the nursing facility agrees to provide room and board services identical to those received by non-hospice patients.

Physician certification of the terminal illness and the necessity for hospice services is required for the first 210 days. The 210-day benefit period comprises three periods: 90 days, 90 days, and 30 days. In addition, the Division offers a fourth unlimited benefit period for the recipient when the attending physician recertifies the patient's terminal illness beyond 210 days. This provision allows Medicaid to continue to reimburse as needed for hospice services if the recipient survives beyond the period of the initial benefit periods without the threat of discontinuation of services.

The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

For the first period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician).

If the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these two days, and a written certification obtained no later than eight days after care is initiated. If these requirements are not met, no payment can be made for days prior to the certification.

For any subsequent period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course and the signature(s) of the physician(s). The hospice must retain the certification statements.

The proposed new rules delineate the basis of hospice and physician reimbursement and the limitations to this reimbursement. The structure of reimbursement closely parallels the Federal Medicare methodology for parallel hospice services. For patients who are dually eligible (both Medicare and Medicaid), Medicare reimburses the four per diem rates and Medicaid reimburses for room and board services, including certain leave days, if applicable. In addition, Medicaid will pay the Medicare co-payment for drugs and biologicals and for inpatient respite care.

The Fiscal Agent Billing Supplement, which contains instructions for provider claim submittal to Paramax/Unisys (the Division's Fiscal Agent), will be Appendix XII to the Hospice Services manual. The Fiscal Agent Billing Supplement is filed as part of the manual but is not reproduced in this proposal. Interested parties may contact the Division's Fiscal Agent or the Office of Administrative Law for copies of this material. Updates/replacement pages to the Fiscal Agent Billing Supplement will be provided to the Office of Administrative Law by the Division's Fiscal Agent when they are issued to providers.

The proposed amendments to N.J.A.C. 10:71-5.6 modify the rules on Medicaid eligibility for an institutional level of care to include persons receiving hospice benefits residing in the community. Normally, persons in the community are evaluated for eligibility against a monthly income standard of $453.25. With this modification, the income standard that would apply for persons electing hospice benefits would be the same as that used for persons seeking an institutional level of care. This higher standard is currently $1,266 monthly. In the context of the entire proposal, health options are enhanced for persons residing in the community who are not currently Medicaid eligible.

With respect to retroactive eligibility pursuant to Section 1902(a)(34) of the Social Security Act, 42 U.S.C. 1396a, this will be available to those Medicaid recipients who elect the hospice benefit but it will only be available from the date the recipient signed the election of hospice benefits statement, (see N.J.A.C. 10:53-3.2). This limitation does not apply to non-hospice Medicaid services.

Social Impact

The New Jersey Medicaid Hospice Services Program, by providing reimbursement for hospice services provided to Medicaid hospice recipients, enables hospices to expand the client base which they serve, thus providing access to care that would not otherwise be available to Medicaid recipients.

The hospice program is available to recipients who are categorically or optionally categorically needy. The hospice program is not available to Medically Needy recipients.

The use of the current monthly income standard for institutional care ($1,266), commonly referred to as the institutional "cap" standard, will enable categorical recipients to qualify for hospice care at a level of care appropriate to their condition. Recipients who elect hospice care will not have to have to become institutionalized to qualify under the "cap" standards (for hospice care only).

Because hospice services are based on principles of care emphasizing supportive and palliative care, rather than curative care, they constitute an alternative to acute patient care. Individuals who elect to receive hospice benefits may revoke that decision, and may later, if they so desire, resume care in another benefit period through the hospice program. Inpatient hospital care is provided when required for relief of symptoms. Hospice coverage is available to qualified applicants regardless of whether they reside in the community or in a nursing facility. It must be emphasized again that that the individual's participation in hospice is voluntary.

The proposed new rules impact upon hospice providers that enroll in the New Jersey Medicaid program. Hospice providers are required to comply with the provision of this manual regarding staffing, recordkeeping, patient care, billing and reimbursement, etc.

The proposed new rules impact indirectly on nursing facilities, who may have a Medicaid hospice patient residing therein. The NF will be reimbursed by the hospice, not the New Jersey Medicaid program.

Economic Impact

The combined Federal financial participation and State expenditure for hospice services in the State of New Jersey for the first fiscal year of the program is expected to be $500,000.

Qualified applicants in nursing facilities may be required to contribute towards the cost of their care. An individual in a facility is entitled to a personal needs allowance of $35.00 and an allowance for any medical insurance premiums. If he or she is married, an evaluation is made of the community spouse and a portion of the institutionalized spouse's income may be protected for the community spouse. This process is described at N.J.A.C. 10:71-5.6(e). Any remaining income of the institutionalized individual must be applied to the cost of his or her care.

Qualified applicants in the community are not required to contribute to the cost of their care. Recipients in the NF will be required to contribute to the cost of their care from their available income. The determination of available income will be made by the county welfare agency and entered on the PA-3L, Statement of Available Income for Medicaid payment (see proposed Appendix X).

Hospice providers will be reimbursed according to one of four per diem rates using HCPCS codes. (The acronym "HCPCS" refers to the Health Care Financing Administration Common Procedure Coding System). These codes represent four levels of care, Routine Care (Y6333), Continuous Care (Y6334), Inpatient Care (Y6335), and Respite Care (Y6336). The reimbursement rates are established annually by the Health Care Financing Administration, and adjusted by the Division using a wage index for designated geographic areas. Code numbers and narrative descriptions are described in the text of N.J.A.C. 10:53A-5.2.

With respect to HCPCS code Z2015, Room and Board Rate, this is used only for a recipient of hospice services residing in a nursing facility (NF) who has both Medicare/Medicaid coverage. The Division will reimburse the hospice provider at the prescribed rate. The hospice provider is responsible for reimbursing the NF.

The same concept of reimbursing the hospice at a percentage of the NF rate applies to procedure codes Y6337, "therapeutic leave day rate," and Y6338, "bed hold day rate." However, it should be noted that the "bed hold day rate" applies only to NF patients who require inpatient hospitalization for a period not to exceed 10 days pursuant to N.J.S.A. 30:4D-6.8, 6.9.

There are two HCPCS procedure codes used to cover co-payment situations for recipients who have both Medicare and Medicaid coverage. HCPCS code Y6339, Hospice Respite co-payment was designed to allow Medicaid to make a co-payment as described in the text when Medicare is providing coverage and is paying most of the claim. HCPCS code Y6343, Hospice Drug and Biological co-payment, allows Medicaid to make a co-payment as described in the text of the rule for biologicals and drugs prescribed on an outpatient basis.

Regulatory Flexibility Statement

A regulatory flexibility analysis is required because a hospice could be considered a small business under the Regulatory Flexibility Act (N.J.S.A. 52:14B-16 et seq.)

The proposed new rules apply equally to all Medicaid providers of hospice services. There is no differentiation based on size. Providers are required to maintain sufficient documentation of the recipient's medical history and changes in condition, pursuant to State law (N.J.S.A. 30:4D-12), and they are required to protect the health, safety and welfare of the recipients receiving treatment. The type of documentation required by Medicaid would be maintained by a provider in the normal course of providing hospice services and would comply, as well, with Medicare certification standards.

The type of records a hospice is required to keep are specified in N.J.A.C. 10:53A-2.6. Providers are required to keep medical records including, as a minimum, identifying information, the recipient's medical history and physical examination, date, test results, initial and subsequent assessments, certification and recertification documents, and plan of care. All medical records shall be signed and dated by the professional staff person providing the service, and made available to the Division or its agent for audit and review.

In addition, the provider must maintain the hospice eligibility forms, informed consent documents, and election forms and make them available to the Division or its agents.

With respect to the Division's "monitoring" system indicated in N.J.A.C. 10:53A-2.7, the provider must maintain sufficient data for the Division to monitor the Medicaid recipients receiving hospice service, dates of service, nature of the service, the cost per recipient, recipient eligibility, and to perform a comparative analysis between claim payments and the plan of care.

Providers who maintain adequate records and render services in accordance therewith will not be subject to the sanctions set forth in N.J.A.C. 10:53A-2.7(b).

The proposed rules are designed to reduce the adverse economic impact upon small businesses by mandating only recordkeeping essential to proper functioning and quality assurance of a hospice program. Hospice providers would be expected to maintain a medical history of the patient. In addition, these requirements are necessary for the health, safety and welfare of the recipients receiving hospice services.

Hospices are required to provide "core services" directly or under contract with other providers. They are required to hire the necessary staff with appropriate qualifications to implement hospice services.

There are no capital costs associated with these rules for hospices which are Medicaid approved providers.

A regulatory flexibility analysis is not required for the eligibility determination process because the recipients and the governmental agencies that determine eligibility are not considered small businesses under the terms of the Act.

Full text of the proposed new rules and amendments follows (additions indicated in boldface **thus**; deletions indicated by brackets [thus]):

CHAPTER 53A
HOSPICE SERVICES MANUAL

SUBCHAPTER 1. GENERAL PROVISIONS

10:53A-1.1 Introduction

Reimbursement for hospice services provided by Medicaid was authorized pursuant to 1905(o) of the Social Security Act, codified as 42 U.S.C. 1396(d). N.J.S.A. 30:4D-6b(20) authorizes that the New Jersey Division of Medical Assistance and Health Services develop a program of hospice services. The Hospice Services Manual (N.J.A.C. 10:53A) sets forth the rules for the provision of hospice services to the terminally ill who are eligible for Medicaid. Room and board services are also available for those Medicaid recipients residing in a nursing facility that are eligible for hospice services. The Home Care Services Manual, N.J.A.C. 10:60, is applicable to hospice care as a waiver service provided under the AIDS Community Care Alternatives Program (ACCAP).

10:53A-1.2 Definitions

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

"Benefit period" means a period of time when an individual is eligible to receive hospice services. Hospice benefit periods are for the following periods of time: 90 days; 90 days; 30 days; and an unlimited fourth period.

"CAP" means a limitation on the payment amount or aggregate days of inpatient care as imposed by Medicaid on the hospice provider. The "CAP" year begins on November 1st of one year and ends on October 31st of the next year.

"Comprehensive hospice benefit" means the covered services provided by hospices and physicians for hospice care, room and board services provided to Medicare/Medicaid recipients residing in a nursing facility, and services unrelated to the terminal illness that may be provided by Medicaid as part of the hospice plan of care. The comprehensive hospice benefit does not include hospice services under ACCAP or any other waiver program.

"Dietician" or "dietary consultant" means a person who:

1. Is registered or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association; or

2. Has a bachelor's degree from a college or university with a major in foods, nutrition, food service or institution management, or the equivalent course work for a major in the subject area; and has completed a dietetic internship accredited by the American Dietetic Association or a dietetic traineeship approved by the American Dietetic Association or has one year of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting; or

3. Has a master's degree plus six months of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting.

"Division" means the Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

"Election of Hospice Benefit Statement" means a written document signed by a Medicaid eligible individual for hospice services, indicating the following: the identification of the particular hospice that will provide care to the individual; the scope of services and conditions under which hospice services are provided; which other Medicaid services are forfeited when choosing hospice services; the individual or his or her representative's acknowledgement that he or she has been given a full understanding of hospice care; and the effective date of the signing of the Election of Hospice Benefits Statement (FD-378) (incorporated herein by reference as Appendix I).

"Hospice," for the purposes of the New Jersey Medicaid program (hereafter referred to as the Program), means a public agency or private organization (or subdivision of such organization) that is Medicare certified for hospice care and has a valid provider agreement with the Division to provide hospice services. A hospice is primarily engaged in providing supportive or palliative care and services, rather than curative care, to the terminally ill and/or bereaved. Hospice providers in New Jersey are hospital-based or free-standing home health agencies, or free-standing hospice agencies.

"Hospice indicator" means a unique date specific identifier in the Medicaid eligibility record which is used in the processing of hospice claims for eligible recipients.

"Hospice services," for the purposes of the Program, means services which support a philosophy and method for caring for the terminally ill emphasizing supportive and palliative rather than curative care, and includes services, such as home care, bereavement counseling, and pain control.

"Interdisciplinary group" means a group of professionals who are employees of the hospice, that provide and/or supervise hospice services. The interdisciplinary group, at a minimum, must be composed of a physician, a registered professional nurse, a medical social worker and a pastoral or other counselor.

"Medical Director" means a physician (M.D. or D.O.) who assumes overall responsibility for the medical component of the hospice services as an employee of the hospice.

"Room and board services," as referred to in this chapter, means the performance of personal care services, assistance in activities of daily living, provision of patient social activities, the administration of medications, the maintenance of the cleanliness of a resident's room, and supervision and assistance in the use of durable equipment and prescribed therapies provided to hospice recipients in a nursing facility (identical to those provided to non-hospice recipients in a nursing facility).

"Terminal illness," as referred to in this chapter, means having a medical prognosis of a life expectancy of six months or less as certified or recertified, in writing, by a licensed physician (M.D. or D.O.).

"Unrelated services" means services provided that are necessary for the diagnosis and treatment of diseases or illnesses that are not in and of themselves related to or are not caused primarily by the terminal condition for which hospice services are provided.

SUBCHAPTER 2. PROVIDER REQUIREMENTS

10:53A-2.1 Hospice enrollment requirements

(a) To be approved by the Division as a hospice provider, a hospice must:

1. Be approved for Medicare (Title XVIII) participation by the federal Health Care Financing Administration (HCFA) as a hospice provider. A copy of the Medicare certification must be submitted to the Division of Medical Assistance and Health Services; and

2. Complete and submit the Medicaid "Provider Application" (FD-20); "Ownership and Controlling Interest Statement" (HCFA-1513); and the "Medicaid Provider Agreement" (FD-62).

i. The documents, referenced in (a)2 above, are located as Forms 8, 9, and 10 in the Appendix of the Administration Chapter, (N.J.A.C. 10:49-Appendix) at the end of the chapter, and may be obtained from and submitted to:

Paramax/Unisys Corporation
Provider Enrollment
CN 4804
Trenton, New Jersey 08650-4804

ii. Hospice provider agreements are approved by the:

Chief, Provider Enrollment Unit
Division of Medical Assistance and Health Services
CN-712
Trenton, New Jersey 08625-0712

iii. A change in the ownership of a hospice is not considered a change in the individual's designation of a hospice and requires no action on the Medicaid hospice recipient's part. The hospice shall notify the Division in writing of a change in ownership and shall submit a new application package.

(b) If the hospice is providing hospice services to a Medicaid recipient residing in a nursing facility (NF), the nursing facility must be a Medicaid-approved nursing facility. The hospice must also have a written contract with the nursing facility under which the hospice takes full responsibility for the professional management of the individual's hospice services and the nursing facility agrees to provide room and board services to the individual.

1. Room and board services include the performance of personal care services, assistance in activities of daily living, provision of patient social activities, the administration of medications, the maintenance of the cleanliness of a resident's room, and supervision and assistance in the use of durable equipment and prescribed therapies provided to hospice recipients in an NF (identical to those provided to non-hospice recipients in an NF).

(c) If the hospice is already a Medicaid ACCAP hospice provider, in lieu of the process listed in (a) above, the hospice shall send a letter citing its ACCAP provider status to the Provider Enrollment Unit of the Division whose address is listed in (a)2ii above, requesting approval as a hospice provider of room and board services and/or as a provider of the comprehensive hospice benefit.

(d) Upon approval as a hospice provider, the hospice shall be assigned a Medicaid provider number. In the event the hospice provider is also an ACCAP hospice provider, the hospice provider number will be the same under both programs.

(e) For the purposes of reimbursement, if a physician provides direct patient care services to a hospice recipient, he or she must be an approved Medicaid physician provider (see Physician Services Manual, N.J.A.C. 10:54).

(f) The Fiscal Agent shall furnish a provider manual and an initial supply of pre-printed claim forms.

10:53A-2.2 Changing from one hospice to another

(a) In order for a hospice recipient to change hospices, the hospice policies and procedures listed below shall be followed:

1. An individual may change hospices once in each benefit period. The change of the hospice is not considered a revocation of the election of hospice services.

2. In order to change the designation of the hospice, an individual shall file a signed statement, the Change of Hospice, FD-384 (6/92) form (incorporated herein by reference as Appendix VII), with the hospice where the individual was initially enrolled and also with the newly designated hospice. The statement shall include the following information:

i. The name of the hospice from which the individual received hospice services; and

ii. The name of the hospice from which the individual will receive hospice services and the date the change is effective.

3. The original hospice of enrollment and the new hospice must send the Hospice Eligibility Form, FD-383 (6/92) to the MDO, CWA or DYFS, as applicable, in order to change providers. (See Appendix VI in this manual, incorporated herein by reference, for the Hospice Eligibility Form, FD-383 (6/92) and N.J.A.C. 10:53A-3.2 for the application policy for medical and financial eligibility.)

10:53A-2.3 Physician certification and recertification

(a) The hospice shall follow these policies and procedures to obtain physician certification of the applicant's terminal illness and to certify that hospice services are reasonable and necessary for the palliation and management of the terminal illness or related conditions.

1. The attending physician, who must be a doctor of medicine (M.D.) or osteopathy (D.O.), is the one identified by the Medicaid applicant at the time the applicant elects to receive hospice services as the primary physician in the determination and the delivery of the applicant's medical care.

2. The written Physician Certification/Recertification for Hospice Benefit Form, FD-385 (6/92) (Appendix VIII, incorporated herein by reference) shall be obtained within two calendar days after hospice care is initiated for the first period of hospice coverage.

i. If the hospice does not obtain written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these two days and a written certification no later than eight calendar days after care is initiated. If these requirements are not met, no payment can be made for any days prior to the certification.

ii. The signing of the written form shall be done by the hospice Medical Director, or physician of the interdisciplinary team and the attending physician (if the applicant has an attending physician), and shall include the statement that the applicant's medical prognosis is such that the life expectancy is six months or less.

3. If the hospice recipient revokes the hospice benefit package and then reenters the hospice in any subsequent period, the hospice shall obtain, no later than seven calendar days after the beginning of that period, a written Physician Certification/Recertification for Hospice Benefit Form, FD-385 (6/92) prepared by the Medical Director of the hospice or the physician member of the hospice's interdisciplinary group.

4. For subsequent recertifications, a written recertification must be obtained no later than two business days after the period begins (after the first 90-day benefit period, after the next 90-day benefit period, and after the third 30-day period). The Medical Director of the hospice or physician member of the interdisciplinary team shall recertify that the individual is terminally ill and that hospice services are reasonable and necessary for the palliation and management of the terminal illness or related condition, and, in addition, recertify the necessity of the continuing need for hospice services.

5. In addition, the individual's attending physician is required to recertify the terminal illness for the fourth unlimited benefit period, as described below:

i. An additional Physician Certification/Recertification for Hospice Benefit Form, FD-385 (6/92) must be obtained prior to the fourth unlimited period but no later than two days after the period begins.

6. The hospice must retain the Physician Certification/Recertification for Hospice Benefits Form(s), FD-385 (6/92) on file for review by the Division in the recipient's medical record.

10:53A-2.4 Standards for staffing

(a) The Medical Director of the hospice shall assume overall responsibility for the medical component of the hospice services.

(b) The hospice shall designate an interdisciplinary group or groups composed of, at a minimum, the following individuals who are employees of the hospice and who provide and/or supervise the services offered by the hospice:

1. A physician (doctor of medicine or osteopathy);

2. A registered professional nurse;

3. A medical social worker (see N.J.A.C. 10:53A-3.4 for qualifications); and

4. A pastoral or other counselor.

(c) The interdisciplinary group shall be responsible for the following:

1. Participation in the establishment of the plan of care;

2. Provision or supervision of hospice services in coordination with the recipient's attending physician;

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

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

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

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

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

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

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

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

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

(b) If the recipient residing in an NF chooses hospice benefits, the NF shall submit to the Fiscal Agent, a completed Long Term Care Turnaround Document (MCNH-117) (Appendix XI, incorporated herein by reference) form to remove the patient from the Long Term Care Billing System. The following information shall be placed on the MCNH-117 in the REMARKS column (Field #38 on the bottom):

"DISCHARGED FROM NURSING FACILITY TO HOSPICE"

1. The hospice recipient is removed from the Long Term Care Billing System effective on the date the Election of Hospice Benefit Statement, FD-378 (6/92) (Appendix I) is signed. On that date and thereafter, the Medicaid Fiscal Agent will directly reimburse the hospice for services rendered to the hospice recipient and the NF will no longer be reimbursed for care beginning this date. The hospice shall be responsible for reimbursing the NF for room and board services provided under contract with the hospice.

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

"ADMITTED TO NURSING FACILITY AND DISCHARGED FROM HOSPICE"

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

10:53A-2.6 Recordkeeping

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

1. Identification information;
2. Certification/recertification documents;
3. Informed consent documents;
4. Election forms;
5. Hospice eligibility forms;
6. Pertinent medical history and physical examination data;
7. Test results;
8. Initial and subsequent assessments;
9. Plan of care and updates; and
10. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

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

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

10:53A-2.7 Monitoring

(a) On a random selection basis, the Division shall conduct post-payment quality assurance reviews based on Surveillance and Utilization Review System (SURS) reports and other sources to assure compliance with program, personnel, recordkeeping and service delivery requirements. Provisions shall be made to recover funds,

when reviews by the Division reveal that overpayments to the hospice have been made. At the specific request of the Division, the hospice shall submit a plan of care and other documentation for those Medicaid recipients selected for a quality assurance review.

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

i. Number of recipients;

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

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

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

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

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

10:53A-2.8 Provision for provider fair hearings

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

10:53A-2.9 Advance directives

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 3. RECIPIENT REQUIREMENTS

10:53A-3.1 Eligibility for covered hospice services

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

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

1. The transfer of resource provisions of N.J.A.C. 10:71-4.7 apply to persons seeking hospice services while residing in a nursing facility as well as to persons seeking eligibility for hospice services in the community but whose income disqualifies them from New Jersey Care ... Special Medicaid Programs.

2. Persons not already eligible for Medicaid but who express interest in hospice services should be referred to the county welfare agency for a determination of eligibility. Persons already residing in a nursing facility should be referred to a county welfare agency of the county in which the facility is located. Persons in the community or waiting for placement in a nursing home should be referred to the county welfare agency in their county of residence.

3. When providing services to members of the Garden State Health Plan (GSHP), an authorization number shall be obtained from the applicant's GSHP physician case manager prior to providing hospice services. Hospice agencies shall use this authorization number when billing for services provided to a GSHP member.

(c) In addition to financial eligibility, the individual applying for Medicaid hospice eligibility shall meet the following conditions:

1. He or she shall voluntarily elect the hospice services (see N.J.A.C. 10:53A-3.2);

2. If eligible for Medicare, he or she shall assign his or her Medicare Part A benefits for hospice care. For dually eligible Medicare and Medicaid hospice recipients, the hospice benefits election applies simultaneously under both the Medicare and Medicaid programs;

3. He or she shall be certified or recertified as terminally ill by the attending physician (see N.J.A.C. 10:53A-2.3) and be certified by the attending physician that hospice services are reasonable and necessary for the palliation or management of the terminal illness or related conditions by the completion of the Physician Certification/Recertification for Hospice Benefit Form FD-385 (6/92). A copy of this form shall be part of the medical record at the hospice agency;

4. He or she shall have a plan of care for hospice services established prior to and consistent with the provision of hospice services. (For information on the plan of care, see N.J.A.C. 10:53A-3.6); and

5. He or she shall waive all rights to the following:

i. Those hospice services provided by a hospice other than the one designated by the recipient (unless provided under written arrangements made by the designated hospice); and

ii. Any Medicaid services that are related to the treatment of the terminal condition for which hospice services were elected, or for a related condition, or for services equivalent to hospice care, except for the following services:

(1) Those provided (either directly or under arrangement) by the designated hospice; and

(2) Those provided by the recipient's physician or consulting physician in treatment of the terminal condition, if that physician is not an employee of the designated hospice receiving compensation from the hospice for those services.

(d) Applicants in the following categories may be eligible for hospice if the applicant meets the criteria listed in (b) and (c) above.

1. The aged;

2. The blind;

3. The disabled;

4. Children under 21 years of age including those under the supervision of the Division of Youth and Family Services (DYFS);

5. Caretaker relatives who have dependent children in their care; or

6. Pregnant women (up to 60 days postpartum).

10:53A-3.2 Application policy for medical and financial eligibility for hospice services

(a) The application policy for medical eligibility for hospice services is as follows:

1. Individuals requesting or initiating hospice eligibility should be referred to a Medicaid approved hospice to complete the hospice medical eligibility requirements for hospice services through the completion of the Physician Certification/Recertification for Hospice Benefit Form, FD-385 (6/92) and the Election of Hospice Benefits Statement, FD-378 (6/92).

2. The hospice shall notify the agency (that is, the county welfare agency (CWA), the Division of Youth and Family Services (DYFS), or the Medicaid District Office (MDO) (for SSI recipients), as applicable), responsible for maintaining the hospice "indicator" (Special Program Number 15) of the completion of the medical eligibility requirements in (a)1 above. The notification must be done through the use of the Hospice Eligibility Form, FD-383 (6/92). The form shall also be sent to the address listed below to indicate to the Division of the completion and/or change in the medical eligibility:

Hospice Program
Division of Medical Assistance and Health Services
CN-712
Trenton, New Jersey 08625-0712

i. The date of the signing of the Election of Hospice Benefits Statement, FD-378 (6/92) determines the date of eligibility for hospice services if the applicant is eligible for Medicaid.

(b) The application policy for financial eligibility is as follows:

1. After medical eligibility has been determined, all applicants (whether previously eligible for Medicaid or not) should be referred to the CWA, DYFS or the MDO, as applicable, for hospice financial eligibility processing. If the applicant's Medicaid eligibility status has not been established, is not known, or is uncertain, the hospice agency shall contact the MDO to determine where to refer the potential applicant.

2. For the recipient who had been eligible for regular Medicaid benefits (such as through AFDC, Medicaid Only or New Jersey Care ... Special Medicaid Programs), the CWA is responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD-383) (6/92).

3. Exceptions: The instructions in (b)1 and 2 above do not apply if the applicant is eligible through DYFS or SSI. For instructions for those eligible through DYFS or SSI, see (b)4 or 5 below, respectively.

4. If the applicant for hospice services is under the supervision of DYFS, DYFS shall be responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of the Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD-383) (6/92).

5. If the applicant for Medicaid hospice services is SSI eligible, the MDO is responsible for assigning the hospice "indicator" and to notify the hospice, in writing, of the date of the Medicaid eligibility for hospice by returning the Hospice Eligibility Form (FD-383) (6/92). (See N.J.A.C. 10:49, Administration, (Appendix), for the list of Medicaid District Offices.)

6. The medical eligibility materials (copies of the Physician Certification/Recertification for Hospice Benefits, FD-385 (6/92) form and the Election of Hospice Benefits Statement, FD-378, (6/92)) shall be forwarded by the hospice to the MDO, CWA or DYFS, as applicable.

7. All other applicants for room and board services, including those who would lose SSI because of monthly income shall be referred to the CWA. For individuals determined eligible, see (b)2 above for processing responsibilities.

(c) Rules for retroactive Medicaid eligibility in N.J.A.C. 10:49 apply to those recipients eligible for Medicaid, prior to their Medicaid application for hospice. In addition, the following retroactive eligibility rule applies:

1. No retroactive eligibility payment will be authorized for hospice services prior to the date the Election of Hospice Benefits Statement, FD-378 (6/92) is signed. Retroactive eligibility for hospice services may be established for up to three months prior to Medicaid eligibility provided the Election of Hospice Benefits Statement, FD-378 (6/92) had been signed. Such cases must be referred to the following address for determination of retroactive eligibility:

Retroactive Eligibility Unit
Division of Medical Assistance and Health Services
CN-712
Trenton, New Jersey 08625-0712

2. For an applicant who becomes initially eligible for Medicaid, solely because of his or her hospice status, Medicaid eligibility begins with the date the Election of Hospice Benefits Statement, FD-378 (6/92) was signed by the applicant, or his or her representative. In these cases, retroactive eligibility is not available prior to the date on the Election of Hospice Benefits Statement, FD-378 (6/92).

(d) The hospice shall notify the agency determinining eligibility (MDO, CWA or DYFS) through a copy of the Hospice Eligibility Form, FD-383 (6/92) of a change in the recipient's status which could affect the eligibility for Medicaid and/or for hospice services, a change in the hospice provider status, or a change in a recipient's address.

(e) A limited access Medicaid Eligibility Identification Card (MEI) with the statement "Except for hospice and physician services, CHECK WITH HOSPICE PROVIDER for other services" shall be issued to a Medicaid recipient who is eligible for hospice services. The hospice shall provide the name and telephone number of the contact person within the hospice so that other providers may obtain approval from the hospice for other than hospice and physician services.

1. When the hospice applicant is also a Garden State Health Plan member, the following process shall be followed by the hospice:

i. A member of the Garden State Health Plan has a message on his or her Medicaid Eligibility Identification Card (MEI) which states, "HMO-Check GSHP ID Card". Each member of the GSHP will also have a gold-colored GSHP-ID card which lists the name and telephone number of the member's physician case manager. The hospice provider shall obtain from the member of the Garden State Health Plan who requests hospice services, a Garden State Health Plan Authorization Form (GSHP-7) (9/91) which is completed by the member's physician case manager and specifically authorizes hospice services.

ii. The hospice provider shall use the authorization number which is imprinted on the top right hand corner of the GSHP-7 form when billing for services provided to a member of the GSHP.

10:53A-3.3 Benefit periods

(a) There are two 90-day benefit periods, one 30-day period, and a fourth unlimited period. The two 90-day periods must be used before the 30-day period and all three periods must be used before the fourth unlimited benefit period. The benefit periods shall be recorded on a Hospice Benefits Statement, FD-379 (6/92) (Appendix II, incorporated herein by reference) and filed in the recipient's medical record.

(b) Contents of the Election of Hospice Benefits Statement, FD-378 (6/92) shall include the following:

1. The identification of the particular hospice that will provide the care to the applicant;

2. The applicant's or his or her representative's acknowledgment, that he or she has been given a full understanding of hospice services;

3. The applicant's or his or her representative's acknowledgment that he or she understands that the regular Medicaid services other than hospice services are waived by the signing of the Election of Hospice Benefits Statement, FD-378 (6/92) and/or the Representative Statement for the Election of Hospice Benefits, FD-380 (Ap-

pendix III, incorporated herein by reference), unless the services are prior authorized;

4. The effective date of the election statement; and

5. The signature of the applicant or the applicant's representative.

(c) The hospice applicant is eligible for three benefit periods of hospice services (90 days, 90 days, and 30 days, totaling 210 days) and a fourth unlimited benefit period with the approval of the hospice provider, if the applicant or his or her representative files an Election of Hospice Benefits Statement, FD-378 (6/92) with a particular hospice.

1. A hospice recipient shall designate an effective date for the beginning of hospice services which shall not be earlier than the date the election is made.

(d) Revocation of election of hospice services shall be as follows:

1. The recipient may choose at any time to institute a "break" (a time period when care other than hospice care is given) between benefit periods or by a revocation of hospice services.

2. The Election of Hospice Benefits Statement, FD-378 (6/92) shall be considered to be valid through subsequent benefit periods if there is no "break" in care.

3. A new Election of Hospice Benefits Statement, FD-378 (6/92) is required to be filed following a break or revocation of hospice service.

i. The recipient or his or her representative shall file a signed statement with the hospice provider that indicates the recipient revokes the election for Medicaid coverage of hospice services for the remainder of the election period with the date that the revocation is to be effective.

ii. When revoked, the recipient forfeits hospice services for any remaining days in the benefit period. A recipient may not receive hospice services later than the effective date that the revocation is signed.

iii. The hospice shall immediately notify the agency that determined hospice eligibility (either CWA, DYFS or the MDO) of the revocation of hospice, verbally if possible, and also by filling out and submitting the Hospice
Eligibility Form, FD-383 (6/92) to the eligibility source (CWA, MDO or DYFS, as applicable) so that the recipient's hospice eligibility may be terminated. The hospice shall also fill out the Termination of Hospice Benefits, FD-382 (6/92) (Appendix V, incorporated herein by reference) and retain this form in the recipient's medical record.

(e) Entitlement to all other Medicaid services may be restored if the recipient continues to be Medicaid eligible, under the following circumstances:

1. When the 210 days of hsopice entitlement has expired, and the recipient does not choose the fourth unlimited benefit period; or

2. When the recipient revokes hospice services.

(f) When a hospice recipient residing in a nursing facility revokes the hospice benefit and returns to the status of a patient of the NF, the hospice shall proceed as follows:

1. The Hospice Eligibility Form, FD-383 (6/92) shall be completed and submitted to the MDO after the recipient has signed the Revocation of Hospice Benefits, FD-381 (6/92) form indicating he or she has revoked the Medicaid hospice benefit.

2. The nursing facility shall conform to the nursing facility rules in the Long Term Care Facilities Services Manual, N.J.A.C. 10:63 for admission and placement for this recipient similar to any admission to the NF.

i. Upon discharge from the hospice, the recipient, upon admission or readmission to the NF, is counted in the "occupancy rate" by the NF. The recipient is not counted as part of the NF census or "occupancy rate" if he or she is a hospice patient residing in the NF.

10:53A-3.4 Covered hospice services

(a) The amount, character, and scope of New Jersey Medicaid hospice services shall be the same for all hospice recipients and shall not be less than the hospice services provided under Medicare (Title XVIII) (Section 1861 (dd) et seq. of the Social Security Act, codified as 42 U.S.C. Section 1395x(dd)1).

(b) The Division reimburses for covered hospice services that are reasonable and necessary for the palliation and management of the terminal illness, and which are provided to a hospice recipient consistent with the recipient's individualized plan of care.

1. Required hospice services which shall be available to the hospice recipient include nursing care, medical social services, supervisory physician services, counseling services, durable medical equipment and supplies including drugs and biologicals, homemaker/home health aide services, physical therapy, occupational therapy and speech-language pathology services.

i. The following services are considered "core" hospice services: nursing care, medical social services, physician services and counseling services.

(1) A hospice provider shall ensure that substantially all core services are routinely provided directly by hospice employees.

(2) A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of hospice recipients during periods of peak patient loads or under extraordinary circumstances or to obtain physician specialty services.

(3) If contracted staff is used, the hospice shall maintain professional, financial and administrative responsibility for the services and shall assure the qualifications of the staff and that services meet all requirements under each level of care.

(c) Covered hospice services are reimbursed at predetermined, prospective, inclusive rates corresponding to one of four levels of care. Two of the levels of care are reimbursed for services provided in the home: Routine Home Care and Continuous Home Care; and two levels of care are reimbursed for services provided on an inpatient basis: Inpatient Respite Care and General Inpatient Care in either a hospital or nursing facility (see also, N.J.A.C. 10:53A-4.1). The provisions at (c)1 through 4 below apply to the levels of care provided by the hospice.

1. The routine home care rate is reimbursed if less skill than professional registered nursing, or licensed practical nursing, or less intensity than continuous home care is needed to enable the person to remain at home.

i. The routine home care rate includes the following services: routine nursing services, social work, counseling services, durable medical equipment, supplies, drugs, home health aide/homemakers, physical therapy, occupational therapy, and speech-language pathology services. The routine home care rate includes respite care delivered in the home that is not predominately nursing care.

ii. The routine home care rate is reimbursed when the recipient is not receiving continuous home care, regardless of the volume and intensity of routine home care services.

2. The continuous home care rate is reimbursed only during a period of medical crisis to maintain the recipient at home where most of care is skilled nursing care on a continuous basis to achieve palliation or management of the recipient's acute medical symptoms and only as necessary to maintain the recipient at home.

i. A minimum of eight hours of nursing care must be provided during a 24-hour day which begins and ends at midnight before the Continuous Home Care rate can be paid. The nursing care need not be sequential, that is, four hours may be provided in the morning and four hours in the evening of the same day.

ii. The nursing care must be provided either by a registered professional nurse, or a licensed practical nurse under the supervision of a registered professional nurse. More than half (four hours or more) of the period of care must be nursing care provided by licensed nurses.

iii. The Continuous Home Care rate includes homemaker/home health aide services which may be provided to supplement the nursing care, but not to substitute for the minimal amount of nursing care provided by the licensed nurses.

3. Inpatient respite care is short-term, occasional, inpatient care provided to the recipient in a hospital or nursing facility only when necessary to relieve the family members or other persons caring for the recipient at home.

i. The inpatient respite care rate is not reimbursed for more than five consecutive days.

ii. Inpatient respite care is provided by a hospice to a Medicaid hospice recipient in either a hospital or a nursing facility. The inpatient respite care rate or the payment of room and board services under hospice is not provided when a recipient is considered a nursing facility patient and not a hospice patient.

4. The general inpatient care rate is reimbursed when provided in a hospital or nursing facility during periods of acute medical crisis, for palliative care, for pain control, or management of acute and severe clinical problems which cannot be managed in another setting.

5. Concerning the limitation on the aggregate payments to hospice providers for inpatient respite care and general inpatient care, see N.J.A.C. 10:53A-4.3.

(d) Specific services provided by a hospice within each level of care related to the terminal illness and paid under the per diem rate schedule, are listed as follows:

1. Nursing care provided by or under the supervision of a registered professional nurse;

2. Physical therapy, occupational therapy, and speech-language pathology provided by a qualified therapist for the purpose of symptom control or to enable the recipient to maintain activities of daily living and basic functional skills;

3. Medical social services provided by a social worker who has at least a bachelor's degree in social work from a school accredited or approved by the Council of Social Work Education, and who is working under the direction of a physician and with the interdisciplinary team;

4. Homemaker/Home Health aide services shall be provided by a homemaker/home health aide who has been certified as having successfully completed a training program approved by the New Jersey State Board of Nursing, Department of Law and Safety. Home health aides shall provide those personal care services as described in the Home Care Services Manual, (N.J.A.C. 10:60), N.J.A.C. 10:60-2.2(c) under the supervision of a registered professional nurse;

i. Homemaker/Home Health aide services may be provided on a 24-hour, continuous basis but only during periods of a recipient's crisis, not a family crisis, and only as necessary to maintain the terminally ill recipient at home;

ii. A registered professional nurse shall visit the home of the hospice recipient at least every two weeks when homemaker/home health aide services are provided for the purpose of assessing the homemaker/home health aide services and provide education and supervision to the aide, as needed;

5. Durable medical equipment and supplies included in the plan of care, as well as self-help and personal comfort items which are reasonable and necessary for palliation and management of the recipient's terminal illness;

6. Drugs and biologicals included in the plan of care primarily for the relief of pain and symptom control for a recipient's terminal illness;

7. Nutritional supplements that are part of the palliation and routine care of the hospice recipient; and

8. Counseling, provided with respect to care of the terminally ill recipient, for family members or other persons caring for the recipient at home and provided by members of the interdisciplinary group, as well as by other qualified professionals as determined by the hospice provider.

i. Counseling, including dietary counseling, shall be provided both for the purpose of training the recipient's family or other caregiver to provide care, and for the purpose of helping the recipient and those caring for him or her to adjust to the nature of the recipient's illness.

ii. Bereavement counseling consists of counseling services provided to the recipient's family after the recipient's death under the supervision of a qualified professional. Bereavement counseling is a required inclusive component of hospice service and is not separately reimbursed by Medicaid.

(1) The plan of care shall clearly delineate the type of counseling services to be provided and the frequency of the delivery of the service which shall be offered up to one year following the death of the recipient.

iii. Dietary counseling, when necessary, provided by a qualified professional dietician or dietary consultant.

iv. Spiritual counseling including notice to the recipient as to the availability of appropriate clergy.

(e) Room and board services identical to those provided to non-hospice Medicaid recipients shall be provided for hospice recipients residing in a nursing facility. The recipient eligible for hospice services who is residing in a Medicaid approved nursing facility is considered a hospice recipient, not a patient of a nursing facility.

1. Room and board services include the performance of personal care services, assistance in activities of daily living, provision of patient social activities, the administration of medications, the maintenance of the cleanliness of a resident's room, and supervision and assistance in the use of durable equipment and prescribed therapies.

2. The Pre-admission Screening (PAS) rules do not apply to a hospice patient admitted directly to a nursing facility or changed from nursing facility care to hospice care. This individual would be considered a hospice patient, not an NF patient. If the hospice patient revokes the hospice benefit and returns to that NF's care or the care of another NF, the PAS rules apply which are in the Long Term Care Services Manual, N.J.A.C. 10:63 (see N.J.S.A. 30:4D-17.10).

(f) Physician services for administration, interdisciplinary group activities, and general supervisory activities of the medical director, his or her designated representative, or other physician employees of the hospice provider, or those working under arrangements with the hospice, are considered "core services" and are included in the hospice per diem rate. These services shall not be billed separately to the Fiscal Agent.

1. The cost of physician services for direct personal care shall be covered as a separate service only for physician employees of the hospice who do not volunteer for these services. In such instances, the physician may receive separate reimbursement above the hospice per diem rate when physician services are billed by this employee. The hospice shall not bill on behalf of the physician for these direct personal care services. For the procedures for the reimbursement of these services, see N.J.A.C. 10:53A-4.2.

(g) Regarding other covered services, some Medicaid services which are not duplicative of hospice services may be covered by Medicaid for the hospice recipient. These services include optometric and optical services, prosthetic and orthotic services, medical day care services, and personal care services. These services must be approved by the interdisciplinary team, be consistent with the plan of care and be determined to be medically necessary.

10:53A-3.5 Services unrelated to the terminal illness

(a) The hospice recipient, by signing the Election of Hospice Benefits Statement, FD-378 (6/92) agrees to waive most regular Medicaid services. However, Medicaid covered services unrelated to the terminal illness, included in the plan of care, may be provided by approved Medicaid providers upon approval of the interdisciplinary team of the hospice.

1. The reasons for providing unrelated services and the verification that the unrelated services are not, in any way, related to the terminal illness shall be documented in the plan of care by a member of the interdisciplinary team.

i. Documentation shall clearly specify those services that are related to and those services that are unrelated to the terminal illness.

ii. Services unrelated to the terminal illness are subject to the same coverage provisions, limitations, prior authorization requirements, and conditions applied to services available to other general non-hospice Medicaid recipients.

iii. All payments for services (except for physician's services) that are unrelated to the terminal illness may be denied if not approved by the interdisciplinary team, documented in the plan of care and on file in the patient's medical record.

(b) The fourth unlimited benefit period beyond 210 days of hospice care must also be approved by the interdisciplinary team of the hospice as an integral part of the plan of care.

1. If a fourth unlimited period of hospice services is anticipated, the hospice shall document in the recipient's medical record, the approval of this period by the interdisciplinary team at the beginning of the third benefit period. Approval by the interdisciplinary team prior to the delivery of hospice services is required for payment for services.

2. A new Physician Certification/Recertification for Hospice Benefits Form, FD-385 (6/92) is required for the approval by the interdisciplinary team for the fourth unlimited benefit period.

(c) The documentation of the approval of unrelated services and the fourth benefit period shall be filed in the recipient's medical record with the copy of the claim form and be made available upon request for post-payment review purposes.

10:53A-3.6 Plan of care

(a) Requirements for the initial plan of care for recipients of hospice services are listed below:

1. At least one of the persons involved in developing the initial plan of care shall be a registered professional nurse or physician.

2. In establishing the initial plan of care, the member of the basic interdisciplinary group (a physician, a registered professional nurse, a medical social worker, or a counselor) who assesses the recipient's needs shall contact at least one other group member before writing the initial plan of care.

3. The initial plan of care shall be established on the same day as the assessment if the day of assessment is to be considered a covered day for hospice services.

4. At a minimum, the other two members of the basic interdisciplinary group shall review the initial plan of care and provide their input to the plan of care within two calendar days of the day of assessment.

5. The initial plan of care shall be approved by the Medical Director of the hospice by his or her signature on the plan of care in the medical record, thereby assuming professional medical responsibility for the hospice care.

(b) Requirements for the continuing plan of care for recipients of hospice services are listed below:

1. All services provided to each hospice recipient must be approved by the interdisciplinary team of the hospice as an integral part of the plan of care. The medical necessity for emergent/urgent services shall be justified by the attending physician and documented in the plan of care in the medical record.

2. The plan of care shall be signed by the attending physician, the Medical Director or his or her physician designee and the interdisciplinary group prior to the complete implementation of the plan of care, thereby assuming the professional medical responsibility for the hospice care.

3. The plan of care shall be reviewed and updated in a timely manner as specified by the plan of care, but at least once a month, by the attending physician, the Medical Director or physician designee, and the interdisciplinary team. These reviews shall be documented in the hospice recipient's medical record.

4. The plan shall include the assessment of the recipient's needs and identification of the services, including the management of discomfort and symptom relief. The scope and frequency of hospice services and other services needed to meet the needs of the hospice recipient and the family shall be stated in detail in the plan of care and appropriately documented in the medical record.

10:53A-3.7 Provision for recipient fair hearings

Pursuant to N.J.A.C. 10:49-10 (Notices, Appeals and Fair Hearings), Medicaid recipients have the right to file for fair hearings.

SUBCHAPTER 4. BASIS OF PAYMENT

10:53A-4.1 Post-eligibility treatment of income

(a) For a hospice recipient residing at home, who is eligible only for hospice services, the policy for handling the post-eligibility treatment of income is the same as that of the Division's home and community-based waivers, for example, CCPED. For these recipients, there is no available income to be applied to the cost of care because the maintenance standard in the home and community-based waiver programs has been determined to be equal to the income eligibility standard for Title XIX approved facilities (see N.J.A.C. 10:71-5).

(b) For a recipient who is residing in a nursing facility and receiving hospice under Medicaid, payment to the hospice for room and board services shall be reduced by the recipient's available income. Available income is that amount which remains after deducting certain amounts from the recipient's gross income, as determined in accordance with the N.J.A.C. 10:71.

1. Instructions for the use of the "Statement of Available Income for Medicaid Payment (PA-3L)" form, incorporated herein by reference as Appendix X, are as follows:

i. The hospice is responsible for ensuring that the amount of the recipient's available income is reported and that the amount corresponds to that attributed to the recipient's account on the Statement of Available Income for Medicaid Payment (PA-3L). The available income must be deducted by the hospice from the amount billed the Fiscal Agent. The hospice shall be liable to the Division for any available income not reported to the Fiscal Agent by the hospice.

ii. The Statement of Available Income for Medicaid Payment (PA-3L) is completed by the CWA on each non-SSI Medicaid recipient that receives hospice services in the community, the NF or the hospital.

(1) The PA-3L form reflects the recipient's available income that remains after deducting certain amounts for the maintenance of a community spouse, the maintenance of other dependent relatives, health insurance premiums, and the personal needs allowance (PNA). A PA-3L form must be attached to a copy of the 1500 N.J., Health Insurance Claim Form and be kept in the recipient's billing record when requesting payment from Medicaid for the cost of hospice care, as specified in (b)1ii(2) through (5) below.

(2) The hospice is responsible for maintaining a personal needs allowance (PNA) account and making these monies available for use by the recipient.

(3) It is the responsibility of the hospice to deduct the applicable amount of the available income (which corresponds to that attributed to the recipient on the PA-3L form) from the total per diem charges for the payment of room and board services on the 1500 N.J. claim form.

(4) The PA-3L form shall be obtained by the hospice from the NF for each recipient of hospice services who has been on the Long Term Care Billing System. The hospice shall negotiate the change in the collection of this income with the nursing facility, if applicable, or collect it from the recipient and/or family.

(5) For the hospice applicant who has not previously been on the Long Term Care Billing System as an NF patient, the CWA shall generate the PA-3L form for the use of the hospice.

(6) For individuals with no income, or income below $60.00 per month, who continue to qualify for Supplemental Security Income (SSI) payments and Medicaid, no PA-3L form is required upon admission to hospice care status.

(A) For these hospice recipients, confirmation of the SSI status should be obtained from the MDO and documented in the hospice billing record.

(B) When submitting the 1500 N.J. claim form, the hospice shall note in the recipient's billing record and state in the "REMARKS" area of the claim form, the wording "SSI Eligible."

(c) Regarding adjustments to the PA-3L, the CWA is required to report all changes of income on an amended PA-3L form to the hospice.

1. When special exceptions apply (for example, in the month of admission, for verified living expenses, and for the first two months of Medicare premium deductions), the PA-3L form will reflect those changes for the applicable month(s).

2. The recipient and/or the family are required to report all changes of available income to the CWA. Additionally, the hospice should report any changes in financial circumstances to the CWA. For those changes which impact on available income, a new PA-3L form must be generated by the CWA, indicating the month for which the change is effective.

3. When an amended PA-3L form affects the periods of service that have already been billed by the hospice, a "RETROACTIVE ADJUSTMENT" shall be submitted to the Fiscal Agent. The reason for the adjustment shall be recorded in the "REMARKS" area of the 1500 N.J. claim form and also in the recipient's billing record at the hospice.

4. On post-payment quality assurance review, the hospice is liable to the Division for any of the recipient's available income not deducted appropriately from the claim forms.

(d) For any full or part of a calendar month in hospice care status, all available income shown on the PA-3L form should be applied to the cost of the care and subtracted from the per diem charge on the 1500 N.J. claim form, except as indicated in (d)1 through 4 below.

1. For the recipient who is admitted to hospice care status from an NF during a given calendar month, the available income may have already been utilized by the NF to offset the cost of care in the same month of admission to hospice care status. Thus, no income is applicable to the hospice for the first calendar month. This applies only if it is a partial calendar month of hospice room and board services. No new PA-3L form is generated by the CWA, but a copy of the PA-3L form must be obtained from the NF and kept in the patient's record. The hospice must certify to this fact in the recipient's billing record and in the "REMARKS" area of the claim form with the following statement:

"INCOME APPLIED TO THE NF COST OF CARE FOR (ADD THE MONTH AND YEAR TO WHICH THE COST IS APPLIED)"

2. For a hospice recipient admitted from the community, an exemption for verified living expenses is permitted in computing available income. An amended PA-3L form must be generated from the CWA indicating the adjusted amount to be deducted from the hospice per diem charge for that month. Under no circumstances will the requested exemption exceed the verified living expenses. (This deduction is not applicable for hospice recipients who are returning to hospice care from the hospital.)

3. In reviewing the PA-3L form to determine what income should be applied to a billing month, the effective date in each of the numbered columns (PA-3L #1, #2, and #3) shall be carefully checked. This is particularly significant for hospice recipients admitted from the community or the hospital, as income may change within the first three months due to changes in income deductions, specifically Medicare premium payments.

4. The instructions for completing the PA-3L form when the recipient has been discharged or has died, are as follows:

i. For the discharge month or that partial part of the month in the hospice care, the available income amount shown on the PA-3L form shall be applied to the cost of care. If the income exceeds the charge for that month, the balance of income not applied to the cost of care shall be returned to the recipient. Exceptions to this general policy are indicated in (d)4ii through v below.

ii. For the hospice recipient who is discharged to the community, the amount of available income may be reduced by an amount to cover anticipated living expenses. However, this must be reflected on the PA-3L form by the CWA. When the PA-3L form does not reflect the reduction, contact the CWA to effect the change.

iii. For the hospice recipient who dies on the first, second, or third day of the month, and income is not available because the check could not be endorsed and was returned, the 1500 N.J. claim form must be so annotated in the "REMARKS" area stating "Recipient expired on (date)—income not available for use." No further documentation is required.

iv. For the hospice recipient who dies after the third day of the month and the income is not available because the check was returned, the 1500 N.J. claim form should be so annotated and documentation (that is, SSA transmittal receipt) retained in the hospice billing files. The 1500 N.J. claim form must be annotated in the "REMARKS" area—"Check returned—SSA transmittal receipt available—income not available for use."

v. For the hospice recipient who is admitted to nursing facility care (in the same or in a different NF) after being discharged from the hospice, the hospice shall provide information to the NF concerning the amount of available income which was applied to the bill in the discharge month so that the NF may accurately reflect the balance amount for the NF admission month billing. The nursing facility must also complete an MCNH-33 form to notify the CWA and MDO of the discharge of the hospice patient from hospice care and the income applied to the hospice service, so that a new PA-3L form can be issued for the month of admission to the NF.

10:53A-4.2 Basis of payment—hospice providers

(a) The Division reimburses an approved hospice provider for those hospice services related to the terminal illness and included in the recipient's plan of care according to the methodology and indices in section 1814(i)(1)(C) (ii) and 1814(i)(2)(B) of the Social Security Act.

1. One of four predetermined, cost-related prospective payment rates subject to the "cap" amounts (see N.J.A.C. 10:53A-1.1 for definition of "cap") is reimbursed for each day the recipient is receiving hospice services (see N.J.A.C. 10:53A-4.3 for calculations). The rates vary depending on the level of care which is based on the type and intensity of services furnished on that day and are consistent with the plan of care. The levels of care are, as follows:

i. Routine home care;

ii. Continuous home care;

iii. Inpatient respite care; and

iv. General inpatient care.

(b) The rules regarding the reimbursement for each level of care which relate to the per diem rate are described below:

1. The hospice is reimbursed at the routine home care rate for routine nursing services, social work, counseling services, durable medical equipment, medical supplies and equipment, drugs, biologicals, home health aide/homemakers, physical therapy, occupational therapy, and speech-language pathology services. Routine home care is also reimbursed for home care provided continuously that is not predominately nursing care and includes respite care delivered in the home.

i. The routine home care rate is reimbursed when the recipient is not receiving continuous home care, regardless of the volume and intensity of routine home care services.

2. The hospice is reimbursed at the continuous home care rate for services provided in periods of acute medical crisis, where the predominance of care is skilled nursing care on a continuous basis, to achieve palliation or management of the recipient's acute medical symptoms and only as necessary to maintain the recipient at home.

i. At least eight hours of nursing care in a 24-hour period has to be provided before the continuous home care rate may be paid. Continuous home care is reimbursed at the continuous home care daily rate divided by 24 to determine the hourly rate. For every hour of continuous care furnished, the hourly rate is reimbursed up to 24 hours furnished in a day, as applicable.

ii. Up to 24 hours of nursing care in a 24-hour period in the home may be provided primarily by the registered professional nurse, or a licensed practical nurse together with and under the supervision of a registered professional nurse, with the support of the homemaker/home health aide staff.

3. The hospice is reimbursed at the inpatient respite care rate for care provided on an intermittent, non-routine, and/or occasional need basis for each day a hospice eligible recipient is in an approved inpatient facility (nursing facility or general hospital) receiving respite care. The recipient is not in need of general inpatient care.

i. Payment for Inpatient Respite Care is made for a maximum of five consecutive days at a time, including the date of admission but not counting the date of discharge. Payment of the sixth day and any subsequent day is reimbursed at the Routine Home Care rate.

(1) The hospice may be paid the appropriate home care rate (either the routine or continuous home care rate) for the discharge day unless the recipient dies as an inpatient. When the recipient dies as an inpatient, the Inpatient Respite Rate is reimbursed for the day of death.

ii. Payments to a hospice for inpatient respite care are also limited according to the aggregate number of days of inpatient respite care furnished to Medicaid patients per year for that

particular hospice. (See N.J.A.C. 10:53A-4.4 for further description relating to the calculation of this limitation.)

iii. The inpatient respite care rate is not reimbursed to the nursing facility for care provided to nursing facility patients that are not Medicaid hospice patients of a Medicaid approved hospice.

4. The general inpatient care rate is reimbursed for services provided in a hospital or nursing facility in periods of acute medical crisis, for hospitalized recipients for palliative care for pain control or management of acute and severe clinical problems which cannot be managed in other settings. For example, reimbursement at the general inpatient care rate is made during situations when the recipient's condition is such that it is no longer possible to maintain the recipient at home, as determined and specified in the plan of care.

i. None of the other fixed payment rates, such as routine home care, are applicable for the day on which the patient receives hospice general inpatient care, except as stated below for the day of discharge.

(1) For the day of discharge from an inpatient unit, the appropriate home care rate (either the routine or continuous home care rate) is reimbursed unless the recipient dies as an inpatient. In this situation, when the recipient dies, the general inpatient care rate is reimbursed for the day of death.

ii. Payments to a hospice for general inpatient care are limited according to the aggregate number of days of inpatient care furnished to Medicaid patients per year for that particular hospice. (See N.J.A.C. 10:53A-4.4 for information on calculating this limitation.)

(c) In addition to the per diem rates listed in (a) above, the following rates may be reimbursed according to the special circumstances listed below:

1. The room and board rate is reimbursed on a per diem basis for hospice services provided to Medicaid hospice recipients at the specific Medicaid approved NF where the hospice recipient is residing. This rate may be reimbursed to the hospice in addition to the rate for routine home care or continuous home care. (Note: The hospice patient residing in a NF is not a Medicaid recipient of nursing facility care but a hospice recipient.)

i. The room and board rate is calculated at 95 percent of the highest approved Medicaid NF per diem rate (institutionally specific) effective at the time services are provided, and excluding add-ons and special program rates. The rate is adjusted every six months to reflect changes in the nursing facility's case mix. The NF contracts with the hospice to accept the recipient based on actual room and board components provided to the recipient by the NF. The provider number and name of the nursing facility where the recipient resides and with whom the hospice contracts must be placed in the "REMARKS" area of the 1500 N.J. claim form.

(1) The calculated rate used by the hospice as the per diem room and board rate may be obtained from:

Bureau of Institutional and Provider Reimbursement
Division of Medical Assistance and Health Services
CN-712
Trenton, New Jersey 08625-0712

ii. The Division shall continue to pay the hospice the room and board rate for the purpose of retaining the bed for therapeutic leave or during a period of hospitalization, if indicated. The hospice is responsible through its contract with the NF to reimburse the NF to retain the bed.

(1) Nursing facility bed reservation days rate (for therapeutic leave from the NF to home): The hospice is reimbursed the room and board rate for reserving an NF bed for hospice recipients residing in an NF who return to a home setting temporarily for therapeutic leave. The bed reservation days rate (not to exceed 24 days per calendar year) is paid to the hospice provider in addition to the rate of routine home care or continuous home care.

(2) Nursing facility bed reservation days during a period of hospitalization (commonly known as "bed hold days") not to exceed 10 consecutive days per period of hospitalization: The hospice is reimbursed the room and board rate for reserving a nursing facility bed for hospice recipients residing in a nursing facility who require inpatient hospitalization. Bed reservation days (not to exceed 10 consecutive days per period of hospitalization) are paid to the hospice in addition to the rate for general inpatient care.

(3) The responsibility for the bed reservation policy, listed in (c)1ii(1) and (2) above, and the submission of claims for these days rests with the hospice.

(d) Payment of the four "level of care" rates will be made to hospice providers at the predetermined minimum prospective Medicaid payment rates revised annually by the Federal Health Care Financing Administration (HCFA) (see N.J.A.C. 10:53A-5 for the references for the methodology). The payment rates will be adjusted by the Division for regional differences in wages, using indices and methodology determined by HCFA.

1. The regional designation of a provider for wage adjustment purposes will be determined by the location of the main business office of the hospice provider.

2. Since the four level of care rates are prospective rates, there shall be no retroactive adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. The rate paid for any particular day may vary depending on the level of care furnished to the recipient. The cap and limitation on payment for inpatient care are described in N.J.A.C. 10:53A-4.4.

(e) No deductible shall be imposed for services furnished by hospices to Medicaid recipients during the period of election, regardless of the setting in which the services are provided.

1. Hospices shall not charge Medicaid recipients directly for Medicare coinsurance amounts.

(f) For recipients at home who are dually eligible for both Medicare and Medicaid, and who are receiving Medicare hospice benefits, the hospice may bill Medicaid Fiscal Agent for the five percent co-payment for outpatient drugs and biologicals on the 1500 N.J. claim form.

1. The co-payment reimbursement shall be a maximum of five percent per prescription cost of each outpatient drug and/or biologicals but shall not exceed $5.00 for each prescription.

2. Copies of the Explanation of Medicare Benefits (EOMB), or other health, or insurance carriers' denial, or Explanation of Benefits (EOB) statements, or other third party liability statements, shall be attached to the copy of the 1500 N.J. claim form filed in the recipient's billing record, as well as an invoice for the outpatient drugs and/or biologicals to which the five percent co-payment is applied for post payment review. The pharmacy attachment or EOMB (EOB, etc.) shall not be attached to the 1500 N.J. claim form submitted to the Fiscal Agent.

(g) For recipients who are dually eligible for Medicare and Medicaid and who are receiving Medicare hospice benefits, the hospice may bill the Medicaid Fiscal Agent for the co-payment for each Inpatient Respite Care day equal to five percent of the payment made for each respite care day by Medicare.

1. Copies of the EOMB, or other health or life insurance carriers' denial, or EOB statements, or other third party liability statements shall be attached to a copy of the 1500 N.J. claim form filed in the recipient's medical record, as well as an invoice for Inpatient Respite care to which the five percent co-payment is applied. The invoice for Inpatient Respite Care or the EOMB (EOB, etc.) shall not be attached when submitting the 1500 N.J. claim form to the Fiscal Agent.

(h) In addition, for dually eligible Medicare and Medicaid hospice recipients, the hospice shall submit claims first to Medicare. Payment by Medicaid for unrelated services or for coinsurance requires an EOMB or EOB to be attached to the claim submitted to the Medicaid Fiscal Agent.

(i) The hospice shall not overlap from one calendar month to another in the billing process or bill for more than one month's comprehensive hospice benefit and/or room and board charges on each claim form.

(j) The amount of the Medicare co-insurance payment to be reimbursed to the hospice by Medicaid shall be submitted on a separate 1500 N.J. claim form from the other per diem charges.

10:53A-4.3 Basis of payment—physician services

(a) The method of calculation of the basic per diem rates for hospice services listed in N.J.A.C. 10:53A-4.1 includes the costs of the administrative and general supervisory activities performed by physicians who are employees of the hospice provider or those working under financial arrangements with the hospice provider.

1. The administrative and supervisory activities are generally performed by the physician serving as the Medical Director and/or the physician member of the hospice interdisciplinary group.

i. Interdisciplinary group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and the establishment of governing policies.

(b) The Division shall pay the physician for only direct patient care services furnished to Medicaid hospice recipients by hospice physician employees, and for physician services furnished under arrangements made by the hospice, unless the services were provided on a volunteer basis. The cost of the direct patient care services of the physician who is an employee of the hospice agency shall be submitted on the 1500 N.J. by the physician to the Medicaid fiscal agent.

1. Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement.

2. The physician may bill for services which are not provided on a volunteer basis. However, the physician shall treat Medicaid recipients on the same basis as other recipients in the hospice. For instance, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid recipients.

(c) The attending physician shall bill only for direct personal care services and not for other costs such as laboratory or X-rays, which are to be included in the hospice per diem rate.

1. The costs of attending physician's direct personal care services shall not be included in the hospice cap determinations.

(d) Attending physician services and other specialty physician services, including consultation services provided by physicians who are not employees of the hospice are reimbursed as covered services on a fee-for-service basis under the Physician Services Manual (N.J.A.C. 10:54) separate from the method of calculation of the hospice per diem rates listed in N.J.A.C. 10:53A-4.1.

1. The hospice shall state the name of the physician who has been designated the attending physician (whenever the attending physician is not a hospice employee) in the plan of care and on the Election of Hospice Benefits Statement, FD-378 (6/92); and specify whether the attending physician services are either related or unrelated to the recipient's terminal illness.

10:53A-4.4 Limitations on reimbursement for hospice services

(a) The Division limits aggregate payments to a hospice during a hospice "cap" period to the same degree, amount, and methodology as Medicare except the room and board per diem amounts reimbursed to hospice providers for services provided in a nursing facility are not subject to the "cap limitations" on the overall reimbursement to hospice providers.

1. Any payments in excess of the "cap" must be refunded by the hospice to the Division.

(b) The Division also limits payment for inpatient care according to the number of days of inpatient care furnished to hospice recipients in the aggregate for that provider. The computation of the limitation is as follows:

1. During the 12-month period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period.

i. The maximum allowable number of inpatient days shall be calculated by multiplying the total number of days of Medicaid hospice care by 20 percent.

ii. If the total number of days of inpatient care furnished to Medicaid hospice recipients is less than or equal to the maximum, no adjustment shall be made.

iii. If the total number of days of inpatient care exceeds the maximum allowable number, the amount of the limitation will be determined by: calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursed for inpatient care (general and respite reimbursement); multiplying the excess inpatient care days by the routine home care rate; adding the amounts determined in the calculations of (b)1iii(1) and (2) above; and comparing the amount in (b)1iii(3) above with interim payments made to the hospice for inpatient care during the "cap period."

(1) The aggregate number of inpatient days (both for inpatient general and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period.

(2) Any payments in excess of the "cap" must be refunded by the hospice to the Division.

(c) The hospice shall report to the Medicaid Hospice Program, the aggregate number of inpatient days (both for inpatient general and inpatient respite care) and the aggregate total number of days of hospice care provided to all Medicaid recipients during the "cap" period. For a hospice enrolling as an approved Medicaid hospice provider during a time other than the first day of the "cap year" for the first time, the "cap" will be applicable for a period of more than 12 months and not more than 23 months.

1. The report shall be sent and received no later than the January 1 following the end of the "cap" period (October 31 of the previous year) to the following address:

Division of Medical Assistance and Health Services
Hospice Program
CN-712
Trenton, New Jersey 08625-0712

SUBCHAPTER 5. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:53A-5.1 Introduction

(a) The New Jersey Medicaid program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS procedure codes as listed in this subchapter are relevant to certain Medicaid hospice services.

(b) For a complete description of the basis of payment for the HCPCS codes listed below, refer to N.J.A.C. 10:53A-4.2, Basis of payment—hospice providers in the Hospice Services Manual. Section 1814 (i)(1)(C)(ii) of the Social Security Act authorizes the rates and provides for annual increases in payment rates for hospice services. The Federally predetermined prospective annual rates are calculated based on the annual hospice rates established by Medicare. In addition, section 1814(i)(2)(B) of the Act provides for an annual increase in the hospice cap amounts. Hospice payment rates for care and services are in effect from October 1 of one year to September 30 of the following year. For the "cap" amounts, the fiscal year ends on October 31 of the calendar year.

(c) States have the flexibility to establish hospice rates at amounts no lower than Medicare hospice rates based on the same methodology used in setting Medicare rates, and adjusted to disregard offsets attributable to Medicare coinsurance amounts. The New Jersey Medicaid program is setting hospice rates for the four "levels of care" at the prospective predetermined levels which are determined by HCFA.

(d) The rates marked with an asterisk are adjusted for regional differences in wages, using indices based on regions listed in Addendums A and B in the State Medicaid Manual, Transmittal No. 27 (April 1987) (section 4305-4309), in the State Medicaid Manual, Transmittal No. 50 (October 1990) and in Federal statute as referenced in (b) above. These State Medicaid Manuals give specific directions for calculating individual hospice agency rates for the four levels of hospice care (routine, continuous, inpatient respite and general inpatient care) and for the co-payment for inpatient

respite care. State Medicaid Manuals may be obtained through the United States Department of Health and Human Services, Health Care Financing Administration.

10:53A-5.2 HCPCS procedure codes for hospice services

Note: The rates of the procedure codes marked with an asterisk (*) are subject to an adjustment based on regional differences in wages as set by Federal statute as referenced in N.J.A.C. 10:53A-5.1(b)

*Y6333 ROUTINE HOME CARE RATE

Per diem rate, calculated as referenced in N.J.A.C. 10:53A-5.1(d)

*Y6334 CONTINUOUS HOME CARE RATE

The continuous home care rate is reimbursed at an hourly rate for at least eight hours of nursing care in a 24 hour period calculated as referenced in N.J.A.C. 10:53A-5.1(d).

*Y6335 INPATIENT RESPITE CARE RATE

Inpatient respite care is reimbursed on a per diem basis for not more than five consecutive days (including the day of admission and not the day of discharge) for short-term, occasional inpatient care subject to the limitation of the "cap" according to Federal statute as referenced in N.J.A.C. 10:53A-5.1(b), adjusted annually as specified in Sections 4306.3 of the State Medicaid Manual and described in N.J.A.C. 10:53A-4.4.

*Y6336 GENERAL INPATIENT CARE RATE

Payments are limited according to the aggregate inpatient days furnished to all recipients subject to the limitation of the "cap" according to Federal statute as referenced in N.J.A.C. 10:53A-5.1(b), adjusted annually as specified in Sections 4306.3 of the State Medicaid Manual and described in N.J.A.C. 10:53A-4.4.

Z2015 ROOM AND BOARD RATE

Room and board rate is reimbursed on a per diem basis for hospice services provided to a Medicaid recipient at the specific Medicaid approved NF rate (see NF rate setting methodology in Long Term Care Services Manual (N.J.A.C. 10:63)) where the recipient is residing. The rate is calculated at 95 percent of the highest approved per diem rate (institutionally specific) effective at the time services are provided and excluding add-ons and special program rates adjusted every six months.

Y6337 THERAPEUTIC LEAVE DAYS RATE

Reimbursed at the same rate as the room and board rate in Z2015 for reserving an NF bed for a recipient who returns home, not to exceed 24 days per calendar year, in addition to the routine home care or continuous home care rate, as applicable.

Y6338 BED HOLD DAYS RATE

Reimbursed at the same rate as the room and board rate in Z2015 for reserving an NF bed for a recipient who requires inpatient hospitalization, not to exceed 10 consecutive days per period of hospitalization, in addition to the general inpatient care rate.

*Y6339 HOSPICE RESPITE CO-PAYMENT

Reimbursed on a per diem basis for dually Medicare/Medicaid recipients at five percent of the hospice Medicare inpatient respite care rate.

Y6343 DRUG AND BIOLOGICALS CO-PAYMENT

Reimbursed at a maximum of five percent per prescription cost for each outpatient drug or biological not to exceed $5.00 for each prescription for those recipients residing in an NF who are dually eligible Medicare/Medicaid recipients.

APPENDICES

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APPENDIX I
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ELECTION OF HOSPICE BENEFITS STATEMENT

I, _____,
(Applicant's Name and HSP (Medicaid) Case Number)
elect to receive the Medicaid hospice benefits from _____

(Hospice Agency and Medicaid Provider Billing Number)
this day of _____ 19___. I am aware that I have a life threatening illness. I consent to the management of the symptoms of my disease by the above hospice agency. My family and I will help to develop a plan of care based on our needs. My care will be supervised by my attending physician, _____, and the Hospice Medical Director in conjunction with the hospice interdisciplinary group.

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aide/homemaker services, physical therapy, occupational therapy, speech-language pathology services, inpatient care for acute symptoms and procedures ordered by my physician and hospice, and continuous nursing care in the home in medical crisis.

I may request volunteer services from the hospice.

I realize that my family and I have the opportunity for limited respite or relief care in an inpatient nursing facility or hospital.

In accepting these services, I relinquish my rights to regular Medicaid benefits, except for services of my attending physician, and for treatment for medical care unrelated to my terminal illness, except when the unrelated services are approved by the hospice interdisciplinary group, or provided in the case of accidental injury, or sudden or serious illness requiring treatment on an emergency basis.

I understand that I can revoke and terminate my hospice benefits at any time and resume regular Medicaid benefits if I am still eligible for Medicaid.

I understand that the hospice benefits consists of four benefit periods—two 90-day periods, one 30-day period, and a fourth unlimited period. I may be responsible for hospice charges if I become ineligible for Medicaid.

I am aware that if I choose to revoke hospice benefits during a benefit period, I am not entitled to coverage for hospice services for the remaining days of that benefit period. I understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s).

I understand, that should I choose to do so, I may change the designation of the particular hospice once during the election period by filing a statement with the particular hospice from which care has been received and with the newly designated hospice. I understand that changing hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the hospice benefits, hospice coverage will continue for 210 consecutive days. After the 210 days of hospice benefits, my benefits will automatically expire unless I choose to request to enter the fourth unlimited benefit period upon physician recertification of my continued need for hospice services related to my terminal illness.

I understand that if I am a dually eligible Medicare and Medicaid recipient, I must elect to use the Medicare and Medicaid hospice benefits simultaneously.

Check one:

☐ I am a Medicare recipient and have elected to use the Medicare hospice benefits. My Medicare eligibility for hospice benefits begins _____.
(Date)

☐ My Medicare hospice benefits have been exhausted as of _____.
(Date)

☐ I am not a Medicare recipient.

☐ I am currently a nursing facility resident, residing at:

_____
Facility Name/Address

_____

_____

_____
Signature of the Applicant

FD-378 (6/92)

APPENDIX II
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

HOSPICE BENEFITS STATEMENT

_____ _____
Recipient's Signature or Mark | Recipient's Name (Print or Type)

HSP (Medicaid) Case Number _____

_____ _____
Witness' Signature | Relationship to Hospice Recipient

_____ _____
Date Signed | Effective Date of Election

_____

SECOND CERTIFICATION PERIOD
(To be signed only if benefits previously revoked or temporarily terminated)

_____ _____
Recipient's Signature or Mark | Recipient's Name (Print or Type)

_____ _____
Witness' Signature | Relationship to Hospice Recipient

_____ _____
Date Signed | Effective Date of Second Period

_____

THIRD CERTIFICATION PERIOD
(To be signed only if benefits are previously revoked or temporary terminated)

_____ _____
Recipient's Signature or Mark | Recipient's Name (Print or Type)

_____ _____
Witness' Signature | Relationship to Hospice Recipient

_____ _____
Date Signed | Effective Date of Third Period

_____

FOURTH CERTIFICATION PERIOD (To be signed if hospice benefits are to continue)

_____ _____
Recipient's Signature or Mark | Recipient's Name (Print or Type)

_____ _____
Witness' Signature | Relationship to Hospice Recipient

_____ _____
Date Signed | Effective Date of Fourth Period

FD-379 (6/92)

APPENDIX III
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REPRESENTATIVE STATEMENT FOR THE
ELECTION OF HOSPICE BENEFITS

I,_____, due to the physical/mental
(Legal Representative)
incapacity of _____, am authorized
(Applicant's Name and HSP (Medicaid) Case Number)
in accordance with State laws to execute, change or revoke the election of Medicaid hospice benefits on behalf of _____, who has been certified as terminally ill. As the representative for _____, I will sign all necessary forms required for the administration of hospice benefits.

_____
Signature of the Legal Representative

_____
Date

_____
Witness

_____
Date

FD-380 (6/92)

APPENDIX IV
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REVOCATION OF HOSPICE BENEFITS

I,_____ revoke the hospice benefits allowed
(Recipient's Name and HSP (Medicaid) Case Number)
to me by Medicaid and rendered by_____,
Hospice Agency and Medicaid Provider Billing Number
this _____ day of _____, 19____.

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice services at a later time if this revocation has occurred during either of the two initial 90-day benefit periods.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

_____
Hospice Recipient's Signature or Mark

FD-381 (6/92)

APPENDIX V
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TERMINATION OF HOSPICE BENEFITS

Hospice benefits for_____ are hereby
(Recipient's Name and HSP (Medicaid) Case Number)
terminated effective _____, 19____, for the following reason.

☐ Patient is deceased. Date of death is _____, 19____.

☐ Patient has not requested extension of Medicaid hospice benefits.

☐ Patient has become financially ineligible for Medicaid.

☐ Patient has become medically ineligible for hospice benefits as there is no physician certification or recertification of the terminal illness or need for hospice services.

☐ OTHER: (Please explain.)_____

_____

_____

_____

☐ Condition improved. Inactive status.

_____
(Hospice Agency and Medicaid Provider Billing Number)

will continue to follow patient but active hospice benefits are temporarily discontinued. Patient may return to active status any time change in condition necessitates.

_____ _____
Hospice Medical Director Date

FD-382 (6/92)

APPENDIX VI
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

HOSPICE ELIGIBILITY FORM

THIS SECTION TO BE COMPLETED BY THE HOSPICE AGENCY
☐ Initial application ☐ Change in status
☐ Change of address

1. Recipient's Name _____
2. HSP (Medicaid) Case # _____
3. Recipient's Address _____
4. Birthdate:
Sex: Male ☐ Female ☐
SSN: _____
Race: _____
5. Is the recipient currently receiving Room and Board Service in a nursing facility:
Yes ☐ No ☐ If yes, give name and address of facility:
6. Medicare entitlement: Yes ☐ No ☐ HIC #_____
7. Medicaid eligibility: Yes ☐ No ☐ Unknown ☐
If no, give the name of the person, the relationship to recipient, and the telephone number of the person who will initiate the Medicaid application.
8. Other insurance (Include company name, policy number, and policy holder):
9. ☐ Election of hospice benefit on _____
Physician Certification on _____
10. ☐ Termination of benefit on _____
Reason: Death ☐ Revocation ☐ Other (Explain)_____
11. ☐ Change of hospice provider on _____
From: _____, Medicaid Provider Billing No.____
To: _____, Medicaid Provider Billing No.____

Name, Address and Medicaid Provider Billing Number of provider submitting form:

Contact person and telephone number:_____ Date: _____

THIS SECTION TO BE COMPLETED BY THE MDO, CWA, OR DYFS DISTRICT OFFICE AS CONFIRMATION OF ELIGIBILITY
12. Medicaid eligibility effective date: _____ termination date: _____
13. HSP (Medicaid) Case # (if not entered above): _____
14. Attach copy of computer screen showing effective date and termination date of "Special Program Code 15".

Note: Hospice eligibility dates correspond to election or revocation dates.

Contact person and telephone number:_____ Date_____

Agency_____

FD-383 (6/92)

INSTRUCTIONS FOR SUBMITTING THE HOSPICE ELIGIBILITY FORM (FD-383 (6/92))

The Hospice Eligibility Form (FD-383 (6/92)) is to be initiated by the hospice provider. The purpose of this form is to ensure that the recipient is medically and financially eligible for Medicaid hospice services and is identified in the eligibility system at the CWA, MDO, or DYFS District Offices as a hospice recipient (Special Program Segment 15). Accurate completion of this form will ensure payment to the hospice provider for services provided to Medicaid hospice recipients.

Form FD-383 should also be completed by the hospice provider when the person elects or revokes the hospice benefit, the Medicaid recipient dies, if there is a change of hospice providers, or a change in Medicaid recipient's address.

The first section of form FD-383 must be completed by the hospice provider and sent to the agencies as follows:

- To the Medicaid District Office (MDO) for SSI eligibles.
- To the County Welfare Agency (CWA) of the person's residence for Medicaid Only and New Jersey Care ... Special Medicaid Programs applicants.
- To the Division of Youth and Family Services (DYFS) District Office for children in DYFS foster care.

The hospice provider must send the original copy of form FD-383 to one of the above agencies with a copy to:

Division of Medical Assistance and Health Services
Hospice Program CN-712
Trenton, New Jersey 08625-0712

The MDO, CWA, or DYFS District Office will process the data and return a copy of form FD-383 to the hospice provider with a copy of the computer screen showing the effective date and termination date of "Special Program Code 15". Please refer to the Hospice Services Manual instructions for more detail on the eligibility process.

APPENDIX VII
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHANGE OF HOSPICE

I,_____,
(Recipient's Name and HSP (Medicaid) Case Number)
wish to change the designation of the particular hospice from which I receive hospice care. I no longer with to receive hospice service from _____, but instead wish to receive hospice services
(Hospice Agency and Medicaid Provider Billing Number)
from _____ effective this _____ day of
(Hospice Agency and Medicaid Provider Billing Number)
_____, 19____.

I understand that this change of hospice providers is not a revocation of the remainder of this election period.

_____ _____
Recipient's Signature or Mark Witness Signature

_____ _____
Date Date

FD-384 (6/92)

APPENDIX VIII
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PHYSICIAN'S CERTIFICATION/RECERTIFICATION
FOR HOSPICE BENEFITS FORM

I,_____, as the attending physician of _____, who is under my care at this time, hereby
(Recipient's name and HSP (Medicaid) Case Number)
certify (or recertify) that this patient is terminally ill, this his/her life expectancy is six months or less provided the illness follows its usual course, and that hospice services are reasonable and necessary for the treatment of this terminal illness or related condition.

_____
Signature of the Attending Physician

_____
Print the Attending Physician's Name

_____
Date

FD-385 (6/92)

APPENDIX IX

NOTIFICATION FROM LONG TERM CARE FACILITY OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT (MCNH-33)
SAMPLE

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NOTIFICATION FROM LONG-TERM CARE FACILITY OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT

I. PATIENT INFORMATION:

1. Name: _____ (LAST / FIRST) 2. Social Security Account No.: __ __ __ - __ __ - __ __ __ __
3. HSP(Medicaid) Case No.: __ __ __ __ __ __ __ __ __ __ __ __ Confirmed By: _____ (CWA) ☐ Medicaid Only ☐ SSI
4. Authorized by: _____ Medicaid District Office

II. PROVIDER INFORMATION:

1. Provider Number: __ __ __ __
2. LTCF Name: _____ 5. MEDICAID DISTRICT OFFICE
3. Address: _____ MDO Street Address: _____
4. City, State, Zip: _____ City, State, Zip: _____

III. ADMISSION INFORMATION:

1. Admission Date: ___ / ___ / ___ 2. Is this a new admission? ___Yes ___ No (If yes, send copy of MCNH-33 to CWA.)
3. Admitted to room number: _____ Bed number: _____
4. Admitted from: ___ Community Boarding Home ___ Medicare to Medicaid ___ Psychiatric Hospital
   ___ Private to Medicaid (anticipated Medicaid effective date: ___ / ___ / ___ (Attach PA-4 to MDO copy)
   ___ Hospital ___ Other LTCF ___ Other (identify) _____
5. Name and Address of hospital/LTCF: _____ Admission Date: ___ / ___ / ___
   _____
6. If admitted from hospital/LTCF give the name/address of previous residence:
   _____
   (Hospital Name and Address or Home Address)

IV. TERMINATION INFORMATION:

1. Discharge Date: ___ / ___ / ___ 2. Has discharge been ordered by physician? ___Yes ___ No
3. Bed will be reserved in room number: _____ Bed number: _____
4. Discharged to hospital _____ (do not send MCNH-33 to CWA)
   NAME OF HOSPITAL
5. Discharged to: ___ Community (from LTCF/Hospital) ___ Other LTCF ___ Other (identify)
6. Death: ___ in LTCF ___ in hospital

V. CERTIFICATION:

CERTIFICATION: The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program. The facility also certifies that upon discharge to a hospital, the patient's room/bed will be reserved for the full period of time covered by the New Jersey Medicaid Bed Reserve policy.

This form completed by: _____ (Name) _____ (Title) _____ (Date) _____ (Signature)

VI. CWA USE ONLY:

Medicaid Effective Date: ___ / ___ / ___
_ Medicaid Only - PA-3L attached
_ SSI only - no PA-3L required
_ Not eligible
_ Transcript requested - Date: ___ / ___ / ___
Remarks:

COUNTY WELFARE OFFICE

Street Address: _____
City and Zip: _____

Signature of Case Worker: _____ Date: _____

APPENDIX X

STATEMENT OF AVAILABLE INCOME FOR MEDICAID PAYMENT (PA-3L)

SAMPLE

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

STATEMENT OF AVAILABLE INCOME FOR MEDICAID PAYMENT

Redetermination Date: _____ (MM/YY) SSA No.: _____ _____ (ELIG. EFF. DATE) _____ (PRINT DATE)

_____ (HSP (Medicaid) CASE NUMBER) _____ (LAST) _____ (FIRST) _____ (COUNTY)

Long-Term Care Facility: _____

Address: _____

SSI STATUS _ _ _ _ (LAC/PS) LTCF Provider No._____ Previous Provider No.: _____

	LTCF Information		PA3L #1 Information	PA3L #2 Information	PA3L #3 Information		Remarks
Effective Date							Admit, Change, Redetermination
Social Security Income							Claim #
Buy-In Amount							HIC #
Gross Social Sec. Benefit							
Railroad/Veteran							Claim #
Pension/Other Benefit							Specify
Other Income							Specify
Total Other Income	$						Spouse's S.S.A. #
Total Gross Income			$	$	$		M=Married Couple same LTCF G=Foreign Pension/VA A & A C=Combined Situation
Workshop/Other							
Maint./Home							Specify
Maint./Spouse Dependent							Specify
Health Premium	$						Policy #
Total Exempt Income			$	$	$		
PNA	$-						
Available Income			$	$	$		R=Representative Payee
Month of Adm./Disch. Exempt							Specify
Resources	SPECIFY (i.e., address)						Circle One Yes No

Name and Address of Representative Payee

Signature: IM Worker: _____ Date: _____

Supervisor: _____ Date: _____

PA-3L (rev. 6/88)

BUREAU OF CLAIMS & ACCOUNT

APPENDIX XI

LONG TERM CARE TURNAROUND DOCUMENT (TAD)

SAMPLE

RETURN TO UNISYS, CN 4805, TRENTON, NJ 08650

PROVIDER NO. PER DIEM

LONG TERM CARE TURNAROUND DOCUMENT (TAD)

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

BILLING MONTH/YEAR _____

PAGE _____ OF _____

1 REF	2 ACT	3 PATIENT LAST NAME	4 INIT	5 MEDICAID HSP#	6 PAT. ACCT. NO.	7 ATTEND PHYS	8 ADMIT DT	9 ADM CODE	10 FROM DOS	11 TO DOS	12 DS CD	13 LOC

LINE	14 DX 1	15 DX 2	16 DX 3	17 ADDITIONAL NURSING SERVICES	18 THERAPIES	19 FUTURE USE	20 COTTAGE #	21 CO CD	22 LV USE
1				TRA RES IVT HTR OXY NGT WOU	PHY SPE OCC	FUT1 FUT2 FUT3			

23 CD	24 FR	1ST LOA TO	25 CD	26 FR	2ND LOA TO	27 CD	28 FR	3RD LOA TO	29 CD	30 FR	4TH LOA TO	31 CD	32 FR	5TH LOA TO	33 TPL 1	34 TPL 2	35 PAT. PYMT.	36 INS. PYMT.	37 OTH. PYMT.

1 REF	2 ACT	3 PATIENT LAST NAME	4 INIT	5 MEDICAID HSP#	6 PAT. ACCT. NO.	7 ATTEND PHYS	8 ADMIT DT	9 ADM CODE	10 FROM DOS	11 TO DOS	12 DS CD	13 LOC

LINE	14 DX 1	15 DX 2	16 DX 3	17 ADDITIONAL NURSING SERVICES	18 THERAPIES	19 FUTURE USE	20 COTTAGE #	21 CO CD	22 LV USE
2				TRA RES IVT HTR OXY NGT WOU	PHY SPE OCC	FUT1 FUT2 FUT3			

23 CD	24 FR	1ST LOA TO	25 CD	26 FR	2ND LOA TO	27 CD	28 FR	3RD LOA TO	29 CD	30 FR	4TH LOA TO	31 CD	32 FR	5TH LOA TO	33 TPL 1	34 TPL 2	35 PAT. PYMT.	36 INS. PYMT.	37 OTH. PYMT.

1 REF	2 ACT	3 PATIENT LAST NAME	4 INIT	5 MEDICAID HSP#	6 PAT. ACCT. NO.	7 ATTEND PHYS	8 ADMIT DT	9 ADM CODE	10 FROM DOS	11 TO DOS	12 DS CD	13 LOC

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3				TRA RES IVT HTR OXY NGT WOU	PHY SPE OCC	FUT1 FUT2 FUT3			

23 CD	24 FR	1ST LOA TO	25 CD	26 FR	2ND LOA TO	27 CD	28 FR	3RD LOA TO	29 CD	30 FR	4TH LOA TO	31 CD	32 FR	5TH LOA TO	33 TPL 1	34 TPL 2	35 PAT. PYMT.	36 INS. PYMT.	37 OTH. PYMT.

1 REF	2 ACT	3 PATIENT LAST NAME	4 INIT	5 MEDICAID HSP#	6 PAT. ACCT. NO.	7 ATTEND PHYS	8 ADMIT DT	9 ADM CODE	10 FROM DOS	11 TO DOS	12 DS CD	13 LOC

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23 CD	24 FR	1ST LOA TO	25 CD	26 FR	2ND LOA TO	27 CD	28 FR	3RD LOA TO	29 CD	30 FR	4TH LOA TO	31 CD	32 FR	5TH LOA TO	33 TPL 1	34 TPL 2	35 PAT. PYMT.	36 INS. PYMT.	37 OTH. PYMT.

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APPENDIX XII
FISCAL AGENT BILLING SUPPLEMENT

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

Paramax/Unisys Corporation
CN-4801
Trenton, New Jersey 08650-4801

or contact:

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

10:71-5.6 Income eligibility standards

(a)-(c) (No change.)

(d) Institutional eligibility: For the purpose of the Medicaid program, Title XIX approved facilities shall include acute care general hospitals, [skilled] nursing facilities, intermediate care facilities **for the mentally retarded** [level A, B, and] ICF/MR and licensed special hospitals (Class A, B, C) and Title XIX psychiatric hospitals (for persons under age 21 and age 65 and over).

1. Persons are considered institutionalized if they enter a Title XIX approved facility and a physician has certified that the duration of stay in the Title XIX facility (or a combination of such facilities) is expected to be [a full calendar month] **30 consecutive days** or more. Income eligiblity shall be determined in accordance with the variations contained in N.J.A.C. 10:71-5.4(b). However, the income of the institutionalized individual shall not be reduced by any of the income exclusions found in N.J.A.C. 10:71-5.3.

2. Institutionalized individuals, **identified in (d)1 above,** who are found Program eligible will receive benefits as of the date of [application which is usually the date of] admission.

3. Persons **in a facility which is** not [in a] Title XIX approved [facility] or whose stay is expected to be a period of less than [a full calendar month] **30 consecutive days** will have eligibility determined in accordance with the community living arrangement which existed prior to entering the facility.

4. (No change.)

5. Persons living in the community who do not otherwise qualify for Medicaid benefits and who elect to participate in the hospice program, or who are assigned a slot in the CCPED or other waiver programs, will have financial eligibility determined in the same manner as those who reside in an institution.

i. Such individuals who are found eligible will receive benefits on the date of the election of hospice benefits, or the date of assignment to a waiver slot, whichever is applicable.

(a)

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

Business Enterprise Program

Proposed Amendments: N.J.A.C. 10:97-1.3 and 7.3.

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:1-12, 30:6-15.1 and 15.2, 20 U.S.C. 107 et seq., 34 CFR 395.

Proposal Number: PRN 1992-358.

Submit comments by September 16, 1992 to:
Jamie C. Hilton
Executive Director
Commission for the Blind and Visually Impaired
153 Halsey Street, P.O. Box 47017
Newark, New Jersey 07101

The agency proposal follows:

Summary

The New Jersey Administrative Code at N.J.A.C. 10:97 sets forth the rules governing the Business Enterprise Program of the New Jersey Commission for the Blind and Visually Impaired, designated as the State Licensing Agency by the United States Department of Education, Rehabilitation Services Administration. The Commission was so designated by the Federal government as provided for at 34 CFR 395 and is required to promulgate rules for the operation of the Business Enterprise Program under 34 CFR 395.4.

The Commission's policies governing the Business Enterprise Program promotion and transfer system for licensed operators in the program have been reviewed by the Committee of Business Enterprise Operators, elected representatives of all licensed operators. The Committee, in concurrence with a majority of the operators, has requested the Commission to change those policies to enable administration of the system in an improved manner. The Commission agrees with the request and is proposing these amendments.

In general, proposed amendments include the setting of prerequisites for eligibility to apply, an improved scoring system for evaluation and interview, clarification of when an interview shall be waived, and use of seniority as a "tie breaker" for promotions and transfer decisions.

Specific amendments are summarized below:

At N.J.A.C. 10:97-1.3, the definition for "seniority" is being added to describe the meaning in regard to its use for operator evaluation in deciding promotions and transfers.

N.J.A.C. 10:97-7.3(b) is proposed to be amended to require prerequisites for the interview and performance evaluation parts of the selection process. To be eligible, operators shall be required to have made regular payments on stock loans. Also, operators who have received a transfer or promotion during the previous 12 months shall be ineligible to apply.

At N.J.A.C. 10:97-7.3(c), the proposed amendment requires that the selection by the supervisor of the Business Enterprise Program shall be limited by evaluation of the operator's record of performance for the previous year, and the results of a panel interview.

N.J.A.C. 10:97-7.3(d), the proposed amendment sets a new formula in scoring performance evaluation for the selection process. The performance evaluation shall count for 50 percent, rather than 75 percent, of the overall evaluation score. In addition, weight value range is changed from a zero to three range, to be zero for unsatisfactory, ranging up to a maximum weight of two, for satisfactory.

The amendment proposed for N.J.A.C. 10:97-7.3(e) changes the interview portion of the evaluation from 25 percent, to 50 percent of the overall evaluation score.

The amendment at N.J.A.C. 10:97-7.3(f) is proposed to award an extra three points to the final interview score of the candidate with the highest seniority.

At N.J.A.C. 10:97-7.3(h), it is proposed to exempt from interview any person who has been interviewed, for the same type of business enterprise only, within the previous six months. Such person would receive the interview score that he or she had received from the previous interview of the same type of business enterprise.

The proposed amendment at N.J.A.C. 10:97-7.3(i) provides that, in the event of a tie of candidates with the highest overall rating, the candidate with the highest seniority shall receive the appointment.

Social Impact

The proposed amendments will allow the 66 operators in the Business Enterprise Program to participate in a more equitable system of selecting persons appointed to operate new business enterprises through promotion or transfer. The interview process, which includes the participation of the Committee of Business Enterprise Operators, is given greater weight than previously, thus emphasizing greater representation of the operators' peers in the process.

Economic Impact

During the past Federal fiscal year, there were sales of over $6 million by operators in the program and the average income of the operators was almost $24,000 per year. The 66 operators in the Business Enterprise Program will be affected economically by the proposed amendments. The revisions of N.J.A.C. 10:97 will allow for more professional development of business operators in the program due to the improved promotion system. More competent persons will be encouraged to realize their full potential, thus achieve self-sufficiency. The program encourages participants to rely more on their abilities rather than resorting to public

assistance to sustain them. The Business Enterprise Program staff provides continuing management services to operators, thus makes it possible for New Jersey to receive Federal funding.

Regulatory Flexibility Analysis

All businesses licensed under the Program are small businesses, as the term is defined in N.J.S.A. 52:14B-16 et seq. Currently, the Program consists of 66 businesses, including cafeterias, snack bars, newsstands and vending machines, on Federal, State, county, and municipal property, throughout all areas of the State. Operators are responsible for submitting weekly sales reports (see N.J.A.C. 10:97-5.1) to the Commission on at least a monthly basis, due on or before the 15th day of the following month, as well as keeping payments current on any stock loan (see N.J.A.C. 10:97-3.4(b)). The amendments will not change these requirements. The amendments, which change the manner of evaluation for promotion (see Summary) also disqualify anyone from applying, if he or she has received a promotion within the past 12 months. The Department has concluded that there should be no differentiation based on business size in these amendments, since all of the regulated public are small businesses.

Full text of proposal follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]):

10:97-1.3 Definitions

The following words and terms shall have the indicated meanings, unless the context clearly indicates otherwise.

...

"Seniority" means the total of unbroken work time as a licensed operator in the Business Enterprise Program.

...

10:97-7.3 Promotions and transfers

(a) (No change.)

(b) Any **eligible** interested operator shall apply, in writing, to the supervisor of the Business Enterprise Program within two weeks of the vacancy announcement.

1. Any operator who is not current in repayment of his or her stock loan, under conditions set forth in N.J.A.C. 10:97-3.4(b), or has not satisfied the debt, in full, within 30 days prior to the application for appointment, shall be ineligible to apply.

2. Any operator who has received a promotion or transfer to a business enterprise in the previous 12 months shall be ineligible to apply. Any exceptions, which would be due to extenuating circumstances that might be detrimental to the Program or the operator, shall be determined by the Program supervisor.

(c) The selection shall be made by the supervisor of the Business Enterprise Program based on an evaluation of the operator's record of performance **for the previous year** and the results of a panel interview.

(d) Performance evaluation shall account for [75] **50** percent of the total promotion and transfer evaluation procedure. Evaluation shall be based on individual site visit reports, semi-annual evaluations and any other documented reports completed by field representatives assigned to work with the interested operators. The supervisor of the Business Enterprise Program shall give weight value to each factor, depending on the type and needs of the specific business enterprise up for bid. Weight values for all factors shall total 25 points. Each weight value shall be multiplied by the respective performance value ranging from zero for ["below average"] **"unsatisfactory"** to one for "conditionally satisfactory" to [three] **two** for ["outstanding."] **"satisfactory."** The factors on which all interested operators shall be rated are management ability, health and sanitation, public relations, compliance with Business Enterprise Program rules and participation in meetings and instructional conferences sponsored by the Commission.

(e) The prescribed interview shall account for [25] **50** percent of the total promotion and evaluation procedure. The interview panel shall consist of the supervisor of the Business Enterprise Program (who shall serve as lead interviewer), the field representative assigned to the announced vacant business enterprise, a non-vocational rehabilitation employee of the Commission and a member of the Committee of Business Enterprise Operators (excluding Committee members who have expressed an interest in the vacant business enterprise) or a designee assigned by the Chairperson of the Committee.

(f) As a group, the panel shall give each candidate a rating for the interview based on a scale of 1 to [25] **50. The candidate with the highest seniority shall be awarded an additional three points to his or her final interview score.** Questions to be asked of all candidates, based on the requirements of the vacant business enterprise, and procedures for scoring shall be designated by the supervisor of the Business Enterprise Program when the panel convenes and before the interviews are held.

(g) (No change.)

(h) If a candidate has been interviewed for a promotion or transfer opportunity **for the same type of business enterprise** within the previous six months, the score from the previous interview shall be used for scoring the interview segment of the current evaluation process.

(i) The candidate with the highest overall rating shall be selected for appointment as operator of the business enterprise for which he or she has applied. **In the event of a tie, the candidate with the highest seniority shall receive the appointment.**

(j) (No change.)

CORRECTIONS

(a)

THE COMMISSIONER

Inmate Access to Courts

Proposed Readoption with Amendments: N.J.A.C. 10A:6

Authorized By: William H. Fauver, Commissioner, Department of Corrections.

Authority: N.J.S.A. 30:1B-6, 30:1B-10 and P.L. 1986, c.141.

Proposal Number: PRN 1992-355.

Submit comments by September 16, 1992 to:

Elaine W. Ballai, Esq.
Regulatory Officer, Standards Development Unit
Department of Corrections
CN 863
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 10A:6, Inmate Access to Courts, expires November 2, 1992. The Department of Corrections has reviewed these rules and, with the amendments to Subchapters 1, 2 and 3, has determined these rules to be necessary, reasonable and proper for the purpose for which these rules were originally promulgated, and is, therefore, proposing them for readoption at this time.

Subchapter 1 provides the purpose and the scope of the chapter, and the definitions of words and terms used. Proposed amendments to N.J.A.C. 10A:6-1.3 add the definition for "in forma pauperis" and corrects the title of "Legal Services Coordinator."

Subchapter 2 establishes the policies for the provision of legal services which facilitate the access of inmates to State and Federal Courts. Throughout Subchapter 2, the word "indigent" has been changed to "in forma pauperis" in order to more clearly define the status of inmates eligible for photocopying of legal materials at no charge to them and to limit the use of such status. The Office of the Deputy Commissioner has been changed to the Division of Policy and Planning. Since correctional facilities are now responsible for the initial purchase of legal reference material, a proposed amendment to N.J.A.C. 10A:6-2.4(c) changes the responsibility of the Legal Services Coordinator to recommending initial purchases of legal reference material. The Office of Hispanic Services has been added to the list of agencies and individuals that inmate paralegals and professional staff may place calls to for assistance in legal research and preparation of legal documents. This is done to afford Spanish speaking inmates the opportunity to communicate with staff persons fluent in their language.

Subchapter 3 establishes the procedures whereby correctional facility records can be altered to reflect an inmate's new legal name. The section heading of N.J.A.C. 10A:6-3.2 was amended to reflect the current term "correctional facility." Amendments to N.J.A.C. 10A:6-3.2 change Central Office Senior Classification Officer to Offender Records Unit, Central Office, Department of Corrections, and Bureau of Information and Classification Services to Correctional Information and Classification Services (C.I.C.S.) Data Base, Garden State Reception and Youth Correctional Facility.

Social Impact

The proposed readoption with amendments of N.J.A.C. 10A:6 will assure continued access of inmates to both State and federal courts through the use of inmate law libraries and trained inmate paralegals, and will permit the continuation of the procedures whereby correctional facility records can be altered to reflect the inmate's new legal name. By redefining "indigent" as "in forma pauperis," fewer inmates may be eligible for deferred postage and photocopying charges.

Economic Impact

Any decrease or increase in cost of deferred postage or photocopying services for inmates is directly related to the population of inmates incarcerated at any one time and the courts granting inmates in forma pauperis status. However, the proposed amendment regarding in forma pauperis status seeks to free staff to perform functions other than photocopying by limiting staff time used in this process. The financial resources to provide these services and/or procedures are obtained by the Department of Corrections through established State budgeting process.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed readoption with amendments does not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed readoption with amendments impacts on inmates and the New Jersey Department of Corrections and have no effect on small businesses.

Full text of the proposed readoption appears in the New Jersey Administrative Code at N.J.A.C. 10A:6.

Full text of the proposal follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]).

10A:6-1.3 Definitions

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

"In forma pauperis" means that an individual has been relieved of paying fees in a pending legal action, by the court, because of inability to pay.

. . .

"Legal [Service] **Services** Coordinator" means a Department of Corrections Central Office staff person who coordinates the provision of inmate legal services by maintaining adequate legal materials in inmate law libraries and training inmate paralegals.

. . .

10A:6-2.2 Inmate legal services

(a) Inmate legal services which permit inmates access to the court shall include the following:

1.-6. (No change.)

7. Payment of postage for [indigent inmates] **mail which is related to the pending litigation for which an inmate has been granted in forma pauperis status.**

10A:6-2.4 Inmate law library

(a)-(b) (No change.)

(c) The Legal Services Coordinator, [Office of the Deputy Commissioner] **Division of Policy and Planning,** Department of Corrections is responsible for **recommending** initial purchases of legal reference materials.

(d)-(h) (No change.)

10A:6-2.5 Legal photocopying services

(a) The Department of Corrections shall provide photocopies of legal material, as that term is defined in N.J.A.C. 10A:6-1.3, at no charge to the [indigent] inmate **who has been granted in forma pauperis status.**[, in accordance with the following guidelines and limitations.] **The legal material shall be limited to that which has been prepared pursuant to pending litigation.** Inmates who [are not indigent] **have not been granted in forma pauperis status** shall be charged in accordance with N.J.A.C. 10A:1-1.3.

(b)-(i) (No change.)

(j) The material referenced in (a) through (i) above will be copied at the inmate's expense unless the inmate [is indigent] **has been granted in forma pauperis status by the Court in presently pending litigation.**

10A:6-2.6 Legal telephone calls

(a) The Superintendent shall establish written rules and regulations by which inmate paralegals and/or professional staff members may place telephone calls to the following individuals or agencies requesting assistance in legal research or preparation of legal documents:

1.-5. (No change.)

6. Ombudsman; [and]

7. Office of Hispanic Services; and

[7.]**8.** The Legal Services Coordinator, [Office of the Deputy Commissioner] **Division of Policy and Planning,** Department of Corrections.

(b) (No change.)

10A:6-2.11 Inmate paralegal training

(a) The Legal Services Coordinator, [Office of the Deputy Commissioner] **Division of Policy and Planning,** shall be responsible for training inmate paralegals.

(b)-(f) (No change.)

10A:6-2.14 Department Review

Written [institutional] **correctional facility** policies and procedures regarding Inmate Legal Services and any new policies and procedures related to this subject shall be submitted to the [Office of the Deputy Commissioner] **Regulatory Officer, Division of Policy and Planning,** for legal review prior to implementation.

10A:6-3.2 Amendment of [institutional] **correctional facility** records

(a)-(b) (No change.)

(c) The Superintendent shall also notify the following of the inmate's name change:

1. The [Central Office Senior Classification Officer] **Offender Records Unit, Central Office, Department of Corrections;**

2. The [Bureau of] Correctional Information and Classification Services **(C.I.C.S.) Data Base, Garden State Reception and Youth Correctional Facility;** and

3. (No change.)

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS

State Board of Dentistry

Complaint Review Procedures

Proposed Amendment: N.J.A.C. 13:30-8.5

Authorized By: State Board of Dentistry, William Cinotti, D.D.S., President.

Authority: N.J.S.A. 45:6-3.

Proposal Number: PRN 1992-348.

Submit written comments by September 16, 1992 to:

Agnes Clarke, Executive Director
State Board of Dentistry
Post Office Box 45005
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Dentistry is proposing to clarify and refine N.J.A.C. 13:30-8.5, Complaint review procedures, in response to licensees who have expressed confusion as to when the Board will forward the full text of a complaint to the licensee and when, instead, a summary of allegations made will be provided.

The Board annually receives approximately 400 written complaints from patients, dentists, insurance carriers and other third parties who believe a dentist may have violated the law. N.J.A.C. 13:30-8.5 presently provides that the Executive Director reviews the complaint for sufficiency and, if the complaint does not contain sensitive material, forwards it to the licensee.

However, in some instances release of the full text is inappropriate; that is, the patient may prefer that the letter not be disclosed in its entirety, some informants may wish to remain anonymous, and in some instances the Board may find that release of the complaint could jeopardize the course of the investigation.

In order to ensure that a letter is released only with the consent of the writer, the proposed amendment imposes upon the Board an obligation to obtain written consent before releasing the full text of a complaint letter to the licensee. If consent is not obtained, the Executive Director must provide the licensee with a summary of the allegations made in the complaint. Furthermore, the proposed amendment clarifies that all or part of a letter may be withheld if, in the opinion of the Executive Director and the Board, it could jeopardize the investigation. The rule continues to provide that a complaint letter may be withheld if it contains sensitive material.

Social Impact

The proposed amendment clarifies for the benefit of licensees the circumstances in which the Board will release the full text of a complaint and when it will release only a summary of allegations made.

The proposed new written consent requirement will give the patient the opportunity to articulate his or her wishes with regard to release of the letter and will protect the patient against undesired release of all or any part of the letter. However, signing the consent form is not mandatory. If the patient does not sign for any reason, the Board will release only a summary of the allegations made.

Economic Impact

There will be no economic impact upon Board licensees or the public as a result of the proposed amendment, which merely clarifies the Board's complaint review procedures.

The requirement that the Board obtain written consent prior to the release of a complaint letter will create additional administrative expenses for the Board. The Board may also incur expenses to the extent that the proposed amendments result in the need for additional complaint summaries. In the Board's opinion, however, these additional administrative costs are outweighed by the benefits the amendments provide to the patient—protection against unauthorized release of the full text of a complaint and assurance that enforcement proceedings will not be jeopardized.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendments place compliance requirements only upon the Board of Dentistry, which would not be considered a "small business" under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16.

Full text of the proposal follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]):

13:30-8.5 Complaint review procedures

(a) (No change.)

(b) The Executive Director of the Board shall, **with the written consent of the complainant,** then forward the completed complaint to the licensee(s) involved with a request for all records, [X-rays] **x-rays**, models, and any other pertinent materials as well as a complete narrative, **where appropriate,** in response to allegations contained in the complaint. **If the complainant does not consent to release of the written complaint, the Executive Director shall provide the licensee with a written summary of the allegations contained in the complaint.** Should sensitive material be contained in the complaint **or if release of the complaint could jeopardize the course of the investigation,** the Executive Director may, with the consent of the Board, withhold all or part of said complaint from forwarding to the licensee(s).

1. (No change.)

(c)-(e) (No change.)

(a)

DIVISION OF CONSUMER AFFAIRS

State Board of Dentistry

Advertising

Proposed Amendment: N.J.A.C. 13:30-8.6

Authorized By: State Board of Dentistry, William R. Cinotti, D.D.S., President.

Authority: N.J.S.A. 45:6-3.

Proposal Number: PRN 1992-351.

Submit written comments by September 16, 1992 to:

Agnes Clark, Executive Director
State Board of Dentistry
124 Halsey Street
P.O. Box 45005
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Dentistry is proposing to amend N.J.A.C. 13:30-8.6 concerning professional advertising in order to clarify or change the existing regulatory standards. During the course of enforcement actions, the Board has become aware of certain areas of the rule which may be potentially confusing or burdensome to professional advertisers. The proposed amendments address the following areas:

N.J.A.C. 13:30-8.6(b): The Board proposes to eliminate the "dignified" standard in advertising because of the ambiguity inherent in the term. The Board is satisfied that the more specific standards set forth in the remainder of the rule are adequate to protect the public from misleading or deceptive information.

N.J.A.C. 13:30-8.6(c)2: Claims that services or materials are professionally superior may be permitted if they can be substantiated by the licensee.

N.J.A.C. 13:30-8.6(d): The amendment is intended to clarify the Board's existing rule which authorizes the Board to require from a licensee substantiation of the truthfulness of an advertised claim. By limiting this requirement to "objective" assertions the Board makes clear that it will only require substantiation of those claims which lend themselves to factual documentation. For example, a claim of the "best bonding material" may be substantiated by objective documentation while a claim of "friendly staff" cannot be so substantiated.

N.J.A.C. 13:30-8.6(h): All advertisements will be required to contain the name, address or telephone number of at least one licensee responsible for the dental practice rather than the existing requirement to set forth such information for all principals, partners and officers who are licensees in the practice. In view of the growth of multi-dentist practices, the existing requirement was deemed burdensome to advertisers.

N.J.A.C. 13:30-8.6(m): This proposed new subsection will permit both lay and expert testimonials so long as they are rendered within the stated parameters. The amendment also repeats the Board's requirement that any objective statement of fact appearing in a testimonial must be substantiated upon request by the Board. This new subsection replaces paragraph (c)5 which is deleted by this proposal.

Social Impact

The proposed amendments to N.J.A.C. 13:30-8.6 will provide licensees with a framework in which to more clearly and accurately advertise their services to the public. The amendments will benefit the consumer by improving the quality and expanding the availability of information in advertising about a practicing dentist's services to better enable the consumer to make an informed choice among those offering dental services.

Economic Impact

The proposed amendments to N.J.A.C. 13:30-8.6 concerning professional advertising should have no general economic impact other

than that which might be associated with better informed decision-making by consumers who will choose among those licensees advertising their dental services. Some advertising savings may be realized by large multi-dentist practices which will no longer be required to list the names of all principals in the practice.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., dentists are deemed "small businesses" within the meaning of the statute, the following statement is applicable:

The proposed amendments will apply to the approximately 9,000 licensed dentists in the State, regardless of the size of the dental practice. The amendments do not involve reporting or recordkeeping requirements. They do not require submissions to the Board or the maintenance of records which were not previously required.

The amendments eliminate the "dignified" standard in professional advertising, permit superiority claims which can be substantiated in regard to dental services and materials, clarifies the Board's existing requirement that licensees substantiate "objective" claims upon request, limits the requirement to set forth the name, address or telephone number to one responsible licensee in the practice, and permits lay and expert testimonials within stated parameters. The amendments involve no capital costs or reporting requirements, and it is unlikely that any professional services will be needed to comply with the amendments.

The only potential cost will be that incurred by a licensee who may need to change a current advertising format in order to be in compliance with the rules. Such costs will not vary with the size of the business but may be proportionate to the scope and nature of the advertising. In view of the fact that the economic impact of the amendments, if any, is minimal, a design to further minimize any adverse economic impact on small businesses is not feasible. Similarly, no exemptions, whether for small or large practices, are possible since this would frustrate the intent of the rule.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:30-8.6 Professional advertising

(a) (No change.)

(b) A licensed dentist who is actively engaged in the practice of dentistry in the State of New Jersey may provide information to the public by advertising in print or electronic media [in a dignified manner].

(c) A licensee who engages in the use of advertising which contains the following shall be deemed to be engaged in professional misconduct:

1. (No change.)

2. Claims that the service performed or the materials used are professionally superior to that which is ordinarily performed or used **unless such claims can be substantiated by the licensee.**

3.-4. (No change.)

[5. The use of any personal testimonial attesting to the technical quality or technical competence of a service or treatment offered by a licensee. Other testimonials shall be permitted so long as they are not violative of any other section of these regulations.]

Recodifying existing 6.-9. as 5.-8. (No change in text.)

(d) The Board may require a license to substantiate the truthfulness of any **objective** assertion or representation set forth in an advertisement. Failure of a licensee to provide factual substantiation to support a representation or assertion shall be deemed professional misconduct.

(e)-(g) (No change.)

(h) All licensee advertisements and public representations shall contain the name and address or telephone number of the licensee, professional service corporation or trade name under which the practice is conducted and shall also set forth the names of [all licensees who are principals, partners, officers in the professional service] **at least one licensee responsible for the dental practice in the** facility identified in the advertisement and/or public representation.

(i)-(l) (No change.)

(m) An advertisement may contain either a lay or expert testimonial, provided that such testimonial is based upon personal knowledge or experience obtained from a provider relationship with the licensee or direct personal knowledge of the subject matter of the testimonial. A lay person's testimonial shall not attest to any technical matter beyond the testimonial giver's competence to comment upon. An expert testimonial shall be rendered only by an individual possessing specialized expertise sufficient to allow the rendering of a bona fide statement or opinion. An advertiser shall be able to substantiate any objective, verifiable statement of fact appearing in a testimonial, and the failure to do so, if required by the Board, may be deemed professional misconduct.

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF OPTOMETRISTS
Requirements for Issuing Prescriptions and Dispensing of Medications; Certification by Examination; Fees
Proposed New Rules: N.J.A.C. 13:38-2.4 and 4.1
Proposed Amendment: N.J.A.C. 13:38-5.1

Authorized by: State Board of Optometrists, Susan Gartland, Executive Director.

Authority: P.L. 1991, c.385.

Proposal Number: PRN 1992-367.

Submit written comments by September 16, 1992 to:

Susan Gartland, Executive Director
State Board of Optometrists
Post Office Box 45012
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Optometrists is proposing new rules in order to implement the provisions of the Consumer Access to Eye Care Act of 1991, P.L. 1991, c.385 (the "Act"), which became effective on July 14, 1992. The rules establish certification and dispensing requirements for licensed optometrists who, under the Act, may now prescribe some medications for treatment purposes.

Proposed new rule N.J.A.C. 13:38-2.4 sets forth information required to appear on every prescription blank. Also included in this section is a requirement that patients be notified that they may request generic substitution; the statutory prohibition against dispensing more than a 72-hour medication supply, unless dispensed at no charge; labeling requirements in connection with containers of medication dispensed directly to a patient; and a prohibition against signing blank prescription forms.

N.J.A.C. 13:38-4.1 sets forth the purpose and scope of the new rules, and N.J.A.C. 13:38-4.2 lists application requirements.

Educational requirements are set forth in N.J.A.C. 13:38-4.3. Applicants for certification must have successfully completed all educational requirements in ocular pharmacology at an accredited school. The applicant must submit to the Board verification from the accredited school that the education received was the same as that required of currently enrolled students.

N.J.A.C. 13:38-4.4, Examination requirements for certification, identifies as the Board-approved examination the Treatment and Management of Ocular Disease Examination administered by the National Board of Examiners in Optometry.

N.J.A.C. 13:38-4.5 contains continuing education requirements. Completion of 20 hours in Board-approved courses devoted to both ocular pathology and ocular pharmacology is required during each biennial period, 10 hours of which must be in addition to the 50-hour continuing education requirement for license renewal.

Finally, N.J.A.C. 13:38-5.1, the Board's fee schedule, has been amended to include a $210.00 biennial certification fee, prorated on an annual basis for the benefit of individuals who apply during the second year of a biennial renewal period.

Social Impact

The Act, as implemented by the proposed new rules and amendment, benefits New Jersey's health care consumers by broadening access to health care professionals who may treat ocular diseases and other eye

ailments. Currently, 31 states permit certified optometrists to prescribe for treatment of the eye.

Pursuant to the Act, a patient may be treated by a certified optometrist using topically administered therapeutic pharmaceuticals. Referral to a physician in certain cases is no longer necessary. This should prove particularly helpful to patients being treated for diseases which may require a significant amount of continuing care. The proposed education, examination and continuing education requirements will ensure a high level of professional competence, and the dispensing requirements will provide additional safeguards for the protection of the public health and safety.

Economic Impact

Compliance with certification requirements for education, examination, and continuing education are all costs which must be borne by those seeking certification. These requirements have been deemed by the Legislature to be necessary in order to maintain high standards in the profession and to protect the public health. Applicants for certification will also be required to pay an initial $125.00 application fee and a $210.00 certification fee, to be renewed biennially. All fees and other compliance costs will be incurred on a voluntary basis by licensed optometrists who choose to make prescribing for treatment purposes part of their practice.

The Board estimates that approximately 500 licensed optometrists will seek certification. A consumer who chooses to be treated by a certified optometrist using topically administered therapeutic pharmaceuticals may avoid the expenses of an additional visit or visits to a physician for such treatment. To the extent that consumers do choose to be treated by certified optometrists, the practice of other eye care specialists may be affected.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., optometrists are deemed "small businesses" within the meaning of the statute, the following analysis applies.

The Board estimates that 500 of its approximately 1,100 current licensees will seek certification to prescribe for treatment purposes. Compliance requirements under the proposed rules and amendment are no more than those required by statute and by prudent professional practice. Applicants for certification must successfully complete a course of study in ocular pharmacology and a Board-approved examination. Certified optometrists must complete 20 continuing education credits during each biennial period; must provide adequate information on prescription blanks; and must advise patients of their right to request a generic substitution. Professional educational and printing services are likely to be required in order to comply with these rules.

Because the proposed rules seek to promote and protect the public health and welfare, they must be uniformly and consistently applied. Therefore, no differential treatment can be accorded to small businesses.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:38-2.4 Requirements for issuing prescriptions and dispensing of medications

(a) Every optometrist shall provide the following on all prescriptions:

1. The prescriber's full name, address, telephone number, license number and academic degree or identification of professional practice. This information shall be preprinted on all prescriptions;

2. The full name, age and address of the patient;

3. The date of issuance of prescription; and

4. The signature of the prescriber, hand-written.

(b) Every optometrist certified to prescribe pharmaceutical agents pursuant to the provisions of N.J.A.C. 13:38-4 and P.L. 1991, c.385, shall, in addition to the information set forth in (a) above, provide the following on all prescriptions for pharmaceutical agents:

1. The optometrist's certification number;

2. The name, strength and quantity of drug or drugs to be dispensed;

3. Adequate instruction for the patient. A direction of "p.r.n." or "as directed" alone shall be deemed an insufficient direction;

4. The number of refills permitted or time limit for refills, or both; and

5. Every prescription blank shall be imprinted with the words "substitution permissible" and "do not substitute" and shall contain space for the optometrist's initials next to the chosen option, in addition to the space required for the signature in (a)4 above.

(c) In addition to the provisions of (a) and (b) above, optometrists certified to prescribe pharmaceutical agents pursuant to the provisions of N.J.A.C. 13:38-4 and P.L. 1991, c.385, shall comply with the following:

1. The optometrist shall advise all patients by adequate notice, such as, but not limited to, a sign or pamphlet in the waiting room of the optometrist's office, that the patient may request the optometrist to substitute a generic drug for any prescribed medication.

2. The optometrist shall not dispense a prescription as provided for in N.J.S.A. 45:12-1 in an amount exceeding a 72-hour supply unless the prescription is dispensed at no charge to the patient.

3. The optometrist shall ensure that each container of medication dispensed directly to a patient is labeled in a legible manner with at least the following information:

i. The optometrist's full name;

ii. The full name of the patient;

iii. The date the medication is dispensed;

iv. The expiration date of medication;

v. The name, strength and quantity of medication dispensed;

vi. Adequate instructions for the patient regarding the frequency of administration of the medication;

vii. When an optometrist dispenses a pharmaceutical sample which has been packaged and labeled by the manufacturer and such sample package contains the information required by (c)3v and vi above, the information listed in (c)3i through ii, inclusive, above need not be added; and

viii. When an optometrist dispenses a medication, other than a sample exempted pursuant to (c)3vii above, in a container without sufficient space for the information required by this paragraph, the container shall be placed in a larger container or envelope, and the larger container or envelope shall be labeled as indicated in this paragraph and shall contain only one type of medication.

(d) In no instance shall an optometrist sign a blank prescription form or dispense drugs without complying with the above standards.

Recodify existing N.J.A.C. 13:38-2.4 through 2.11 as **2.5 through 2.12.** (No change in text.)

SUBCHAPTER 4. [(RESERVED)] CERTIFICATION BY EXAMINATION

13:38-4.1 Purpose and scope

(a) The rules of this subchapter implement the provisions of the Consumer Access to Eye Care Act of 1991, P.L. 1991, c.385.

(b) This subchapter shall apply to a licensed optometrist utilizing pharmaceutical agents, as defined and limited in P.L. 1991, c.385, for the purposes of treating deficiencies, deformities, diseases or anomalies of the human eye, including the removal of superficial foreign bodies from the eye and adnexae.

13:38-4.2 Application for certification; general requirements

(a) An optometrist licensed in this State who wishes to use pharmaceutical agents for treatment purposes as permitted by P.L. 1991, c.385, must be certified by the Board prior to prescribing or dispensing such agents.

(b) Each applicant for certification shall submit the following to the Board:

1. A completed application form;

2. The application fee set forth in N.J.A.C. 13:38-5.1;

3. Verification that the applicant has successfully completed the educational requirements set forth in N.J.A.C. 13:38-4.3. The applicant shall obtain the required verification from the school where the applicant completed the educational requirements; and

4. Proof that the applicant has successfully completed the examination requirements set forth in N.J.A.C. 13:38-4.4.

(c) An applicant who satisfies all of the requirements set forth in (b) above shall, upon payment of the initial certification fee set forth in N.J.A.C. 13:38-5.1, be certified by the Board to use pharmaceutical agents as defined and limited in P.L. 1991, c.385.

13:38-4.3 Educational requirements for certification

Each applicant for certification shall be required to successfully complete all educational requirements in ocular pharmacology at a school duly accredited by the United States Department of Education and the Council on Postsecondary Accreditation. The education shall be no less than that required of currently enrolled students as part of their requirements for graduation from that school.

13:38-4.4 Examination requirements for certification

Each applicant for certification shall be required to successfully complete the Treatment and Management of Ocular Disease Examination administered by the National Board of Examiners in Optometry.

13:38-4.5 Biennial certification renewal

(a) An application for certification renewal shall be issued by the Board upon the applicant's submission of proof that during the two calendar years immediately preceding application for renewal the applicant successfully completed 20 continuing professional education credits in Board-approved courses devoted to both ocular pathology and ocular pharmacology. Each credit shall represent or be equivalent to one hour of actual course attendance.

(b) Ten credits of the 20-credit continuing education requirement set forth in (a) above shall be in addition to the 50-credit continuing education requirement for license renewal. Credit for a continuing education course which is approved as fulfilling either the certification or the license renewal requirements shall be applied only once, either to the certification or to the license renewal requirement.

SUBCHAPTER 5. FEE SCHEDULE

13:38-5.1 Fee schedule

(a) The following fees shall be charged by the Board:

1.-6. (No change.)

7. Initial certification fee:	
i. If paid during the first year of a biennial renewal period:	**$210.00**
ii. If paid during the second year of a biennial renewal period:	**$105.00**
8. Biennial renewal fee—certification to prescribe:	**$210.00**
9. Each additional certificate—certification to prescribe (for second and third branch locations)	**25.00**

Recodify existing 7.-14. as **10.-17.** (No change in text.)

PUBLIC UTILITIES

(a)

BOARD OF REGULATORY COMMISSIONERS

Demand Side Management Resource Plan

Proposed Amendments: N.J.A.C. 14:12-1.2, 3.6, 4.1 and 4.3

Proposed Recodifications: N.J.A.C. 14:12-4.2 to 4.6 and 4.3 to 4.2

Proposed New Rule: N.J.A.C. 14:12-4.3

Proposed Repeal and New Rule: N.J.A.C. 14:12-5.3

Authorized By: Board of Regulatory Commissioners, Dr. Edward H. Salmon, Chairman and Jeremiah F. O'Connor and Carmen J. Armenti, Commissioners.

Authority: N.J.S.A. 48:2-13, 52:27F-11(g) and (q) and 52:27F-18.

BRC Docket Number: EX90040304.

Proposal Number: PRN 1992-328.

Submit comments by September 16, 1992 to:

Robert Chilton, Director
Division of Electric
Board of Regulatory Commissioners
44 South Clinton Avenue
CN-350
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Board's rules pertaining to Demand Side Management Resource Plans became effective upon publication in the New Jersey Register on November 4, 1991, at 23 N.J.R. 3368(a). At that time, the Board expressed its opinion that the issue of excessive utility earnings possibly resulting from these rules required further review. Accordingly, the Board decided that it would explore the possible implementation of a cap on such earnings.

The issue of excessive utility earnings from implementation of DSM programs can be divided into two categories: (1) the level of incentives earned through implementation of DSM programs; and (2) the recovery of lost revenues. With regard to the level of incentives a utility may earn, the Board is of the opinion that a cap is not required at this time. The Board will preapprove spending levels and will set the level of incentives that a utility may receive based on estimates of costs and benefits. Moreover, given the proposed level of spending by each utility in its DSM Plan filing versus the overall level of utility revenues and annual net income, the impact of potential DSM incentives on the overall earnings situation of a utility is judged to be minor. As the Board will have sufficient control over the level of incentives a utility may receive, no additional earnings cap is necessary.

Should the penetration of DSM technologies and potential magnitudes expand substantially, the Board can impose earnings caps in the future. However, given the groundbreaking nature of the incentive rules and the first round of their implementation, the Board sees no reason to impose restrictions at this time.

The DSM rules allow a utility to recover the contribution to its fixed costs that it would have received were it not for DSM. The proposed modifications to the rules specify that a utility would be entitled to full recovery of lost revenues provided that its overall earnings on utility operations are not in excess of 50 basis points above its allowed rate of return on equity. For earnings that are between 50 and 100 basis points above its allowed rate of return on equity, the level of lost revenues a utility may recover would be reduced linearly from 100 percent at 50 basis points to zero percent at 100 basis points. No recovery of lost revenues would be allowed for a particular year if a utility's earnings for that period exceed its allowed rate of return on equity by 100 basis points or more. The Board believes this proposal balances the conflicting goals of removing disincentives to DSM while providing adequate protection against exacerbating a situation in which a utility is over earning.

The Board is also proposing an amendment to clarify the roles of various interested parties and, thereby, enhance the DSM plan review process. This amendment addresses the Public Advocate's right as a statutory intervenor, outlines discovery and settlement timetables, and provides for evidentiary hearings for issues irreconcilable through settlement.

Various minor modifications are also included. The definition of fixed cost revenue erosion is clarified as is the requirement that a utility fund a contractor to verify installation of measures and delivery of savings for utility implemented DSM programs only.

Social Impact

Adoption of the proposed amendments and new rules will provide a more stringent review process which will result in additional protection to ratepayers. In addition, the pursuit of energy conservation will provide both environmental and economic benefits to the citizens of New Jersey.

Economic Impact

Adoption of the proposed amendments and new rules will neither increase utility spending, other than for evidentiary hearings when necessary, nor result in the recovery of additional costs from ratepayers. However, the proposed amendments and new rules would help to eliminate excessive utility earnings. The amendments and new rules as proposed are intended to clarify certain aspects of the chapter and allow for evidentiary hearings for contested issues. While evidentiary hearings may result in costs to a utility, any reasonable levels of expenses found appropriate within the context of a rate proceeding will be allowed to be recovered through rates to customers.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required as these amendments and new rules impose no reporting, recordkeeping or compliance requirements on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules place requirements only on

investor-owned electric and natural gas utilities in the State, all of which are large businesses in that they are the major energy utilities in the State and employ over 100 employees.

Full text of the proposal follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]):

14:12-1.2 Definitions

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

...

"Fixed cost revenue erosion" means the reduction in contribution towards a utility's fixed costs resulting from a reduction in energy usage **or billing demand which results** from a DSM Program. This figure is determined on a per unit basis by dividing total test year retail revenues minus the sum of test year:

1.-3. (No change.)

...

14:12-3.6 Measurement plan

(a)-(f) (No change.)

(g) Each utility shall fund the procurement of a contractor to verify installation of measures and delivery of savings **from DSM Programs implemented by the utility.** Said contractor shall be selected by and report directly to the Board.

14:12-4.1 Cost Recovery Mechanism

(a) A Demand Side Management Cost Recovery Mechanism proposal shall be filed, as part of the DSM plan, by each electric and gas utility to permit the timely recovery of:

[actual] **1. Actual** program costs plus incentives or disincentives or standard offer payments; **and**

2. Fixed cost revenue erosion.

(b) The DSM Cost Recovery Mechanism shall be a deferred accounting mechanism which shall be adjusted on an annual basis or some other period concurrent with implementation of each utility's fuel adjustment clause to reconcile the difference between:

[actual] **1. Actual** program costs plus incentives or disincentives or standard offer payments; **plus**

2. Fixed cost revenue erosion and the level of expenditures recovered in rates for the most recent annual period.

(c) The Cost Recovery Mechanism shall be limited to:

[actual] **1. Actual** program costs plus incentives or disincentives or standard offer payments; **and**

2. Fixed cost revenue erosion incurred in the implementation of DSM Programs which have been previously approved by the Board pursuant to these rules.

(d) (No change.)

[14:12-4.2 Program Transition Strategy

As part of the initial DSM Plan filed pursuant to this chapter, each utility shall file a DSM Program Transition Strategy which describes the utility's proposed plan to merge its existing DSM Program efforts into the DSM Plan. Such strategy shall address the proposed future status of each of the utility's existing programs, that is, whether an existing program is proposed to be rolled into the Performance-Based Programs or the Core Program established in N.J.A.C. 14:12-2, or whether it is proposed to be eliminated based upon a finding of non cost-effectiveness and insufficient public benefits. A supporting rationale shall be included which underlies the proposed status of each program. Further, the DSM Program Transition Strategy must address the impact, if any, of utility programs implemented as a result of these regulations, on existing DSM contracts that resulted from previous competitive bid solicitations.]

14:12-[4.3]**4.2** [Revenue adjustment mechanism] **Recovery of fixed cost revenue erosion**

(a) Along with the filing of its DSM Plan, each utility may propose for consideration by the Board a mechanism for [addressing] **the recovery of fixed cost revenue erosion which addresses** the impact of DSM initiatives on the overall level of revenues collected by the utility. Such proposals shall address:

1. (No change.)

2. The recovery between base rate changes of [fixed cost contribution losses as specified in (a)1 above] **fixed cost revenue erosion.**

(b) The full recovery of fixed cost revenue erosion occurring over a particular period will be allowed provided that a utility's overall return on equity (ROE) during that period does not exceed 50 basis points above its allowed return on equity. No recovery of fixed cost revenue erosion occurring over a particular period will be allowed if a utility's overall return on equity during that period exceeds its allowed return on equity by 100 basis points or more. If a utility's overall return on equity is between 50 and 100 basis points above its allowed return on equity, the percentage of fixed cost revenue erosion it may recover will vary linearly from 100 percent at 50 basis points above its allowed return on equity to zero percent at 100 basis points above its allowed return on equity. The time period over which fixed cost revenue erosion and ROE calculations are made shall be annual, unless it is specifically determined by the Board that a longer period is appropriate.

1. The return on equity for an annual period shall be calculated by dividing the utility's net income over the period by the utility's average 13 month common equity balance for such annual period as reflected in the utility's monthly reports to the Board. The utility's annual period shall consist of the 12 months for which the utility is requesting the recovery of fixed cost revenue erosion. The average 13 month common equity balance shall be the common equity balance at the beginning of the annual period and the month ending balances for each of the twelve months in the annual periods divided by 13.

i. Fixed cost revenue erosion recovered pursuant to this subchapter shall be excluded from this calculation of a utility's ROE.

ii. DSM incentives/disincentives and income/losses from standard offer programs shall be excluded from the calculation of a utility's ROE.

iii. A utility may propose other adjustments to the calculation of ROE subject to Board approval.

(c) A utility may collect fixed cost revenue erosion for a forecasted year subject to true-up with interest.

14:12-4.3 Earnings

(a) Lost revenues plus incentives/disincentives from shared savings programs and income/losses from standard offer programs shall be excluded from the determination of a utility's base rate revenue requirement.

(b) For the shared savings option, the Board shall set the split of the savings based on a targeted rate of return for the plan based on forecasts of costs and savings and the level of risks associated with the plan.

(c) The Board retains the ability to re-evaluate the treatment of incentives/disincentives and/or income/losses and the recovery of fixed cost revenue erosion from DSM programs. However, any changes will apply prospectively only and any DSM measures implemented in accordance with a particular set of rules shall be exempt from future changes for the life of the measure.

14:12-4.6 Program Transition Strategy

As part of the initial DSM Plan filed pursuant to this chapter, each utility shall file a DSM Program Transition Strategy which describes the utility's proposed plan to merge its existing DSM efforts into the DSM Plan. Such strategy shall address the proposed future status of each of the utility's existing programs, that is, whether an existing program is proposed to be rolled into the Performance-Based Programs or the Core Program established in N.J.A.C. 14:12-2, or whether it is proposed to be eliminated based upon a finding of non cost-effectiveness and insufficient public benefits. A supporting rationale shall be included which underlies the proposed status of each program. Further, the DSM Program Transition Strategy must address the impact, if any, of utility programs implemented as a result of these regulations, on existing DSM contracts that resulted from previous competitive bid solicitations.

14:12-5.3 Public notice and hearing

[(a) Prior to filing its DSM Plan, each utility must contact the Board and its staff to arrange for a pre-filing conference at which a date for public hearing on the DSM Plan shall be established.

(b) Concurrent with its DSM Plan filing, each utility shall provide appropriate public notice of its filing, the date, time and location of the public hearing, and a contact for obtaining a copy of the Executive Summary prepared pursuant to N.J.A.C. 14:12-2.2(a)6. or the complete DSM Plan.

(c) Within 45 days of receipt of a utility's DSM Plan filing pursuant to this chapter, the Board shall conduct a public hearing to solicit comments on the proposed Plan. Provision shall also be made for written comments to be submitted to the Board.]

(a) Concurrent with the filing of its DSM plan, each utility shall contact Board staff to arrange for a public hearing on the DSM Plan.

(b) Subsequent to its filing, each utility shall provide public notice of its filing by publication in newspapers published and circulated in the utility's service area. The public notice shall be subject to review by Board staff prior to its release. The public notice shall include the date, time and location of the public hearing, and a contact for obtaining a copy of the Executive Summary prepared pursuant to N.J.A.C. 14:12-2.2(a)6 or the complete DSM Plan.

(c) Concurrent with the filing of its DSM Plan with the Board, each utility shall provide the Department of the Public Advocate, Division of Rate Counsel with a copy of the Plan and notice of the public hearing.

(d) Written comments on the Plan may be submitted to the Board within 60 days of the public notice announcing the filing, or as otherwise extended by the Board.

(e) The Public Advocate, Division of Rate Counsel, shall be a statutory intervenor pursuant to N.J.S.A. 52:27E-18.

(f) Persons, other than the Public Advocate, Division of Rate Counsel, interested in intervening in the DSM Plan review process must notify the Board within 30 days of public notice of the DSM Plan filing of their intent to intervene.

(g) The Board shall establish a schedule under which each utility and any other party shall be required to respond to information requests including all relevant dates and provide notification of same to the parties, which schedule shall terminate no sooner than 45 days from the date of the filing.

(h) Utilities shall use their best efforts to respond to all discovery requests within 15 days of the date of the request.

(i) Approximately 60 days after the filing date, Board staff will convene a settlement conference of the parties in each case. Additional conferences may be convened. In the event the parties determine that settlement is unlikely, the Board will determine whether it will retain the matter and establish an evidentiary hearing schedule for resolving all contested issues, or whether it will transmit the matter to the Office of Administrative Law for hearing.

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits

Route U.S. 9 in Atlantic County

Proposed Amendment: N.J.A.C. 16:28-1.41

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, and 39:4-98.

Proposal Number: PRN 1992-346.

Submit comments by September 16, 1992 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment will establish revised "speed limit" zones along Route U.S. 9 in the City of Absecon, Township of Galloway, and the City of Port Republic, Atlantic County, for the safe flow of traffic, the enhancement of safety, and the well-being of the populace.

Based upon requests from local government, and as part of a review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted a traffic investigation. The investigation proved that the establishment of the revised "speed limit" zones along Route U.S. 9 in the City of Absecon, Township of Galloway, and the City of Port Republic, Atlantic County, were warranted.

The Department therefore proposes to amend N.J.A.C. 16:28-1.41 based upon local governmental requests and the Department's traffic investigation.

Social Impact

The proposed amendment will establish revised "speed limit" zones along Route U.S. 9 in the City of Absecon, Township of Galloway, and the City of Port Republic, Atlantic County, for the safe flow of traffic, the enhancement of safety, and the well-being of the populace. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local governments will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of revised "speed limit" zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendment does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

16:28-1.41 Route U.S. 9

(a) The rate of speed designated the certain parts of State highway Route U.S. 9 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. (No change.)

2. For both directions of traffic in Atlantic County:

i.-iv. (No change.)

v. In the City of Absecon:

(1)-(5) (No change.)

(6) Zone 17: [45] **40** miles per hour between Route N.J. 157 and the City of Absecon-Township of Galloway line (**approximate** mileposts 43.77 to [44.15] **44.14**): thence

vi. In Galloway Township:

(1) Zone 18: [45] **40** miles per hour between the City of Absecon-Township of Galloway line and East Brook Avenue-**Old Shore Road** (**approximate** mileposts [44.15 to 44.52] **44.14 to 44.53**); thence

[(2) Zone 19: 50 miles per hour East Brook Avenue and 450 feet north of Sommers Town Lane except with a 35 miles per hour School Speed zone in the Oceanville School zone during recess when the presence of children is clearly visible from the roadway or while children are going to or leaving school during opening or closing hours (mileposts 44.52 to 46.48); thence

(3) Zone 20: 45 miles per hour between 450 feet north of Sommers Town Lane and 1225 feet north of Leeds Point Road (County Road 618) (mileposts 46.48 to 47.16); thence

(4) Zone 21: 50 miles per hour between 1225 feet north of Leeds Point Road (County Road 618) and milepost 48 (mileposts 47.16 to 48.00); thence

(5) Zone 22: 45 miles per hour between Mileposts 48 and Old New York Road (County Road 610) (mileposts 48.00 to 48.63); thence

(6) Zone 23: 50 miles per hour between Old New York Road (County Road 610) and the Township of Galloway-City of Port Republic line (mileposts 48.63 to 51.34); thence]

(2) Zone 19: 45 miles per hour between East Brook Avenue-Old Shore Road and Boice Road (approximate mileposts 44.53 to 45.56); thence

(3) Zone 20: 50 miles per hour between Boice Road and 1,418 feet north of Chanese Lane (at stream) (approximate mileposts 45.56 to 46.18); thence

(4) Zone 21: 45 miles per hour between 1,418 feet north of Chanese Lane (at stream) and 620 feet north of Sommers Town Lane except for 35 miles per hour when passing through the Oceanville School zone (mileposts 46.23 to 46.51) while "35 m.p.h. when flashing" signs are operating during recess or while children are going to or leaving school, during opening or closing hours (approximate mileposts 46.18 to 46.54); thence

(5) Zone 22: 40 miles per hour between 620 feet north of Sommers Town Lane and 1,225 feet north of Old Post Republic Road-Oyster Creek Road (Co. Rd. 618) (approximate mileposts 46.54 to 47.21); thence

(6) Zone 23: 50 miles per hour between Old Port Republic Road-Oyster Creek Road (Co. Rd. 618) and Smithville Boulevard (approximate mileposts 47.21 to 48.08); thence

(7) Zone 24: 45 miles per hour between Smithville Boulevard and Quail Hill Boulevard (approximate mileposts 48.08 to 48.30); thence

(8) Zone 25: 40 miles per hour between Quail Hill Boulevard and Old New York Road (Co. Rd. 610) (approximate mileposts 48.30 to 48.72); thence

(9) Zone 26: 45 miles per hour between Old York Road (Co. Rd. 610) and Smith Bowen Road (approximate mileposts 48.72 to 49.04); thence

(10) Zone 27: 50 miles per hour between Smith Bowen Road and the Township of Galloway-City of Port Republic line (approximate mileposts 49.04 to 51.34); thence

vii. In the City of Port Republic:

(1) Zone [24] **28**: 50 miles per hour between the Township of Galloway-City of Port Republic line and the Garden State Parkway **Interchange No. 48 (approximate** [(] mileposts 51.34 to 52.36).

(b) (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping

Routes U.S. 1 in Middlesex and Mercer Counties; U.S. 1 and 9 in Middlesex, Union, Essex, Hudson and Bergen Counties; N.J. 3 in Passaic, Bergen and Hudson Counties; U.S. 9 in Atlantic County; U.S. 1 (Business) in Mercer County and U.S. 1 and 9 (Truck) in Essex and Hudson Counties.

Proposed Amendments: N.J.A.C. 16:28A-1.1, 1.2, 1.3, 1.7, 1.97 and 1.106

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-198.

Proposal Number: PRN 1992-345.

Submit comments by September 16, 1992 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments will establish revised "restricted parking and stopping" zones along Routes U.S. 1 in Middlesex and Mercer Counties; U.S. 1 and 9 in Middlesex, Union, Essex, Hudson and Bergen Counties; N.J. 3 in Passaic, Bergen and Hudson Counties; U.S. 9 in Atlantic County; U.S. 1 (Business) in Mercer County; and U.S. 1 and 9 (truck) in Essex and Hudson Counties for the safe flow of traffic, the enhancement of safety, and the well-being of the populace.

The amendments effect the following changes in the Code: N.J.A.C. 16:28A-1.1, 1.2, 1.3, 1.7, 1.97 and 1.106, the amendments expand the restriction to both sides of the highway, add an exception for other approved parking restrictions, require signs notifying the motorists of the restrictions, and recodify the rules in compliance with the Department's format for clarity by placing the restrictions by county and municipality. Additionally, the amendment to N.J.A.C. 16:28-1.97 effects the name change of Route U.S. 1, formerly "Alternate", to "Business."

Based upon requests from the local governments in the interest of safety, and as part of a review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted traffic investigations. The investigations proved that the establishment of revised "restricted parking and stopping" zones along Routes U.S. 1 in Middlesex and Mercer Counties; U.S. 1 and 9 in Middlesex, Union, Essex, Hudson and Bergen Counties; N.J. 3 in Passaic, Bergen and Hudson Counties; U.S. 9 in Atlantic County; U.S. 1 (Business) in Mercer County; and U.S. 1 and 9 (Trucks) in Essex and Hudson Counties were warranted.

The Department therefore proposes to amend N.J.A.C. 16:28A-1.1, 1.2, 1.3, 1.7, 1.97, and 1.106, based upon the request from the local governments, and the traffic investigations.

Social Impact

The proposed amendments will establish revised "restricted parking and stopping" along Routes U.S. 1 in Middlesex and Mercer Counties; U.S. 1 and 9 in Middlesex, Union, Essex, Hudson and Bergen Counties; N.J. 3 in Passaic, Bergen and Hudson Counties; U.S. 9 in Atlantic County; U.S. 1 (Business) in Mercer County; U.S. 1 and 9 (Trucks) in Essex and Hudson Counties for the safe flow of traffic, the enhancement of safety, and the well-being of the populace. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local governments will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of "restricted parking and stopping" zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendments do not place any reporting, recordkeeping or other compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments primarily affect the motoring public and the governmental entities responsible for the enforcement of the rules. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

16:28A-1.1 Route U.S. 1

(a) The certain parts of [the] State highway Route U.S. 1 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is

prohibited at all times, except as provided in N.J.S.A. 39:4-139. **In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.**

[1. No stopping or standing along both sides of Route U.S. 1 within the entire corporate limits of West Windsor Township including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation.

2. No stopping or standing in South Brunswick Township, Middlesex County:

i. Along both sides:

(1) For the entire length within the corporate limits of South Brunswick Township including all ramps and connections under the jurisdiction of the Commissioner of Transportation, except in approved designated bus stops.

3. No stopping or standing in Edison Township, Middlesex County:

i. Along both sides of Route U.S. 1:

(1) From the northerly curb line of Grandview Avenue to the southerly curb line of Parsonage Road including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation.

4. No stopping or standing in the City of Trenton, Lawrence Township, Mercer County:

i. Along both sides:

(1) Beginning at a point of mile post 0.6 (Conovers Alley) City of Trenton and the southerly curb line of Quakerbridge Road (milepost 8.1) Lawrence Township, including all ramps and connections under the jurisdiction of the Commissioner of Transportation.

(2) (Whitehead Road Extension)—Beginning at the southerly abutment of the bridge over the Delaware and Raritan Canal and the northwesterly abutment of the bridge over the Assumpink Creek.

5. No stopping or standing in Plainsboro Township, Middlesex County:

i. Along both sides:

(1) For the entire length within the corporate limits of the Township of Plainsboro including all ramps and connections under the jurisdiction of the Commissioner of Transportation except in approved designated bus stops and time limit parking areas. Signs to be posted only in areas where an official township resolution has been submitted.]

1. No stopping or standing in Mercer County:

i. Along both sides:

(1) In the City of Trenton, and the Townships of Lawrence and West Windsor:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other approved parking restrictions.

2. No stopping or standing in Middlesex County:

i. Along both sides:

(1) In the Townships of Plainsboro, South Brunswick, North Brunswick, Edison and Woodbridge:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other approved parking restrictions.

[(b) The certain parts of State Highway Route U.S. 1 described in this section shall be designated and established as "no parking" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199 permission is granted to erect appropriate signs at the following established bus stops:

1. Along the northbound (easterly) side in South Brunswick Township, Middlesex County:

i. Near side bus stop:

1. Whispering Woods Boulevard (105 feet).

2. Along the southbound (westerly) side in South Brunswick Township, Middlesex County:

i. Near side bus stop:

1. Wynwood Drive (105 feet).]

(b) The certain parts of State highway Route U.S. 1 described in this subsection shall be designated and established as "no parking bus stop" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1. Along the northbound (easterly) side in Middlesex County:

i. In the Township of South Brunswick:

(1) Near side bus stop:

(A) Whispering Woods Boulevard (105 feet).

2. Along the southbound (westerly) side in Middlesex County:

i. In the Township of South Brunswick:

(1) Near side bus stop:

(A) Wynwood Drive (105 feet).

16:28A-1.2 Route U.S. 1 and 9

(a) The certain parts of State highway Route U.S. 1 and 9 described in [the] **this** subsection shall be designated and established as "no [parking] **stopping or standing**" zones where stopping or standing is prohibited at all times, except as provided in N.J.S.A. 39:4-139. **In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.**

[1. No stopping or standing along both sides of Route U.S. 1 and 9 from the junction of Route U.S. 1 and U.S. 9 in Woodbridge Township to the City of Rahway-City of Linden corporate line including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation.

2. No stopping or standing in Palisades Park Borough, Bergen County along the westbound side:

i. From the easterly curb line of Broad Avenue to a point 200 feet easterly thereof;

ii. From the westerly curb line of Ruff Avenue to a point 100 feet westerly thereof.

3. No stopping or standing in Ridgefield Borough, Bergen County:

i. Along the northbound side:

(1) From the Fairview Borough-Ridgefield Borough corporate line, to the center line of Edgewater Avenue;

(2) From a point 240 feet north of the center line of Edgewater Avenue, to the Ridgefield Borough-Palisades Park Borough corporate line.

ii. Along the southbound side:

(1) From the center line of Elm Avenue, to the center line of Virgil Avenue;

(2) From a point 280 feet south of the center line of Banta Place, to a point 150 feet south of the center line of River Street;

(3) From a point 75 feet north of the center line of Edgewater Avenue, to the Ridgefield Borough-Fairview Borough corporate line.

4. No stopping or standing in the City of Newark, Essex County:

i. Along the westerly side (south local lanes):

(1) From the Bessermer Street ramp (M.P. 47:03) southerly to the Newark-Elizabeth City corporate line.]

1. No stopping or standing in Middlesex County:

i. Along both sides:

(1) In Woodbridge Township:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other approved parking restrictions.

2. No stopping or standing in Union County:

i. Along both sides:

(1) In the City of Linden:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other approved parking restrictions.

3. No stopping or standing in Essex County:

i. Along both sides:

(1) In the City of Newark:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other approved parking restrictions.

4. No stopping or standing in Hudson County:

i. Along both sides:

(1) In the City of Jersey City and the Township of North Bergen:
(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions.
5. No stopping or standing in Bergen County:
i. Along both sides:
(1) In the Boroughs of Ridgefield and Palisades Park:
(A) For the entire length within the corporate limits, including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions.
(b)-(c) (No change.)

16:28A-1.3 Route 3

[(a) The certain parts of State highway Route 3 (Grace Street Connector Road) described in (a) of this section shall be designated and established as "no parking" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139.
1. No stopping or standing along both sides for the entire length within the corporate limits of Borough of East Rutherford, Rutherford Borough, and the City of Clifton including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation.
2. No stopping or standing in Secaucus Town, Hudson County:
i. Along both sides (Grace Street Connector Road):
(1) From the center line of Grace Street (Municipal Street), to a point 1,250 feet north thereof.]
(a) The certain parts of State highway Route 3 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.
1. No stopping or standing in Passaic County:
i. Along both sides:
(1) In the City of Clifton:
(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions.
2. No stopping or standing in Bergen County:
i. Along both sides:
(1) In the Borough of East Rutherford:
(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions.
3. No stopping or standing in Hudson County:
i. Along both sides:
(1) In the Town of Secaucus and the Township of North Bergen:
(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions.
(b) The certain parts of State highway Route 3 described [herein below] **in this subsection** shall be[, and hereby are,] designated and established as "no parking" zones where parking is prohibited at all times. [and in] **In** accordance with the provisions of N.J.S.A. 39:4-199, permission is [hereby] granted to erect appropriate signs at the following established bus stops:
1.-2. (No change.)

16:28A-1.7 Route U.S. 9

(a) The certain parts of State highway Route U.S. 9 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times **except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.**
1. No stopping or standing along both sides for the entire length within the corporate limits of the following municipalities including all ramps and connections **thereto, which are** under the jurisdiction of the Commissioner of Transportation; **except in areas covered by other parking restrictions.**
i.-ii. (No change.)
iii. Marlboro Township, Monmouth County[.]; **and**
iv. In the City of Northfield, Atlantic County.
2.-21. (No change.)
(b)-(c) (No change.)

16:28A-1.97 Route U.S. 1 Business

(a) The certain parts of State highway Route U.S. 1 Business described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. **In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.**
[1. No stopping or standing in Lawrence Township, Mercer County:
i. Along both sides:
(1) Beginning at 0.0 at the intersection of the U.S. 1 Freeway to the northerly curbline of Carnegie Road (milepost 2.31) Lawrence Township, including all ramps and connections under the jurisdiction of the Commissioner of Transportation]
1. No stopping or standing in Mercer County:
i. Along both sides:
(1) In the City of Trenton and the Township of Lawrence:
(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions.
(b) (No change.)

16:28A-1.06 Truck Route U.S. 1 and 9

(a) The certain parts of State highway Truck Route U.S. 1 and 9, which runs from milepost 51 to milepost 54.5 (approximate 4.14 miles), below the Pulaski Skyway, which are described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times, **except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.** [for the entire length, including all ramps and connections under the jurisdiction of the Commissioner of Transportation:]
1. [Within the corporate limits of:] **No stopping or standing along both sides for the entire length within the corporate limits of the following municipalities including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions:**
i. The Town of Kearny, Hudson County; [and]
ii. The City of Jersey City, Hudson County[.]; **and**
iii. The City of Newark, Essex County.

TREASURY-TAXATION

(a)

DIVISION OF TAXATION

Corporation Business Tax
Recycling Tax Credit

Proposed Amendment: N.J.A.C. 18:7-3.18

Authorized By: Leslie A. Thompson, Director, Division of Taxation.
Authority: N.J.S.A. 54:10A-27.
Proposal Number: PRN 1992-354.

Submit comments by September 16, 1992 to:
Nicholas Catalano
Chief, Tax Services
Division of Taxation
CN 269
Trenton, NJ 08646

The agency proposal follows:

Summary

The rule regarding tax credit for recycling equipment which was proposed as a new rule at 20 N.J.R. 48(b) included two references to cost as the same as the Federal cost basis; one at N.J.A.C. 18:7-3.18(d), and one reference in an example used in N.J.A.C. 18:7-3.18(g). During the comment period, comments were received which requested clarification of the term "cost," and deletion of the term "the same basis as used for Federal tax purposes" and substitution with the word "cost." The Department made a change on adoption, at 20 N.J.R. 2318(a), to delete the reference to the "Federal cost basis," at N.J.A.C. 18:7-3.18(d) and to replace it with the word "cost," in response to the comments, since this change gave effect to the language of the statute. However, a corresponding change was, inadvertently, not made at N.J.A.C. 18:7-3.18(g), in the example, which continued to refer to the Federal cost basis. To correct this inconsistency, and because questions have risen regarding the meaning of the term "cost," the Division has now proposed to change the reference in subsection (g) from "Federal cost basis of this equipment" to "cost" and to add a definition of "cost of recycling equipment" to subsection (a).

This meaning of cost is in accordance with the primary, natural and ordinary meaning of the term, and, in absence of the Legislature's attribution of any special or technical meaning to the word "cost," is the most appropriate meaning, in the opinion of the Division. It is also the interpretation which the Division has used since at least November 1990, when it received an opinion from the Attorney General on the subject. Therefore, while there is a change in the rule text, there will be no change in actual practice.

Like a tax exemption, a tax credit is a privilege, granted as a matter of legislative grace and, as such, should be narrowly construed. In New Jersey, the courts have followed a rule of strict construction in determining exemptions from State tax.

Social Impact

The proposed amendment will have a positive social impact in that it will eliminate a point of possible confusion over the scope of the recycling tax credit and clarify the application of the statute. The rule is in accordance with the legislative purpose of encouraging recycling, but also will be in harmony with the evident legislative intent to put certain constraints on applicability of the recycling tax credit which include the "cap" on the amount of the credit allowable each year and limiting the carryover period of the credit. The credit is scheduled to expire in 1996.

Economic Impact

The proposed amendment will prevent potential abuse of the recycling tax credit by setting forth a definition of the term "cost" in the rule. The amendment may have a slight positive effect on the general treasury of the State by confirming the definition of cost to minimize the economic impact on the State's corporate business tax revenues. There is no basis for concluding that, by its silence, the Legislature intended an expansive definition of the "cost of recycling equipment" beyond the reasonable and ordinary meaning of the term. Therefore, the Division is amending the rule to make this reasonable and ordinary meaning clear.

Regulatory Flexibility Statement

The proposed amendments clarify current practice in the Division, which considers the term "cost" to have the primary, natural and ordinary meaning attributed to it by common and reasonable usage. The amendments clarify the amount of tax credit which a corporation may obtain from the purchase of recycling equipment, but do not add or remove any reporting, recordkeeping or other requirements. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]):

18:7-3.18 Recycling tax credit

(a) As used in this section:

"Cost of recycling equipment" means the "invoice cost" or "purchase price" of the eligible equipment itself. The term does not, for example, include peripheral or indirect costs associated with the purchase, installation or construction of the eligible equipment. Ineligible costs include, but are not limited to, sales tax, shipping costs, design and engineering costs and site preparation.

. . .

(b)-(f) (No change.)

(g) The equipment must be used in New Jersey during the year to be eligible for the tax credit.

Example: XYZ Corporation begins to use qualified recycling equipment in this State on January 2, 1990. The [Federal cost basis of this equipment] **cost of the equipment, excluding sales tax, shipping and installation, is** $100,000 and the taxpayer did not receive any loans from the recycling fund to help with the purchase of the equipment. The taxpayer receives an enterprise zone employee tax credit of $5,000 and their corporate tax liability after the credit is $30,000. The credit for the taxpayer is the lesser of $10,000 ($100,000 cost × 50 percent (total credit allowable) × 20 percent maximum yearly credit), or $15,000 (50 percent of the tax liability after the enterprise zone tax credits). In this case the allowable credit for XYZ Corporation is $10,000, the lesser of the two amounts.

(h) (No change.)

HEALTH

(a)

HEALTH FACILITIES RATE SETTING

Standard Hospital Accounting and Rate Evaluation (SHARE) Manual; Rehabilitation and Specialized Hospitals

Per Diem Charge

Proposed Amendments: N.J.A.C. 8:31A-7.4 and 7.5
Proposed New Rules: N.J.A.C. 8:31A-1.5 and Appendix D.

Authorized By: Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq.

Proposal Number: PRN 1992-365.

Submit comments by September 16, 1992 to:
Charles O'Donnell, Director
Health Facilities Rate Setting, CN 360
New Jersey Department of Health
Trenton, NJ 08625-0360

The agency proposal follows:

Summary

The proposed amendments to N.J.A.C. 8:31A will provide for the establishment of a fee to be added to the per diem rate for the support of administrative costs incurred in the rate setting process. This proposed change is reflected in the diagram in Appendix D, and in the amendments to the SHARE Manual at N.J.A.C. 8:31A-1.5, 7.4 and 7.5. A predetermined charge per patient day, for each patient day in the year of the current cost base, beginning July 1, 1992, will be assessed each facility for the Blue Cross prospective per diem rates established by the Department of Health. The fee will be charged on the basis of Blue Cross and Medicaid patient days. Facilities will be allowed to "pass through" the fees as part of their reimbursement rate, in accordance with the proposed amendments. This per diem fee is the most appropriate measure of a payor's "benefit" from a cost containment system. The maximum add-on fee will be at a rate of $5.00 per patient day.

Social Impact

The proposed amendments will insure that the SHARE rate setting system, which operates for the rehabilitation and specialized hospitals, will continue to provide reasonable reimbursement rates for the consumer. This will be accomplished by insuring that all costs are evaluated for reasonableness, while enabling the specialized and rehabilitation hospitals, and the Department, to eliminate ambiguity in N.J.A.C. 8:31A.

Economic Impact

The proposed changes will insure that an effective regulatory system for cost containment in specialized and rehabilitation hospitals will continue to operate for the benefit of the facility, the payor and the consumer. The implementation of a fee to be added on to the per diem rate will have no direct or immediate economic impact on the consumer

or the provider hospitals. It is possible that the general public may bear the costs, if the payor passes these costs on to the consumer through rate increases. The administrative costs of approximately $309,554 will only impact on Blue Cross and Blue Shield. The Department has elected to cover the costs of rate-setting for specialized and rehabilitation hospitals in the same manner as such expenses are covered in residential alcohol treatment facilities, by establishing a charge per patient day based on administrative costs, divided by patient days, to a maximum of $5.00 per patient, per day. The setting of rates for reimbursement is a service which Blue Cross benefits from, since Blue Cross would have to hire staff to accomplish this task, were it not done by the Department. The Department has, therefore, elected to cover these costs via an assessment of the payors, Blue Cross and Medicaid.

The 1971 Health Care Facilities Planning Act authorizes the Commissioner of the Department of Health to establish reasonable reimbursement rates for hospital service corporations, for example, Blue Cross. This statutory provision allows for the development of the proposed fee structure.

Regulatory Flexibility Statement

Neither Blue Cross, nor the hospitals regulated by this chapter, are small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Medicaid is a governmental entity. Therefore, no regulatory flexibility analysis is required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

8:31A-1.5 Per diem charge

(a) A charge per patient day, based on the latest available data, from July 1, 1992 onward, shall be assessed each hospital for which the Department of Health establishes prospective per diem rates.

1. The per diem charge will be calculated by dividing the total Facilities Rate Setting program administrative expenses by the latest available Blue Cross and Medicaid inpatient days, to a maximum of $5.00.

i. The per diem charge, as calculated, will be added to the hospital's effective rate.

2. The provider will remit a check to the State Treasury covering the add-on amount in accordance with the process illustrated in Appendix D, incorporated herein by reference. The check may be monthly, quarterly, semi-annually or annually.

8:31A-7.4 Methodology for calculating Global Rates

(a) (No change.)

(b) An administrative add-on, calculated in accordance with N.J.A.C. 8:31A-1.5 will be added to the reimbursement rates.

8:31A-7.5 Methodology for Alternate Rates

(a)-(b) (No change.)

(c) An administrative add-on, calculated in accordance with N.J.A.C. 8:31A-1.5, will be added to the reimbursement rates.

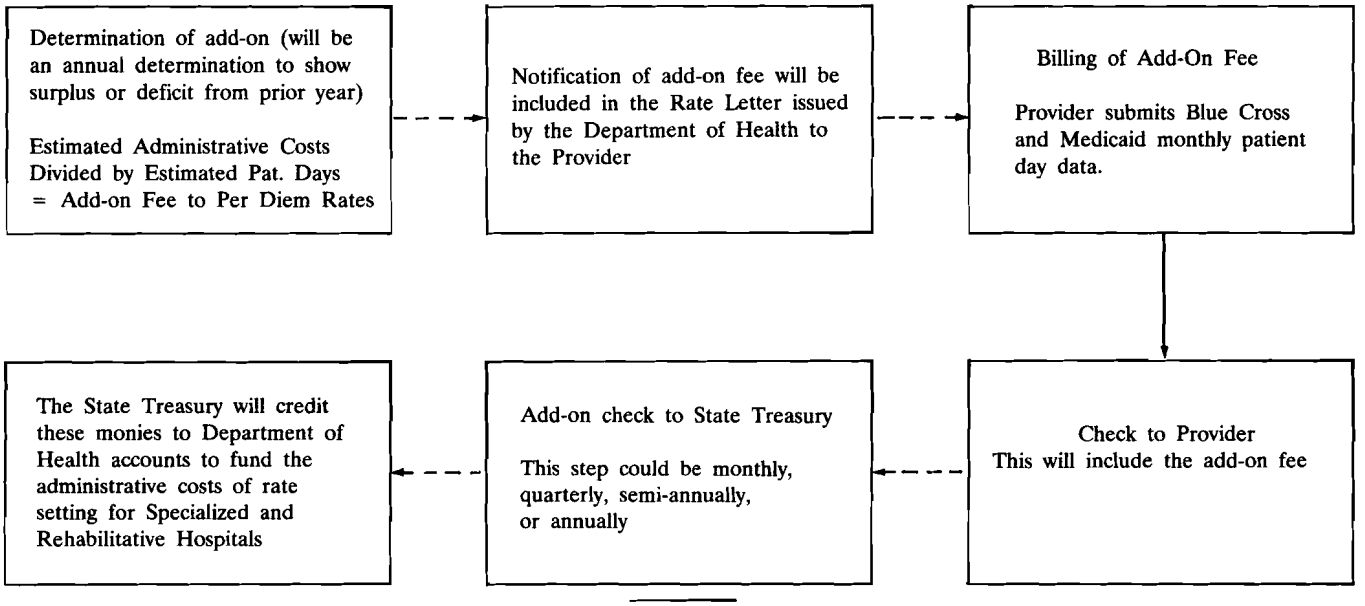
[(c)](**d**) (No change in text.)

Appendix D

FEE STRUCTURE

SHARE

ASSUME:	Administrative Costs	$309,554
	Patient Days	65,000
	Add-On Fee	$4.77



INSURANCE

(a)

DIVISION OF PROPERTY/LIABILITY
Eligible Person Qualifications
Proposed Amendment: N.J.A.C. 11:3-34.4

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.
Authority: N.J.S.A. 17:1C-6(e), 17:29D-1, 17:33B-13 and 17:33B-22.
Proposal Number: PRN 1992-360.

Submit comments by September 16, 1992 to:
Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625

The agency proposal follows:

Summary

The Fair Automobile Insurance Reform Act of 1990 (P.L. 1990, c.8) ("FAIR Act") provides that automobile insurance coverage shall be provided to all "eligible persons" as defined at N.J.S.A. 17:33B-13 (see N.J.S.A. 17:33B-15a). The Department of Insurance ("Department") adopted N.J.A.C. 11:3-34 in order to interpret and implement the statutory definition of "eligible person" set forth at N.J.S.A. 17:33B-13. This proposed amendment to N.J.A.C. 11:3-34(a)6 modifies the definition of "eligible person" which excludes therefrom those individuals who have had policies of automobile insurance cancelled for nonpayment of premium or financed premium within the immediately preceding two-year period, unless the premium due on a policy is paid in full. This amendment excludes only those persons whose cancellation of insurance results in a lapse in automobile coverage of at least 30 days.

The Department recognizes that in certain circumstances, as the result of mere mistake or inadvertence, individuals have had policies of automobile insurance cancelled for non-payment of premium. The Department has determined that in those instances where an individual has acted quickly to restore coverage, the individual should not be unduly penalized by being disqualified for coverage in the voluntary market for two years. Applicants which are deemed ineligible for automobile coverage in the voluntary market are qualified for and are, therefore, required to seek coverage in a residual market mechanism such as the personal automobile insurance plan ("PAIP") created pursuant to N.J.S.A. 17:29D-1. The purpose of this amendment is to clarify the rule with regard to the length of lapse of coverage and to ensure that individuals who have acted quickly to remedy their mistakes are not foreclosed from obtaining coverage in the voluntary market.

The Department has determined that any individual that has restored cancelled coverage within a 30-day time period should be considered eligible to obtain coverage in the voluntary market. Thirty days is a reasonable period because it corresponds with the time frame which many insurers have traditionally allowed as a "grace period" for payment of premium upon renewal.

Because this amendment will reduce the number of "not-eligible" persons, the implementation of this proposed amendment will also give reasonable effect to N.J.S.A. 17:33B-13 and 17:29D-1 by limiting the PAIP to those individuals whose driving record and previous insurance-related behavior warrants their disqualification from coverage in the voluntary market. This reduction in the number of "not-eligible" persons will prevent the incongruous result of placing individuals with bad driving records into the voluntary market, while continuing coverage in the PAIP for individuals whose coverage lapsed only briefly. Such a result certainly was not intended by the Legislature, and the Department believes that the proposed amendment is a reasonable interpretation of N.J.S.A. 17:33B-13.

A further amendment to this rule has also been incorporated into this proposal. The phrase beginning "... with a lapse ..." is intended to modify both "non-payment of premiums" as well as "financed premiums." A comma has, therefore, been deleted to avoid any misinterpretation of the first sentence of N.J.S.A. 11:34.4(a)6, consistent with the original intent of the rule.

Social Impact

This proposed amendment will have a positive social impact on consumers because fewer applicants wil be "not-eligible persons" and therefore able to obtain automobile insurance in the voluntary market. The Department believes that the intent of the Legislature will be served by considering applicants to be eligible where a brief lapse in coverage for non-payment of premium, resulting from either mistake or inadvertence, is cured within a thirty day period. The proposed amendment to the definition of eligible person will: (1) reduce the number of persons deemed ineligible; (2) promote an orderly mechanism for the issuance of automobile insurance to all drivers whose vehicles are registered or principally garaged in New Jersey; and (3) ensure that the PAIP is reserved for drivers with poor driving records and/or poor insurance histories.

Economic Impact

All insurers will be required to provide automobile insurance to eligible applicants despite a cancellation for non-payment of premium with a lapse in automobile insurance coverage of less than 30 days. Insurers will not suffer any undue economic burden as a result of this proposed rule since there is no data to indicate that the applicants to which this rule applies are higher risk drivers than others, and insurers are nevertheless required by law to insure all eligible persons.

The Department, however, may experience an attendant increase in costs which may result in the additional enforcement efforts necessary to ensure that this amendment is uniformly implemented by all insurers.

Regulatory Flexibility Analysis

The proposed amendment will affect all insurers authorized to transact personal private passenger automobile insurance in New Jersey. A few such insurers in New Jersey are "small businesses" as defined by the Regulatory Flexibility Act at N.J.S.A. 52:14B-17.

The proposed amendment has been reviewed by the Department with regard to the Regulatory Flexibility Act. This rule interprets the law which defines the term "eligible person." The definition establishes an individual's right to obtain coverage from the insurer of his or her choice. The definition is to be applied uniformly by all insurers regardless of whether or not they are deemed to be small businesses. Small businesses are, therefore, not disproportionately affected by this amendment. Any exception to an insurer's obligation to issue policies to eligible persons is governed primarily by N.J.S.A. 17:33B-19 and N.J.A.C. 11:3-40.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:3-34.4 Eligible person qualifications

(a) An "eligible person" is a person who is an owner or registrant of an automobile registered and principally garaged in this State or who is resident and holds a valid New Jersey driver's license to operate an automobile, but does not include any person:

1.-5. (No change.)

6. Whose automobile insurance policy has been cancelled for nonpayment of premiums [,] or financed premium with a lapse of coverage **of at least 30 days** within the immediately preceding two-year period, unless the premium due on a policy for which application has been made is paid in full before issuance or renewal of the policy. For the purpose of this section, "paid in full" shall not include any transaction in which a lender obtains authority from an insured to cancel the policy and receive a refund from the insurer in the event the insured defaults on a loan used to pay the premiums;

7.-8. (No change.)

(b)

DIVISION OF PROPERTY AND CASUALTY
Producer Assignment Program
Reproposed New Rules: N.J.A.C. 11:3-42

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.
Authority: N.J.S.A. 17:1C-6(e), 17:1-8.1 and 17:33B-9.
Proposal Number: PRN 1992-362.

Submit comments by September 16, 1992 to:

Verice M. Mason
Assistant Commissioner
Department of Insurance
Legislative and Regulatory Affairs
CN 325
Trenton, New Jersey 08625

The agency proposal follows:

Summary

N.J.S.A. 17:33B-9c requires that the Commissioner of Insurance (Commissioner) establish a producer assignment program to be available upon application to any licensed insurance producer who: (1) is a producer for the New Jersey Automobile Full Insurance Underwriting Association (Association); (2) has no affiliation with a voluntary market company for the purposes of placement of private passenger automobile insurance; (3) had an affiliation with an insurance company for the placement of automobile insurance in the voluntary market which was terminated by the insurer on or after December 31, 1980; (4) has demonstrated to the Commissioner his competency, efficiency and effectiveness in servicing Association other insurance business as determined by a review of the producer for complaints, violations of the licensing law and other factors deemed relevant by the Commissioner; and (5) is located and services insurance in a geographic area which the Commissioner has determined to lack sufficient representation for the placement of automobile insurance in the voluntary market.

On July 2, 1991, the Commissioner issued Order No. A91-281 which established a Producer Assignment Program (Program) in accordance with N.J.S.A. 17:33B-9c for the assignment of eligible Association producers. On August 5, 1991, the Department of Insurance (Department) proposed N.J.A.C. 11:3-42, which essentially codified the Program set forth in Order No. A91-281 (see 23 N.J.R. 2297(a)). As a result of public comments received on the proposed rules pursuant to N.J.S.A. 52:14B-4, and further review and evaluation of the existing Program set forth in Order No. A91-281 and the proposed rules, the Department has determined to make substantive changes to the Program regarding the criteria for determining eligibility for producer assignments, the criteria by which an insurer may demonstrate that its marketing system provides sufficient access to the market and thereby receive an exemption from mandatory producer assignments, and to make other nonsubstantive clarifying changes. On July 2, 1992, the Commissioner issued Amended Order A92-226 which revised the Producer Assignment Program as described above. The Department is reproposing these rules to codify the existing procedures and requirements set forth in the revised Program established by the Amended Order.

When these rules were previously proposed, the Department received 13 written comments from insurers, insurance trade organizations, and a producer organization, as follows:

1. Hannoch Weisman (on behalf of the Aetna Casualty and Surety Company);
2. State Farm Mutual Automobile Insurance Company;
3. Royal Insurance;
4. Farm Family Insurance Companies;
5. The Independent Insurance Agents of New Jersey, Inc.;
6. Allstate Insurance Company;
7. New Jersey Manufacturers Insurance Company;
8. LeBoeuf, Lamb, Leiby and MacRae (on behalf of United Services Automobile Association and USAA Casualty Insurance Company);
9. The American Insurance Association;
10. CNA Insurance Companies;
11. The Alliance of American Insurers;
12. The Prudential Property and Casualty Insurance Company of New Jersey; and
13. The Harleysville Insurance Companies.

COMMENT: Several commenters stated that the rules are arbitrary, unreasonable, capricious, and exceed the statutory authority granted the Commissioner pursuant to N.J.S.A. 17:33B-9c. The commenters generally object to the proposed rules as exceeding statutory authority in that they require insurers to contract with producers formerly representing the Association and the MTF, and further obligate insurers to assume those producers' Association/MTF books of business.

One commenter specifically stated that the Commissioner does not possess the authority to expand the scope of the statute to include voluntary market producers for companies no longer writing automobile insurance in this State.

Another commenter specifically stated that the Program established by these rules is illegal in that it would force companies to employ individuals without any choice in the selection of such individuals, or whether to employ such individuals. Another commenter specifically stated that there is no basis to conclude that the Legislature intended to create what amounts to an "employment agency" within the Department. The commenter does not believe that N.J.S.A. 17:33B-9c provides for mandatory assignment of producers and provides no basis for establishing a contractual relationship between producers and insurers. This commenter believes that the intent of the statute could be effectuated without resorting to "such drastic measures."

Finally, another commenter additionally stated that the statute only authorizes the Commissioner to establish a plan to encourage the broadening of authorities for those producers which are assigned under the plan, which has been accomplished through the producer voluntary placement plan.

RESPONSE: The Department disagrees. N.J.S.A. 17:33B-9c states: "The Commissioner shall, on or before October 1, 1991, establish a producer assignment program. The program shall be available upon application to any licensed insurance producer who [meets specific eligibility requirements]. The program shall provide for the assignment of qualified producers on an equitable basis to insurers writing private passenger automobile insurance in the voluntary market." Accordingly, the Legislature has mandated that the Commissioner establish a plan for the assignment of eligible Association producers. The statute does not provide, as the commenters suggest, that the Commissioner establish a plan for the "voluntary appointment" of eligible Association producers. The word "assign" means "to transfer to another or to appoint to a post or duty"; or "to fix or specify in correspondence or relationship" (Websters 9th New Collegiate Dictionary, 1983). In order to assign producers to insurers, therefore, requires that the insurer appoint the producer as its agent. It must also be noted that while the commenters stated that the intent of the Legislature may be effectuated without resorting "such drastic measures," they failed to suggest any alternative means by which producers may be assigned to insurers in accordance with N.J.S.A. 17:33B-9c.

The Department also disagrees that it is exceeding its statutory authority by requiring insurers to assume assigned producers' Association/MTF business. It is common practice and generally understood that producers own the expirations of their books of business. Implicit, therefore, in the requirement that the Commissioner establish a plan for the assignment of eligible Association producers, is that such producers retain their current book of business and have such business written by the insurer to whom the producer is assigned and appointed as agent. A producer assignment program would be meaningless if the producer was not provided a place to put his or her business. In addition, N.J.S.A. 17:29A-46b requires insurers to apply their underwriting rules uniformly and without exception, so that every applicant or insured conforming with its underwriting rules will be insured or renewed. If an insurer did not offer coverage to eligible persons that meet its approved underwriting rules included in the assigned producer's book of business, the insurer would be in violation of N.J.S.A. 17:29A-46b.

The Department similarly disagrees with the comment that the Commissioner lacks the statutory authority to include voluntary market producers for companies no longer writing automobile insurance. N.J.S.A. 17:33B-9c provides as one of the criteria for eligibility for assignment, that the producer "had an affiliation with an insurance company for the placement of automobile insurance in the voluntary market which was terminated by the insurer on or after December 31, 1990." If a producer is the representative of an insurer who has been permitted or ordered to cease writing automobile insurance, that producer has, in effect, been terminated since it no longer has an insurer with which it may place automobile coverage. The Department has, however, revised the eligibility criteria to provide that an appointed representative of an insurer exempted from insuring all eligible persons pursuant to N.J.S.A. 17:33B-15 shall be eligible for assignment.

Finally, the comment that the statute only allows the Commissioner to establish a plan to encourage the broadening of authorities for producers which are assigned under the plan, is misplaced. N.J.S.A. 17:33B-9b requires that the Commissioner initiate a plan to encourage the broadening of authorities held by those producers who have been active as Association producers. This is independent from the requirement that the Commissioner establish a producer assignment program under N.J.S.A. 17:33B-9c.

COMMENT: Several commenters stated that the rules are unconstitutional. The commenters stated that the rules and the statutory language on which they are based are unconstitutional because they deprive the insurer of its rights under the U.S. Constitution under the Fifth and Fourteenth Amendments, and Article 1 paragraph 1 of the New Jersey Constitution, in that they require insurers to hire persons randomly chosen by the State in the manner proposed by the rules. One commenter additionally stated that the rules violate the Thirteenth Amendment to the U.S. Constitution in that they require employees to "work for a master not of their own choosing." The commenters stated that they have the right to hire their own agents. This right rests on basic concepts of the law of agency and the strong interest the insurer has in the identity of its agents who are part and parcel of the public image that the insurer projects, and the good will that it engenders with the public. The Program established by these rules substantially intrudes on this right by assigning agents to insurers regardless of the need for additional agents and regardless of whether the agents meet the insurer's job qualifications.

One commenter specifically stated that the rule violates the U.S. Constitution in that it results in the impairment of contract since N.J.S.A. 17:33B-9c and the rules impair vested contract rights and eliminate mutually inherent opportunities to enter into contracts. Several commenters also stated that the Program established by these rules will result in a denial of equal protection in that they require that agents be randomly appointed. The commenters believe that this may result in situations where existing agents believe their contractual agreement with a company has suddenly been restrained. The commenters stated that this is particularly compelling in consideration of the plight of insurers that do not sell through agents. Imposing a contractual burden relating to a whole new class of employees who are independent contractors appears on its face to be an unconstitutional denial of equal protection as an intrusion into corporate affairs.

RESPONSE: With respect to the comments that the underlying statute is unconstitutional, the Department notes that statutes are presumed to be constitutional absent a decision by a court of competent jurisdiction to the contrary. There has been no determination that N.J.S.A. 17:33B-9c is unconstitutional. The statute is thus valid and mandates that the Department establish a producer assignment program as provided by these rules. Since the statute has not been held unconstitutional and requires that the Commissioner establish a plan for the *assignment* of eligible Association producers, the Department does not believe that these rules are unconstitutional in that they require insurers to appoint as agents eligible Association producers who are assigned to them.

The Department similarly does not believe that these proposed rules result in an unconstitutional denial of equal protection or the impairment of contracts. To the extent the assignment of producers impairs any contract, it is not an unconstitutional impairment since insurance is a highly regulated industry, and therefore the passage of legislation or regulations which may affect established relationships may be anticipated. The Department similarly disagrees that the Program established by these rules violates the Thirteenth Amendment's prohibition against involuntary servitude since producers are neither compelled to participate in the Program nor to enter into a contract with the insurer to which it is assigned. Finally, the Department does not believe that these rules impose an unconstitutional burden on direct writers. N.J.S.A. 17:33B-9c provides that the producer assignment program shall provide for the assignment of producers "to insurers writing private passenger automobile insurance in the voluntary market." The statute does not provide an exemption for insurers based solely on their marketing system. The goal of the producer assignment program is to provide access to automobile insurance in the voluntary market in underserved areas. The Department therefore believes that it would be inappropriate, and contrary to the intent of the Legislature, to exempt insurers based solely on marketing structure. It must be noted that an insurer may be exempted from producer assignments if it demonstrates that its marketing system, through producers or otherwise, provides sufficient access to the public in inadequately serviced territories; if compliance would place the insurer in an unsafe or unsound financial condition; if it has approved uniform membership requirements as a condition of providing automobile insurance; or if the insurer had less than 1,000 private passenger automobile exposures on December 31, 1983 and September 30, 1988.

COMMENT: Several commenters stated that coupling an insurer's depopulation obligations with the imposition of mandatory assignment obligations (in that the rules require an insurer which is assigned producers to make an offer of coverage to each Association/MTF insured who is serviced by the producer and is an eligible person) is impermissible, in violation of N.J.S.A. 17:33B-9, and inconsistent with the case *In The Matter of the Assignment of Exposures to the Aetna Casualty & Surety Company,* 248 *N.J. Super.* 367, 383 (App. Div. 1991). The commenters stated that the statute is intended to ensure that drivers in the voluntary market have sufficient access to agents within their territory. There is no relationship between this statute and depopulation. In addition, the Appellate Division in *Aetna* found that the statute governing depopulation, N.J.S.A. 17:30E-14, prohibited requiring voluntary market insurers to write depopulation business through the former producer of the business, or requiring insurers to compensate those producers. Finally, the commenters stated that there is no basis upon which the Commissioner has the authority to afford exemptions from producer assignments to those insurers who have met or exceeded their depopulation quota in that there is no statutory relationship between depopulation and producer assignments, and these rules may not alter or amend this legislation.

RESPONSE: The Department disagrees. In *Aetna,* the Appellate Division found that the Department could not assign *exposures* to insurers, as required by N.J.S.A. 17:30E-14i(3), by assigning producers to the insurers with the producers' books of business. N.J.S.A. 17:30E-14i(3), which provides that the depopulation procedures established by the Commissioner may "neither prohibit nor require companies to write Association business through Association producers of record...." The court did not find that the Commissioner may not assign producers, but specifically recognized that N.J.S.A. 17:33B-9c "is intended to create a post-October 1, 1991 assignment program for certain JUA/MTF producers who wish to participate...." The court further noted that "[t]he goal of the assignment program is to protect producers who have built business and developed insurance expertise writing JUA/MTF policies, and at the same time to encourage an auto sales and service presence in underserved urban areas." Thus, the establishment of a producer assignment program is not inconsistent with, and is expressly recognized by, the *Aetna* decision. It must also be noted that P.L.1991, c.462, enacted on January 18, 1992, amended N.J.S.A. 17:30E-14(3) and 17:33B-11c(5) to require that assigned exposures under a mandatory depopulation plan be serviced by the Association or MTF producer of record.

Further, the assignment of producers is not, as the commenters suggest, coupled with depopulation. The rules require the insurer to offer coverage to the eligible persons serviced by the assigned producer. As noted in a response to a previous comment, producers own their books of business. Implicit in the requirement that Association producers be assigned to insurers, is that they retain their current business and place that business with the insurer to whom the producer is assigned and appointed as agent. In addition, as previously noted, insurers must offer coverage to the insureds serviced by the assigned producer appointment as an agent, pursuant to N.J.S.A. 17:29A-46b.

Finally, the Department disagrees that it lacks the authority to exempt insurers from producer assignments. The Program is intended to address the dual goals of protecting producers who have built businesses and developed expertise serving the residual market and of encouraging the sale and servicing of private passenger automobile insurance in inadequately serviced territories. Accordingly, assignment of producers on an equitable basis should consider whether an insurer's own marketing system has, in practice, provided reasonable access to persons in all areas of the State. When an insurer demonstrates that it provides such access, the Department believes it appropriate and equitable to exempt that insurer from producer assignments. It must be noted that the Department has substantially revised the exemption provisions to permit any insurer to apply for an exemption. See N.J.A.C. 11:3-42.9.

COMMENT: Several commenters stated that the proposed rules inappropriately assign producers which qualify under the rules without regard for qualifications established by each individual insurer. The qualifications established by the insurer may be much more stringent than those established by these rules and, accordingly, the rules should permit insurers to require that insurers meet at a minimum the qualifications imposed by that insurer for all other agents.

RESPONSE: The Department disagrees. N.J.S.A. 17:33B-9c specifically provides the criteria for qualification to participate in the Producer Assignment Program. The producer qualifications set forth in these rules reflect the qualification requirements set forth in the statute. To add further requirements as the commenters suggest would impair the right to participate by producers who meet the statutory criteria.

The Department further notes that under N.J.A.C. 11:3-42.7, the Department will conduct a detailed review of any application by a

producer for assignment. This review will include a review of records relating to the producer's performance as an Association or MTF producer, complaints filed against the producer, disciplinary action taken by the Association or MTF with respect to the producer, and any records of bonafide complaints filed against the producer with the Department. In addition, under N.J.A.C. 11:3-42.8, an application for qualification under the Program will be disapproved for various grounds (for example, if the Department determines that the producer has failed to comply with insurance laws or regulations, or if the producer's affiliation with any voluntary market insurer has been terminated for reasons that adversely reflect on the producer's competency, efficiency or effectiveness in servicing business or that otherwise indicate that the producer should not be qualified for the Program). The Department believes that while the qualification standards in the rules may not be as stringent as those imposed by individual insurers in all cases, the detailed review procedures provided by the rules should ensure that only producers who are statutorily qualified are assigned to insurers.

COMMENT: Several commenters objected to N.J.A.C. 11:3-42.9(a), which provides that an insurer may request an exemption from assignments under the Program if it demonstrates that its marketing system provides sufficient access to the public in inadequately serviced territories. The commenters stated that sufficient access is defined as the insurer meeting or exceeding all depopulation quotas and the minimum market penetration levels in all but two inadequately serviced territories. The commenters believe that the criteria established by the rules is too rigid and may result in insurers who just miss qualifying for the exemption.

One commenter specifically stated that because the exemption provision is new, insurers whose marketing system provides good access to the public in inadequately serviced territories, but who just missed qualifying for the exemption, will not have had a chance to take steps necessary to qualify for the exemption from the October 1991 producer assignment list. The commenter stated that an insurer could be in a situation of missing an exemption by a very small number of risks in one small territory. The commenter additionally stated that since the exemption was first published in Order No. A91-281 (issued on July 2, 1991), and the information on the total market size for each territory was not available from the Department until July 22, an insurer will not have had sufficient opportunity to make adjustments in its marketing system and correct deficiencies so as to qualify for the exemption from the April 1992 producer assignment list. The commenter thus suggested that insurers whose marketing systems need only "fine tuning" to qualify for any exemption from producer assignments should be allowed some flexibility for the exemptions based on their April 1, 1991 and October 1, 1991 market shares by territory. The commenter also stated that N.J.A.C. 11:3-42.9(a)2ii, which provides the calculation for determining whether an insurer's market share in inadequately serviced territories is not significantly less than the State-wide average market share of the insurer, utilizes a 90 percent confidence interval of the normal distribution in that it utilizes a factor of 1.645. The commenter believes that the proper statistical distribution is the "T distribution," which is used where the standard deviation is unknown and must be computed from the data. The commenter stated that a 90 percent confidence interval using a T distribution with 26 degrees of freedom (the number of New Jersey territories minus one since the mean is also derived from the data) is 1.706.

In order to incorporate all of the changes discussed above, the commenter suggested that N.J.A.C. 11:3-42.9(a)2ii and iii be amended to read as follows:

ii. If the actual market share of an inadequately serviced territory is less than the State-wide average market share minus the product of the standard deviation and [1.645] **1.706,** the insurer does not provide sufficient access to the public in that territory.

iii. If the insurer's actual market share **in five or more inadequately serviced territories is below the level specified in (a)2ii above for the October 1991 producer assignment list, in four or more inadequately serviced territories is below the level specified in (a)2ii above for the April 1992 producer assignment list, or** in three or more inadequately serviced territories is below the level specified in (a)2ii above **for the October 1992 and April 1993 producer assignment list,** the insurer does not provide sufficient access to the public in inadequately serviced territories of the State and the request for an exemption shall be denied. (Language to be added is boldface; language to be deleted is bracketed.)

Another commenter specifically stated that the exemption provision in N.J.A.C. 11:3-42.9 will yield discriminatory results among insurance companies. For example, the commenter stated that assuming a normal distribution, if an insurer writes between nine and 11 percent of the market in each territory and averages 10 percent State-wide, the equation provided by the rules will disqualify that insurer from an exemption in five percent of the territories in which it writes even though it writes nine percent or more of the business in those territories. In contrast, an insurer that averages a 10 percent market share Statewide, but with territorial market shares ranging from zero to 20 percent (which will create a large standard deviation) will qualify for an exemption until it falls below nine percent in an inadequately serviced territory. The commenter believes that this outcome was not intended and believes that any formula designed around the standard deviation is flawed. The commenter suggested as an alternative to assess minimum amounts or develop a sliding scale of market share per territory that the Department believes meets public policy goals. For example, the commenter stated that if there are 50 insurers writing private passenger automobile insurance in New Jersey, the rules should provide an exemption to any insurer that has X percent or X percent of a sliding scale of the market in each inadequately serviced territory.

Another commenter specifically stated that the exemption provision assumes that all insurers service the public generally. However an insurer with uniform membership requirements of eligibility is only empowered to serve a defined public. For example, this commenter stated that it serves only those individuals that meet their membership criteria. In the case of such a "membership-type" insurer, therefore, sufficiency of access should be measured in relation to that insurer's defined market, rather than the total public market. The commenter believes that the proper tests to determine sufficiency of access for these types of insurers is whether they have provided sufficient access to their markets. Accordingly this commenter suggested that N.J.A.C. 11:3-42.9 be amended as follows:

An insurer that limits its insurance to persons in accordance with paragraph (e) of the definition of eligible person in N.J.S.A. 17:33B-13 shall be exempt from assignments under this Program if the insured demonstrates that its marketing system provides sufficient access to its insurance by all persons eligible for its insurance, including those persons in inadequately serviced territories. Sufficient access in inadequately serviced territories shall mean the following:

1. The insurer's marketing system, either through its own producers, direct marketing or otherwise, is shown to have provided a reasonable opportunity to obtain its insurance to those in adequately serviced territories and to those in inadequately serviced territories during the preceding three year period or such shorter period during which the insurer has been licensed; and

2. The insurer's share of the market eligible for its insurance pursuant to paragraph (e) of the definition of eligible person in N.J.S.A. 17:33B-13 in inadequately serviced territories is not shown to be significantly less than its State-wide share of its eligible market. An insurer's eligible market shall be determined, under this paragraph, by the best available information possessed by the insurer or another source regarding its eligible market.

Finally, one commenter specifically suggested that the Commissioner be given additional leeway in allowing exemptions from assignment requests and suggested that N.J.A.C. 11:3-42.9(a) be amended to provide that if the requirements of N.J.A.C. 11:3-42.9(a)1 and 2 are not met, the Commissioner may in his discretion consider such other evidence he deems relevant in deciding whether to grant the exemption request.

RESPONSE: Upon review of the comments, the Department agrees that the exemption criteria set forth in the rules may yield inappropriate results and be problematical to implement. Accordingly, as previously noted, the reproposed rules provide that an insurer may request an exemption from producer assignments by demonstrating that it provides sufficient access to the public in inadequately serviced territories. An insurer seeking this exemption must submit information in support of its request, as set forth in the rules, depending on whether the insurer utilizes producers or is a direct writer. If the request is denied, the insurer may request a reconsideration of the denial by the Commissioner.

The reproposed rules additionally provide that, upon application, an insurer that has approved uniform membership requirements as a condition of providing insurance, shall be exempt from producer assignments, provided that the insurer is not prohibited from using such membership requirements pursuant to N.J.S.A. 17:33B-26, and provided that if the insurer is part of a group, and there are other insurers in the group authorized to transact private passenger automobile insurance

that do not have approved membership requirements, producer assignments shall be made to the group as a whole.

Finally, the reproposed rules are revised to additionally provide a "de minimis exemption" to insurers which had less than 1,000 exposures on December 31, 1983 and September 30, 1988.

The Department believes that the revised exemption procedures are reasonable, appropriate and will provide insurers with the opportunity to "explain" their systems in place to provide access in inadequately serviced territories, while avoiding the rigidity of the purely statistical test contained in the original proposal. The Department further believes that the revised procedures should address the commenters' concerns that the prior statistical test does not allow for "fine tuning" of the insurer's marketing structure, may yield discriminatory results among insurers, and does not effectively address insurers with uniform, approved membership requirements.

COMMENT: Several commenters objected to the random assignment of producers, as provided by the rules, as arbitrary, capricious and unreasonable. The commenters stated that pursuant to the rules, two companies of equal size will be assigned an equal number of agents, even if one company makes no effort to meet its depopulation quota and another meets them but barely misses the minimum market penetration levels in specific territories required for an exemption.

One commenter specifically stated that there is no difference in assignments between a company which has terminated many agents who are now eligible for assignment under the producer assignment program and a company which has terminated no agents. Several commenters additionally stated that an insurer which has met its depopulation quota but misses the statistical test for an exemption, could be assigned a producer with a large volume of business in territories where the insurer is currently writing a large volume of business. The commenter suggested that producers be assigned on a more equitable basis in accordance with a distribution of business written by the producer and in territories where the companies have shown that they are inadequately represented.

RESPONSE: Upon review of the comments, the Department has determined that no change is required. The Department believes that it would not be feasible to review every insurer's book of business, efforts to meet depopulation quotas, history of agency terminations, and the books of business and mix of business of all qualified producers, and attempt to "match" appropriate producers and insurers prior to the assignment of producers to insurers. Even if such a process were feasible, it would undoubtedly take an inordinate amount of time to match up producers and insurers resulting in extensive delay in the implementation of the Producer Assignment Program.

Further, there is a correlation between the number of agents terminated by an insurer and its apportionment share of producers. Since an insurer's apportionment share of producers is the same as its apportionment share of exposures for mandatory depopulation, if an insurer terminated many agents and transferred that business to the Association or MTF, that insurer's depopulation quota would be greater than an insurer that terminated few agents.

The Department has, however, recognized that a rigid statistical test is inappropriate and has extensively revised the exemption procedures (see response to previous comment). Further, the Department recognized that an undue burden may result from the assignment of a producer with an inordinately large book of business in relation to an insurer's current book of business. Accordingly, the rules in N.J.A.C. 11:3-42.11(a)1 and 2 provide that no insurer whose total automobile exposures is greater than 1,000 will be assigned a producer whose book of business of eligible persons is greater than 25 percent of the total automobile exposures of that insurer; and no insurer whose total automobile exposures is less than 1,000 will be assigned a producer whose book of business of eligible persons is greater than 15 percent of the total automobile exposures of that insurer. An insurer may also request an exemption if compliance would place it in an unsafe or unsound financial condition.

Finally, the Department notes that insurers which voluntarily appoint producers will receive credits against their apportionment share of mandatory producer assignments. Accordingly, an insurer who "just misses" receiving an exemption under the criteria established by the rules may nevertheless appoint sufficient producers on a voluntary basis under the Producer Voluntary Placement Plan to satisfy its mandatory producer assignment obligations.

COMMENT: One commenter stated that these rules lack sufficient standards or guidelines for the determination of inadequately serviced territories by the Commissioner.

RESPONSE: The Department disagrees. The Department believes that standards and guidelines for the determination of inadequately serviced territories are sufficiently detailed in N.J.A.C. 11:3-42.5. It must also be noted that the commenter does not specify how the rules "lack specificity in the determination of inadequately serviced territories."

COMMENT: One commenter objected to basing the apportionment of producers upon each insurer's apportionment share as determined for purposes of depopulation, subject to any credits or exemptions provided other insurers. The commenter stated that this does not provide a suitable mechanism for planning purposes in that an insurer's assignment share is dependent upon exemptions granted to others.

RESPONSE: Upon review of the comment, the Department has determined not to change the provision. The Department believes that it is desirable for insurers to voluntarily enter into agreements with Association producers for the purpose of writing private passenger automobile insurance. In order to encourage and facilitate the establishment of such voluntary agreements, the Department believes that it is appropriate to provide procedures by which insurers may voluntarily appoint Association producers and receive credit toward producer assignments. All insurers are afforded the same opportunity to appoint sufficient Association producers voluntarily to satisfy mandatory assignment apportionment obligations. Obviously, qualified producers otherwise eligible for assignment must be redistributed among all remaining insurers subject to assignment. Such remaining producers, however, will be redistributed among the remaining insurers in the proportion that each of the remaining insurer's producer assignments bears to the total number of such assignments. The Department believes that such procedures are both reasonable, appropriate and equitable. Futhermore, uncertainty may exist as the number of producers eligible for assignment may vary for each assignment period. If a sufficient number of eligible producers are voluntarily appointed, the overall number of eligible producers to be assigned (and an insurer's corresponding apportionment share) may be reduced. It must also be noted that while the commenter stated that the procedures and the rules do not provide a suitable mechanism for planning purposes, it failed to suggest any alternative procedure.

COMMENT: One commenter noted that insurers are to receive one credit toward producer assignments for every five Category B producers located in inadequately serviced geographic areas. The commenter believes that this is burdensome and questions why the threshold is so high.

RESPONSE: The Department initially notes that N.J.A.C. 11:3-42.10(e) provides that for the initial implementation of the Program, an insurer receives one credit toward a producer assignment for every *four* Category B producers voluntarily appointed which are located in inadequately serviced geographic areas. The Department believes that this threshold is appropriate so as to ensure the Commissioner's ability to provide assignments for all or substantially all producers on each list of qualified producers. It must be noted that a "Category B" producer is a producer who is not otherwise eligible for assignment under N.J.S.A. 17:33B-9c. Accordingly, providing a "one-for-one" credit for the voluntary appointment of Category B producers could result in all insurers subject to assignment receiving sufficient credits so as to exempt them from any mandatory assignments, effectively precluding the assignment of qualified producers as intended by the Legislature. Nevertheless, as noted in a response to a previous comment, the Department believes that it is reasonable and appropriate to encourage voluntary relationships between insurers and producers for the purpose of placing private passenger automobile insurance, and accordingly has determined that it is appropriate to provide credits to insurers which voluntarily appoint producers who would not otherwise be eligible for assignment. It must also be noted that N.J.A.C. 11:3-42.10(e) specifies that the credit allowance shall be reviewed and adjusted on a periodic basis.

COMMENT: Several commenters objected to N.J.A.C. 11:3-42.12, which requires that where the insurer assigned a producer is a member of a group which utilizes different member insurers for the purpose of writing standard and non-standard risks, the producer must be appointed as an agent for all such insurers, and questioned the authority and necessity for this requirement.

One commenter specifically stated that it has established a wholly-owned subsidiary which will have both a standard and a nonstandard plan. The commenter itself will continue to write private passenger automobile insurance at standard rates only. The commenter therefore questioned whether the rule will compel the appointment of producers to the commenter (which will write only standard risks) as well as its wholly-owned subsidiary (which will write standard and non-standard risks).

RESPONSE: As was stated in a response to a previous comment, a Producer Assignment Program would be meaningless if the producer who is assigned to the insurer was not able to have all eligible persons in its book of business written by the insurer to which it is assigned and appointed as its representative. If a producer is assigned to an insurer which only writes standard risks or non-standard risks, the producer would not have an affiliation with an insurer to place all eligible persons within its book of business.

With respect to the comment involving the insurer that writes only standard risks and establishes a wholly-owned subsidiary which will have both a standard and non-standard plan, if one member of the group writes both standard and non-standard risks, appointing the producer as agent for the insurer that writes both standard and non-standard risks satisfies the requirements of N.J.A.C. 11:3-42.12, and such producer would not be required to be appointed as an agent to the member of the group that writes only standard risks. The rules as reproposed reflect this clarification.

COMMENT: Several commenters objected to N.J.A.C. 11:3-42.17, which provides the duration of producer appointments and the grounds upon which an insurer may terminate an assigned producer.

One commenter stated that the prohibition against terminating any appointed producer for two years, except in limited circumstances, is arbitrary, capricious, and not authorized by N.J.S.A. 17:33B-9. The commenter stated that this requirement should be eliminated. The commenter also suggested that this provision be amended to provide "failure to follow underwriting guidelines" as a reason for an acceptable termination within the two year period. The commenter stated that assigned producers should not receive more favorable treatment regarding termination than voluntary market producers and terminations should be made in accordance with New Jersey's agency termination statutes. This is especially true in light of the goal of this Program to treat assigned producers as if they are voluntary market producers. Several commenters additionally suggested that "fraud" be added as a reason for acceptable termination.

Finally, one commenter stated that insurers should be permitted to apply their own standards for termination, so long as such standards are applied equally to other representatives of the insurer. This commenter believes that the termination provisions in the rules make it difficult for insurers to take action against agents who fail to comply with the company's requirements or who fail to provide minimum levels of customer service.

RESPONSE: As a general matter, the Department does not regulate agreements between insurers and producers. However, to the extent insurers have "termination at will" provisions in their agency contracts, the Department believes that insurers could utilize such a provision to terminate assigned producers immediately. This, in turn, would render the Program meaningless. In order to provide stability for a reasonable time and to achieve its goal of providing access to the voluntary market, the Department has placed a limitation on the termination of assigned producers for a period of two years. The Department believes that this time frame is reasonable to permit the Program sufficient time to function.

The Department recognizes, however, that there may be circumstances under which an insurer should be permitted to terminate the assigned producer prior to the expiration of the two-year period. These grounds are consistent with those set forth in N.J.S.A. 17:22-6.14a(e), which provides that if the agency termination is based on the producer's insolvency, abandonment, gross and willful misconduct, failure to pay monies due the insurer, or license revocation, the insurer is not required to continue to service the policy through the terminated agent and continue to pay commissions to the terminated agent. The Department believes that these procedures are reasonable and implement the intent of the Legislature as set forth in N.J.S.A. 17:33B-9c. The producer's failure to follow underwriting guidelines, under specified circumstances, is also a ground upon which an insurer may cease servicing business through a terminated agent. The rules as reproposed are revised to provide that a termination "for cause" includes the producer's violation of written underwriting guidelines of the insurer under the criteria set forth in N.J.S.A. 17:22-6.14a(1).

The Department, however, believes that it is unnecessary to include "fraud" as an additional ground for acceptable termination within the two-year period. One of the acceptable grounds is "gross and willful misconduct." The Department believes that "fraud" would be encompassed within this provision.

COMMENT: One commenter objected to the requirement in N.J.A.C. 11:3-42.18(b) that insurers provide notice of any refusal of assignment to the effected producer as unnecessary.

RESPONSE: The Department believes that the possibility of misunderstanding between the parties with respect to refusal of appointment may be considerable. Since the refusal of assignment by the producer precludes any further participation in the Program, the Department believes that it is appropriate and necessary to attempt to minimize any possible misconception on the part of the producer with respect to the refusal of an appointment. The Department, therefore, believes it appropriate that the insurer provide notice of any refusal to the affected producer. The Department believes that no undue burden is imposed on insurers since insurers must submit notice of the refusal of an appointment to the Department. This requirement merely mandates that the insurer provide a copy of this notice (which is only one page) to the producer.

COMMENT: Several commenters stated that the penalties provision, N.J.A.C. 11:3-42.20, which applies to insurers who violate the rules, should apply to producers as well.

RESPONSE: N.J.A.C. 11:3-42.20 states: "Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law." The penalties provision is thus not limited only to insurers but to any person to which the rules apply (that is, insurers licensed to transact private passenger automobile insurance in this State and qualified producers who seek to be assigned to insurers pursuant to the procedures set forth in the rules). Accordingly, N.J.A.C. 11:3-42.20 applies to producers as well as insurers.

COMMENT: Several commenters objected to the application of these rules to insurers with uniform membership requirements of eligibility (for example, membership in the New Jersey Farm Bureau).

One commenter specifically objected to N.J.A.C. 11:3-42.13, which requires that an insurer assigned producers to make an offer of coverage to each Association/MTF insured serviced by the producer determined by the insured to qualify as an eligible person. The commenter stated that because it has a uniform requirement of eligibility for insurance, it is unlikely that the assigned producer's insureds would be "an eligible person." The commenter also stated that it would be burdensome for the assigned producer to explain membership requirements to each client in order to keep their business. Accordingly, the commenter suggested that N.J.A.C. 11:3-42.9, which provides exemptions from producer assignments, be amended to read as follows: "An insurer may request an exemption from assignments under this Program if the insurer demonstrates to the satisfaction of the Commissioner that its membership eligibility requirements would cause undue hardship to the assigned producer and assigned consumer."

Another commenter specifically stated that since the rules exclude a producer from further participation in the Program if he or she refuses an assignment, an assignment to insurers that require membership would create an unavoidable dilemma for the producer. The producer would be required to accept the assignment or be foreclosed from further participation in the Program. In either case, the rules effectively deny the producer access to a market in which he or she could place business. In order to address this problem, the commenter suggested that the rules be amended to permit the producer to decline an assignment in the event that the producer is assigned to a "membership-type" insurer, and specifically suggested that N.J.A.C. 11:3-42.12 be amended to include a new subsection (c) as follows:

1. A producer assigned to an insurer that limits its insurance is provided by paragraph e. of the definition of eligible person in N.J.S.A. 17:33B-13 may, notwithstanding the provisions of N.J.A.C. 11:3-42.18(a), decline such assignment and shall be reassigned, without penalty, to an insurer which does not so limit its insurance. Any such producer may decline such assignment by notifying the ARM Unit in writing.

2. An insurer that limits its insurance as provided in paragraph 1 hereof shall notify any assigned producer of the limitations on the availability of its insurance within 15 days following its receipt of notice of assignment.

The commenter additionally suggested that N.J.A.C. 11:3-42.18(a) be amended as follows: **Except as provided by N.J.A.C. 11:3-42.12(c)**, any producer who refuses an assignment under this Program that provides for his or her appointment as the assigned insurer's agent on fair and equitable terms, or who is terminated within the two year period set forth in N.J.A.C. 11:3-42.17(a), shall be excluded from further participation in this Program. (Language in boldface is to be added.)

RESPONSE: Upon review of the comments, the Department agrees that it may be inequitable to require that producers be assigned to insurers with approved uniform membership requirements for the provision of automobile insurance in this State. Accordingly, as noted in a response to a previous comment, the reproposed rules provide that an insurer that has approved uniform membership requirements, and is not prohibited from using such membership requirements pursuant to N.J.S.A. 17:33B-26, shall be exempt from producer assignments upon application. Provided, however, that if the insurer is a member of a group and other insurers in the group authorized to transact automobile insurance do not have approved membership requirements, producer assignments shall be made to the group. The Department believes that where the insurer is a member of a group and other members in the group do not have membership requirements, no specific exemption is necessary since the assignment may be made to a group as a whole, which, in turn, will assign the producer to the insurer with no approved membership requirements.

The Department does not believe it appropriate or equitable to permit producers to decline appointment to "membership-type" insurers, as some commenters suggest, because all producers would undoubtedly decline such an appointment, thereby effectively exempting all insurers with uniform requirements regardless of whether the insurer is prohibited from using such requirements or is a member of a group where other members have no such requirements. The Department believes, however, that the procedures in the reproposed rules will eliminate any potential burdens imposed on producers in that an insurer with membership requirements will be either exempt from assignment; not be permitted to utilize its membership criteria under N.J.S.A. 17:33B-26; or, as a member of group, will not be assigned the producer.

COMMENT: One commenter objected to N.J.A.C. 11:3-42.4(a)5, which establishes as one of the eligibility criteria for producer assignment that the producer "has derived not less than $7,500 in commission income from Association/MTF policies combined in calendar year 1990." The commenter stated that producers in lower rated territories will have more difficulty in reaching the commission requirement than those in higher rated territories (for example, Newark or Jersey City). Accordingly, the commenter suggested that N.J.A.C. 11:3-42.4(a)5 be amended to state "or serviced not less than 150 policies during the same calendar year."

RESPONSE: The goal of the Program is to provide for the assignment of producers of which Association/MTF business represents a significant portion of their revenue. If a producer has received less than $7,500 in commission income from Association/MTF policies combined for calendar year 1990, the Department believes that commissions of Association/MTF did not represent a significant portion of their income.

COMMENT: One commenter suggested that the implementation date of the Program be delayed to allow sufficient time for the Producer Voluntary Placement Plan (Order No. A91-280 and N.J.A.C. 11:3-41) to function and possibly lessen or eliminate the need for mandatory assignment of producers.

RESPONSE: Insurers have had an opportunity to appoint producers under the Producer Voluntary Placement Plan for over one year. However, as indicated in Order No. A92-226 (amending Order No. A92-281), while some insurers established voluntary agreements under the Producer Voluntary Placement Plan, the industry as a whole has failed to appoint sufficient numbers of eligible producers, leaving over 200 producers eligible for assignment.

COMMENT: One commenter stated that the Program set forth in these rules represents bad public policy. The commenter believes that govenment should not protect a select group of displaced workers by forcing other employers to hire them. While this State may wish to establish a special program for displaced producers, the commenter believes this State may not force private employers to hire such producers.

RESPONSE: As stated in a response to a previous comment, the Legislature requires that the Commissioner establish a plan for the assignment of qualified Association producers. The Department is required to implement this Legislative mandate.

COMMENT: One commenter objected to N.J.A.C. 11:3-42.5(b)2, which provides that a rating territory shall be determined to be inadequately serviced, even if it is not inadequately serviced under the criteria established in the rules, if the volume of exposures insured in the voluntary market was achieved through the mandatory assignment of exposures pursuant to any mandatory depopulation plan. The commenter believes that business assigned to companies through mandatory depopulation should be considered as voluntary since the business is no longer in the Association or MTF, but is being serviced by the voluntary market. The commenter further stated that business transferred to insurers under this Program should be considered in determining whether insurers have satisfied their quotas for mandatory depopulation purposes.

RESPONSE: As was stated in a response to a previous comment, the goal of the Producer Assignment Program is to provide sufficient access to the public in the voluntary market. Since exposures written due to any mandatory depopulation plan were not voluntary, the volume of these exposures is not indicative of whether sufficient access by the insurer is being provided in those territories. Accordingly, the Department believes that it is appropriate to provide that the territory will be considered inadequately serviced if the volume of exposures insured in the voluntary market was achieved through the mandatory assignment of exposures.

The Department similarly disagrees that insurers should receive "up-front" credits for exposures transferred to insurers under this Program. The Department does not believe it is appropriate to grant credits for depopulation purposes for business which is transferred to the insurer by virtue of the assignment of a producer as this business will not actually be in force until each policy comes up for renewal.

COMMENT: One commenter objected generally to these rules in that they would require it to adopt a scheme of marketing alien to their traditional operations since the commenter is a direct writer utilizing paid company employees. The commenter stated that the purpose of these rules is to alleviate the potentially disruptive impact on New Jersey policyholders caused by the termination of Association producers. The commenter stated that direct writers neither caused nor contributed to this problem and questioned the fairness of compelling direct writers to participate in this program.

RESPONSE: The Department disagrees. As previously noted, N.J.S.A. 17:33B-9c requires that the Commissioner establish a plan for the assignment of producers to "insurers writing private passenger automobile insurance in the voluntary market." The statute does not provide any exemption for insurers which are direct writers as opposed to those which employ agents. The Department, therefore, may not provide an additional exemption to these types of insurers employing a direct marketing system. Further, an insurer may request an exemption from producer assignments if, for example, it demonstrates that its marketing system provides sufficient access to the public in inadequately serviced territories, or if assignment would result in it being placed in a hazardous financial condition. The Department believes that this should reduce any undue burden imposed on insurers which are direct writers.

COMMENT: Several commenters expressed concern with respect to N.J.A.C. 11:3-42.14(c) which provides that, for companies which are direct writers, expenses for a direct marketing department and related support staff must be considered in determining the commission to be paid to assigned producers. One commenter stated that this language is rendered meaningless by N.J.A.C. 11:3-42.14(c)1, which requires that commissions be equivalent to the compensation paid to independent agents by insurers that utilize such agents. The commenter questioned how a company which is a direct writer may pay a commission "equivalent to the compensation paid to independent agents by insurers that utilize such agents" when no such allowance for these additional costs are presently contained in its rate structure. One commenter estimates that no more than one-half to two-thirds of its current acquisition expense would be available for the payment of commissions, which it believes would be considerably lower than the level of commission paid to independent agents. The commenter, therefore, suggested that the rules allow the producer to impose a service charge on the policy (to be paid directly to the producer by the consumer and not included in the premium) when he places the coverage in an amount not to exceed the present commission level in the MTF. The commenter alternatively suggested that the Department abandon the proposed compensation scheme and promulgate uniform rates, rules and commission levels for those insureds in the MTF whose producers qualify for the Program. The commenter believes that the latter alternative should cure inequities created by the Program in that the policyholder's premium and the producer's commission will vary significantly as a result of the arbitrary placement of the producer with a particular insurer.

Another commenter stated that, in the industry, the rate paid to independent agents is usually the highest. Accordingly, the commenter contended that it is inequitable and not supported by any rational basis to require a direct writer to pay the highest commission rate in the industry. This requirement is inconsistent with the producer licensing law that provides for freedom of contract, and is contrary to the general requirement that the Program be equitable.

RESPONSE: Upon review of the comments, the Department has determined not to change this provision. As noted in a response to a previous comment, N.J.S.A. 17:33B-9c requires that the Commissioner establish a Producer Assignment Program to provide for the assignment of qualified producers to insurers writing private passenger automobile insurance in the voluntary market. The statute does not provide any exception for insurers which are direct writers. One goal of this statute is to provide access to former Association/MTF producers through normal market channels. The Department therefore believes it would be inappropriate and thwart the intent of the Legislature to exempt insurers which are direct writers.

In providing for the assignment of producers, the Department believes that insurers and producers should enter into agreements on fair and equitable terms. The Department does not designate what terms are fair and equitable. The Department believes however that parameters must be provided to ensure that both producers and insurers are treated equitably. Accordingly, the Program provides that in the case of companies that are direct writers, compensation to the producer shall be comparable to the compensation paid to independent agents by insurers that utilize such agents. This is not a definitive number as compensation paid to independent agents varies. The Department does not dictate the actual compensation level to be paid but merely has provided the parameters for such compensation. N.J.A.C. 11:3-42.15(c), as reproposed, provides that compensation shall be "comparable" rather than "equivalent" to clarify the intent of the provision. However, the Program also provides that for business transferred from the MTF, an insurer authorized to use MTF rates, rules and form shall compensate the producer for such business at the same commisson level as that paid by the MTF. Accordingly, for business transferred out of the MTF, the Program provides for uniform rates, rules and commission levels. With respect to the commission level paid to producers on any new business written through that producer, the Department believes that these amounts should be insignificant in relation to the insurer's current market share as any new business written through the assigned producer would essentially represent normal growth in the market.

COMMENT: One commenter stated that the phrase "fair and equitable terms" as used in N.J.A.C. 11:3-42.18 is too vague to be effective and may result in unnecessary disputes. The commenter suggested that a more objective standard be established.

RESPONSE: As was stated in a response to a previous comment, the rules are not intended to dictate each and every term related to producer assignment, but merely provide certain limitations and parameters regarding termination and compensation deemed necessary and reasonable by the Department to implement the intent of the Legislature. The terms of agency agreements vary and the Department has attempted to provide the maximum flexibility to both insurers and producers with the limitations discussed above. Accordingly, the meanings of fair and equitable will vary and have no definitive meaning. It must also be noted that while the commenter suggested that "that a more objective standard be established," it failed to suggest any such standard.

COMMENT: Several commenters stated that N.J.A.C. 11:3-42.14, Producer compensation; company rates, should be codified as N.J.A.C. 11:3-42.15.

RESPONSE: The Department agrees. The reproposed new rules reflect this change.

COMMENT: One commenter stated that N.J.A.C. 11:3-42.13 does not specify the credit that an insurer will receive against its depopulation quota as a result of assuming the assigned producer's book of business. The commenter stated that the rules should provide such credits and that such credits should have general application to all insurers subject to producer assignments. The commenter further stated that credit amounts should be promulgated by rulemaking.

RESPONSE: As was stated in a response to a previous comment, the Department has determined that an insurer should not receive up-front credit for business assumed from a producer assigned pursuant to these rules since such business will not be in-force until each policy comes up for renewal. The insurer will receive credit for business assumed when the business is actually in-force.

COMMENT: One commenter stated that by providing producer credits under the Program for "ineligible producers" with whom an insurer voluntarily establishes a relationship, the Department is effectively circumventing the precise definition of producers eligible for assignment under the Program. An insurer may appoint a producer that would not otherwise qualify for assignment under the Program and nevertheless receive credit. The commenter believes that through this process the Department is undermining the purported equity of the Program.

RESPONSE: The Department disagrees. N.J.S.A. 17:33B-9b requires that the Commissioner initiate a plan to encourage the broadening of authorities held by brokers who have been active as Association producers in order to avoid disruption of established relationships between these Association producers and insureds. This requirement is in addition to the requirement that the Commissioner establish a producer assignment program. In order to implement the intent of the Legislature as expressed in N.J.S.A. 17:33B-9b, and to avoid disruptions associated with the termination of Association producers which are not eligible for assignment pursuant to N.J.S.A. 17:33B-9c, the Department developed the Producer Voluntary Placement Plan (Order A91-280, as codified in proposed N.J.A.C. 11:3-41). As noted previously, it is necessary and desirable to encourage insurers to voluntarily enter into agreements with Association producers for the purpose of writing private passenger automobile insurance as well as such other lines of insurance as may be mutually agreed upon by the insurer and producer. In order to facilitate the establishment of such voluntary agreements, the Producer Voluntary Placement Plan provides that insurers which voluntarily appoint Association producers may receive credit toward producer assignments made under these rules, as well as credit for business assumed toward their depopulation quota under N.J.S.A. 17:33B-11c(5). As previously noted, however, the credit received for producers which are not eligible for assignment under the Program is not a "one-for-one" credit, but is calculated to ensure the Commissioner's ability to provide assignments for all or substantially all qualified producers. The Department believes that this procedure is appropriate, equitable, furthers the Legislative intent as expressed in N.J.S.A. 17:33B-9b, and does not undermine the equity of the Producer Assignment Program.

COMMENT: Several commenters stated that these rules are inconsistent and contrary to the intent of the FAIR Act in that the FAIR Act turns on the equitable apportionment of policyholders or business, not agents. Under these rules, which are based on agents and not on the volume of business, one carrier could be required to accept agents that generate a volume of business far in excess of its depopulation quota while another carrier could be required to accept many agents and obtain very little business. As a result, the commenter believes that the rules are arbitrary, capricious, and inconsistent and contrary to the intent of the FAIR Act.

RESPONSE: The Department disagrees. N.J.S.A. 17:33B-9c specifically requires that the Commissioner establish a program for the assignment of qualified producers to insurers writing private passenger automobile insurance in the voluntary market. Accordingly, the Program established by these rules is not inconsistent nor contrary to the intent of the FAIR Act, but is specifically mandated. Further, N.J.A.C. 11:3-42.11(a) provides that no insurer whose total automobile in-force exposures at the end of the last quota period is greater than 1,000 will be assigned a producer whose book of business is greater than 25 percent of the total exposures of that insurer, nor will an insurer whose total automobile in-force exposures is less than 1,000 be assigned a producer whose book of business is greater than 15 percent of the total automobile exposures of that insurer. The Department believes that this should alleviate any undue burden that may result through the assignment of a producer with an inordinately large book of business in relation to the insurer to which the producer is assigned. It must also be noted that insurers may seek to avoid mandatory producer assignments by voluntarily appointing eligible Association producers who generate a volume of business that the insurer believes is the most appropriate given its market size. Finally, insurers that are providing sufficient access to the voluntary market and de minimis companies may seek an exemption from producer assignments under this Program. The Department believes that these "safety-valves" should reduce any undue burden on insurers which are assigned producers.

COMMENT: Several commenters objected to the requirement that insurers compensate assigned agents for Association/MTF business at the same commission rate and terms as the company's current schedule of commissions or other formula used to provide compensation to its agents.

One commenter further objected to any requirement that insurers provide assigned agents with support services and other benefits equal to those provided to voluntary market agents. The commenter stated that it is inequitable to require companies to incur various levels of commission expense. The commenter also stated that insurers with a higher commission schedule would be disadvantaged as opposed to direct writers who would be required to pay a minimum rate.

Another commenter specifically stated that this requirement exceeds statutory authority since N.J.S.A. 17:33B-9c merely requires that the Program provide for assignment of producers on "an equitable basis." The commenter believes that the Program should provide flexibility for an insurer to enter into special arrangements with agents assigned under the Program. In the special arrangement, the commenter stated that fees, commissions, and business relationships should be separately designed from the arrangements used with that insurer's existing agents. The commenter stated that the existing contracts were developed for use in a business relationship where the insurer voluntarily competed for sales staff. By their very nature, arrangements with its agents contain provisions which would be substantially different from those that should be made available to meet the minimum needs of an agent being assigned to an insurer.

RESPONSE: N.J.S.A. 17:33B-9c requires that the Commissioner establish a plan for the assignment of producers "on an equitable basis" to insurers. The Department interprets this provision to mean that the assignment of the producers (that is, the number or amount of producers assigned to an individual insurer) be equitable. The Department does not believe the statute was intended to create a "second class of producers." The goal of the statute is to provide for the appointment of eligible Association producers as agents in the voluntary market. Accordingly, the rules require that the terms of any appointment or agency contract between the eligible Association producer and the insurer be consistent with those terms utilized with its current agents. It must also be noted that insurers with commission schedules are not disadvantaged in relation to direct writers as direct writers are required to pay a commission comparable to compensation paid to independent agents pursuant to N.J.A.C. 11:3-42.15(c).

COMMENT: One commenter stated that N.J.A.C. 11:3-42.11, which requires a random assignment of producers to insurers, be revised to provide that a producer's book of business may be analyzed before it is assigned. The commenter stated that producers in underserved markets will have books of business that reflect different risk profiles. These risk profiles should be reflected in the producer assignment that is made since the producer's book of business may be skewed to new drivers, accident-prone drivers, teenage drivers, drivers in high theft neighborhoods, etc. The commenter stated that this business risk translates into extra expense cost and claim cost for insurers, and that this financial impact must be recognized in the assignment process.

RESPONSE: Upon review of the commenter's suggestion, the Department has determined not to change this provision. The financial impacts due to the different risk characteristics of the producer's book of business transferred to the insurer should be addressed by the insurer's standard/non-standard rating plan and other elements of its rating system. If an insurer receives a book of business with higher risk drivers, it is permitted to charge its non-standard rates. The insurer may also address this through the rate making process or other changes to its rating system. The Department does not believe that it is necessary, appropriate, or feasible to conduct an analysis of the risk characteristics of a producer's book of business before that producer's book of business is assigned to an insurer. Similarly, if an insurer were permitted to make this analysis, it could refuse to accept the producer due solely to the "mix" of the producer's business.

COMMENT: One commenter stated that the rules are not specific in addressing credits for producers that are voluntarily appointed by insurers pursuant to the Producer Voluntary Placement Plan. The commenter stated that insurers which voluntarily take agents should be granted exemptions from the mandatory assignment program.

RESPONSE: The Department believes that N.J.A.C. 11:3-42.10(b) specifically provides credits for insurers that voluntarily appoint producers. It must also be noted that while the commenter stated that the rules are "not specific enough when it comes to addressing the credits for companies that have voluntarily participated in a placement program," it failed to suggest alternative or additional language to address its concerns. An insurer may appoint sufficient eligible Association producers or Category B producers to satisfy its obligations under this Program.

COMMENT: One commenter suggested that the Department consider the Pennsylvania Clean Risk Assignment Program now used in that state's assigned risk plan. The commenter stated that that Program can yield depopulation benefits sought without the constitutional or financial harm caused by these rules. The commenter stated that under the Pennsylvania Program, clean risks are assigned to voluntary insurers at a uniform rate and commission level. The producer is offered the opportunity to move the business at subsequent renewal dates. If this is not done, the commenter stated that the business can be written voluntarily by the assigned company or turned to the assigned risk plan for future assignment.

RESPONSE: As was noted in response to a previous comment, these rules do not address the depopulation of risks, but provide for the assignment of producers pursuant to N.J.S.A. 17:33B-9c. The Department believes that the procedures provided by these rules effectively implement the intent of the Legislature. It must also be noted that the rules permit an insurer to compensate producers at the rate paid by the MTF if it is authorized to use MTF rates, rules and forms for policies transferred from the MTF.

COMMENT: One commenter suggested that the rules be modified to permit producers assigned to have only their Association/MTF business serviced by the assigned insurer, rather than allowing the producer the right to submit voluntary business to the insurer. The commenter stated that such an extension of the Commissioner's authority is unfounded and unconstitutional.

RESPONSE: The Department disagrees. As previously noted, one goal of the Producer Assignment Program is to provide access to the voluntary market through normal market channels. Prohibiting the assigned producer from writing new business would hinder such access and thus thwart the intent of the Legislature as expressed in N.J.S.A. 17:33B-9c.

Further, N.J.S.A. 17:29A-46 requires insurers to apply their underwriting rules uniformly and without exception throughout the State, so that every applicant or insured conforming with the underwriting rules will be insured or renewed, and every applicant not conforming with the underwriting rules will be refuse insurance. If the assigned producer was not permitted to effect new contracts of automobile insurance in accordance with the insurer's underwriting rules, the insurer would be in violation of N.J.S.A. 17:29A-46b in that it would be refusing to insure a person that otherwise meets its underwriting rules only because that person attempted to acquire insurance through an assigned producer. In addition, N.J.S.A. 17:33B-18a(1) requires that a licensed insurance agent, as a condition of licensure, provide each eligible person seeking automobile insurance premium quotations for the forms or types of automobile insurance coverages which are offered by all insurers represented by the agent or with which the agent places risks. The Department, therefore, believes that the requirement that the producer be authorized to solicit, negotiate and effect new contracts of automobile insurance is consistent with, and required by, these other statutory provisions and as such is not an unconstitutional extension of the Commissioner's authority.

COMMENT: One commenter suggested that the $7,500 commission income threshold in N.J.A.C. 11:3-42.4(a)5 is too low. The commenter suggested that the commission should be at least $20,000.

RESPONSE: Upon review of the commenter's suggestion, the Department has determined not to change this provision. The Program is intended to provide access to producers to normal market channels whose primary source of income was through the servicing of Association/MTF business. Assuming that the average price of a private passenger automobile insurance policy is $800.00, the $7,500 commission income threshold translates into a requirement that the producer service at least 100 policies during 1990. Under these same assumptions, a commission level of $20,000 would translate into a requirement that the producer service upwards of 300 policies. In light of the depopulation of the Association/MTF over the past few years, the Department believes that the current threshold is both reasonable and appropriate.

COMMENT: One commenter objected to N.J.A.C. 11:3-42.5, which provides the criteria upon which the Commissioner shall determine whether a territory is inadequately serviced, as too broad. The commenter stated that the criteria established by this section unreasonably encompasses nearly every territory in New Jersey. The commenter further stated that since there has been a stay in the mandatory depopulation program as a result of court challenges, there is a significant aberration in the number of inadequately serviced territories. The commenter thus suggested that inadequately serviced territories include some statistical analysis beyond that provided in the rules.

RESPONSE: As noted in a response to a previous comment, determination of inadequately serviced territories is not related to mandatory depopulation of exposures. Therefore, no "aberration" has occurred as a result of the previous stay of mandatory depopulation. As noted previously, the Department believes that the basis by which inade-

quately serviced territories are determined is reasonable, appropriate, equitable and fully set forth in N.J.A.C. 11:3-42.5.

COMMENT: One commenter stated that the rules should provide an exemption to any company which meets its depopulation quota. The commenter stated that there is nothing in the statutes requiring depopulation which requires that a company meet depopulation on a territorial basis. Therefore, the commenter believes that any company which meets its depopulation quota should not be subject to any additional mandatory producer assignments. The commenter additionally stated that companies which have adequate market distribution channels throughout New Jersey, and have met the statistical requirements (that is, that they are writing business in all territories in New Jersey), should similarly be entitled to an exemption whether or not those companies have met their depopulation quotas.

RESPONSE: The Department disagrees. As stated in a response to a previous comment, the goal of the Program is to provide sufficient access to the voluntary market through normal market channels. Accordingly, if an insurer demonstrates that its current marketing system provides sufficient access to the market, it may request a exemption from mandatory producer assignments. The Department does not believe that an insurer that merely meets its depopulation quota is necessarily providing sufficent access to the public in inadequately serviced territories because, as the commenter points out, depopulation is not based on territory but is based on the insurer's Statewide market share. As noted previously, however, the Department has substantially revised the exemption provisions. The revised provisions provide that any insurer may apply for an exemption and may be exempted from producer assignments if it demonstrates that it is providing access in inadequately serviced territories.

COMMENT: One commenter suggested that assigned producers be prohibited from hiring sub-agents. The commenter further stated that an insurer should be permitted to terminate a producer who violates this prohibition, and such producer should be barred from further participation in the Program.

RESPONSE: As noted previously, the Department does not dictate the contractual terms between assigned producers and insurers, except to the extent certain parameters or limitations have been deemed necessary to ensure that the Program implements the intent of the Legislature. Therefore, insurers and producers may negotiate in good faith to reach an agreement on fair and equitable terms, which should be consistent with agreements between the insurer and its other agents.

However, the Department does not believe it appropriate to permit an insurer to terminate a producer who violates any contractual provision. Such authority granted to the insurer would encompass a wide range of conduct ranging from innocuous to egregious. If an insurer terminates a producer under these rules, the producer may contest such termination with the Department. At such time the Department would be in a position to review all relevant facts involved, including treatment of the insurer's other agents for similar conduct.

COMMENT: Several commenters stated that assigned producers should not be permitted to be paid in accordance with the company's current commission levels.

One commenter believes that this would be inequitable for the producer, the insurer, and the consumer. If the producer is assigned to a company with a high commission level, that producer may be able to obtain more income based only on random luck as compared to another producer who is assigned to an insurer with a much lower commission level. The commenter additionally stated that insureds would also be required to pay rates which are different based on the same random luck of assignment to an insurer with either a high or low rating schedule.

Several commenters suggested that all assigned producers be paid the same commission and their customers pay the same rates no matter which company to producer or the insureds are assigned. The commenters thus suggested that the use of MTF rates and commission schedules be mandatory for all assigned producers.

RESPONSE: As previously noted, insurers which are authorized to utilize MTF rates rules, rules and forms for MTF business written by the producer, shall pay the producer the compensation rate paid by the MTF. Accordingly, the rules provide for a uniform commission level for business written through the MTF. To the extent MTF rates are not utilized, there may be variations among insurers. The commenter apparently requests that the Department establish a set commission rate applicable to all assigned producers, which may be either higher or lower than commissions paid by any particular insurer. The Department does not believe such action would be appropriate. One of the goals of the Program is to encourage long term business relationships which necessarily requires that the assigned producer be treated similar to the insurer's other producers. Furthermore, the insurer's methods of doing business and rating system presume the commission structure and other terms of agreements of producers that have been developed by the insurer over time. Accordingly, the Department has determined not to impose a fixed commission rate that would impact on these areas for new business written through assigned producers.

COMMENT: One commenter stated that any producer assignments beyond the two year period should not be permitted and after the two year period, if the producer cannot move his or her book of business to another insurer or into another market, the insurer should be entitled to terminate any obligation with the producer and to terminate that obligation without following the requirements of N.J.S.A. 17:22-6.14a(d). The commenter stated that the relationship between the insurer and the producer is not that of an agent voluntarily employed by the company, and thus the producer should not be afforded the protections provided by N.J.S.A. 17:22-6.14a(d). The commenter additionally stated that if the agent is assigned to a company which uses exclusive agents and owns the agents' expirations, the assigned producer should not enjoy the rights and privileges not afforded other agents employed by the company.

RESPONSE: As noted in a response to a previous comment, one goal of N.J.S.A. 17:33B-9c is to provide access to producers and insureds through normal market channels. If a producer were required to lose ownership of its expirations through the random assignment to an insurer which utilizes exclusive agents only, such producer would not be afforded access through normal market channels, thus thwarting the intent of the Legislature. The Department believes, therefore, that it is reasonable to provide that a producer assigned to an insurer retains ownership of its expirations and is entitled to comission on business it continues to service.

COMMENT: One commenter questioned the significance of the requirement that an insurer have an affiliation with a voluntary market insurer which was terminated after December 31, 1980 as one of the conditions of eligibility.

RESPONSE: The December 31, 1980 date is one of the statutory requirements for qualification set forth in N.J.S.A. 17:33B-9c.

COMMENT: One commenter questioned whether there is a distinction between "terminated by the insurer" as set forth in N.J.A.C. 11:3-42.4(a)3 and the phrase "who had such an affiliation" in the same provision. The commenter questioned if a producer was cancelled by insurer "X" after December 31, 1980, whether that producer would be an eligible Association producer for insurer "Y" to appoint, or whether the termination would be required to be from the insurer being assigned the producer.

RESPONSE: The Department does not interpret this provision to require that the termination be made by the insurer to which the producer is being assigned. Any termination of a voluntary affiliation with a voluntary market insurer for purpose of placement of automobile insurance satisfies the requirement in N.J.A.C. 11:3-42.4(a)3.

COMMENT: One commenter inquired how it may verify whether a prospective appointment has been validated as an eligible producer and ascertain the appropriate category.

RESPONSE: The Department shall establish a list of eligible producers determined to be qualified for assignment pursuant to the criteria set forth in the rules, on October 1 and April 1 of each year. An insurer may also separately request verification from the assigned producer that it is eligible, qualified and meets the criteria set forth in these rules.

COMMENT: One commenter stated that the industry has fallen approximately 275,000 exposures short of the depopulation quota. The commenter questioned when these delinquent insurers will begin receiving assignments.

RESPONSE: This comment relates to the mandatory assignment of exposures and is therefore outside the scope of these rules. It should be noted that an initial assignment of exposures to insurers that failed to meet their apportionment share was made on December 31, 1991, and subsequent assignments on May 20, 1992.

COMMENT: One commenter stated that the two-year prohibition against agency termination is inconsistent with prior determinations by the Department that producers be paid commissions on depopulated business for one year only.

RESPONSE: The one year commission schedule related to mandatory assignment of exposures by producers, which has been subject to litiga-

tion (see *Aetna*), has been revised pursuant to P.L.1991, c.462 and is not related to these rules.

COMMENT: One commenter stated that N.J.A.C. 11:3-42.12, which requires insurers to appoint assigned producers as agents, is silent about the terms of the contract or the consequences if the insurer fails to agree to the contractual terms. The commenter stated that insurers should be permitted to offer a contract with terms similar to those offered to its other representatives. If an assigned producer refuses to accept the terms offered, the commenter stated that it should not be entitled to the appointment.

RESPONSE: This is the purpose of the Program. As previously noted, the Program established by these rules is designed to provide maximum flexibility in recognition of the fact that agency agreements vary among insurers. The Department, however, believes it appropriate to provide limitations and parameters with respect to duration and termination of producer assignments and compensation of assigned producers in order to further the intent of the Legislature. Except as otherwise limited, insurers and producers shall negotiate in good faith to reach an agreement on fair and equitable terms. The terms of such agreement should be similar to those terms contained in agency contracts currently in use by the insurer. An insurer is not only permitted, but is required, to offer a contract with terms similar to those offered to its other representatives. If an assigned producer refuses to accept an assignment under this Program that provides for his or her appointment as the insurer's agent on fair and equitable terms, the producer is excluded from further participation in the Program pursuant to N.J.A.C. 11:3-42.18.

A summary of the reproposed new rules follows:

Proposed N.J.A.C. 11:3-42.1 sets forth the purpose and scope of these proposed rules.

Proposed N.J.A.C. 11:3-42.2 sets forth the definitions of terms used in this subchapter.

Proposed N.J.A.C. 11:3-42.3 provides for the establishment of a list of producers qualified for assignment.

Proposed N.J.A.C. 11:3-42.4 sets forth minimum requirements for producer eligibility.

Proposed N.J.A.C. 11:3-42.5 describes the method of the determination of inadequately serviced geographic areas.

Proposed N.J.A.C. 11:3-42.6 describes the application procedures for producers seeking to be assigned under this Program.

Proposed N.J.A.C. 11:3-42.7 provides the review procedures for producer applications.

Proposed N.J.A.C. 11:3-42.8 sets forth the standards for a producer to be qualified for assignment under the Program.

Proposed N.J.A.C. 11:3-42.9 provides exemptions for insurers from the Program.

Proposed N.J.A.C. 11:3-42.10 describes the procedures for the apportionment of producers for assignment and credits against assignments for producers voluntarily appointed.

Proposed N.J.A.C. 11:3-42.11 describes the procedures for the assignment of procedures under the Program.

Proposed N.J.A.C. 11:3-42.12 sets forth requirements for insurer appointment of assigned producers.

Proposed N.J.A.C. 11:3-42.13 sets forth procedures and requirements for the transfer of the appointed producer's Association or MTF business to the insurer.

Proposed N.J.A.C. 11:3-42.14 provides for the effectuation of new business by the insurer.

Proposed N.J.A.C. 11:3-42.15 and 42.16 provide procedures for the compensation of assigned producers.

Proposed N.J.A.C. 11:3-42.17 sets forth the requirements for the duration and terms of producer assignment.

Proposed N.J.A.C. 11:3-42.18 provides for the exclusion of producers from the Program under specified circumstances.

Proposed N.J.A.C. 11:3-42.19 provides special requirements for the initial implementation of the Program.

Proposed N.J.A.C. 11:3-42.20 sets forth the penalties for violations of the subchapter.

Social Impact

These reproposed new rules codify an existing mechanism by which the Commissioner may assign eligible Association producers to insurers pursuant to N.J.S.A. 17:33B-9c. This should reduce any market disruptions associated with termination of eligible Association producers, thus benefiting the public.

Economic Impact

Insurers authorized to transact private passenger automobile insurance in this State will be required to bear any costs associated with the appointment of eligible Association producers which are assigned pursuant to these rules. The Commissioner, however, may excuse an insurer from its obligations under these rules if an insurer demonstrates that it is in an unsafe or unsound financial condition. In addition, insurers may receive credits against producer assignments under these rules for appointing Association producers voluntarily in accordance with procedures set forth in Order No. A91-280, and for demonstrating that it has established voluntary market participation in inadequately serviced geographic areas. These credits should mitigate against any additional costs imposed by these rules.

These reproposed rules should also benefit the public by reducing costs associated with market disruptions due to termination of Association producers and due to the severing of established relationships between eligible Association producers and insureds.

The Department will be required to bear any costs associated with compiling the list of eligible Association producers and all other costs associated with the assignment of producers to insurers in accordance with these rules.

Regulatory Flexibility Analysis

These reproposed new rules may apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The reproposed new rules will apply to small businesses which are insurers authorized to transact private passenger automobile insurance in this State. These small businesses will be required to bear any costs associated with complying with these rules (for example, payment of compensation to producers appointed and assumption of business written by those producers). To the extent the proposed new rules apply to small businesses, they may impose a greater impact on small businesses in that they may have to devote proportionately more staff and financial resources to comply with these rules.

Producers seeking to be assigned under this Program will be required to comply with the application procedures set forth in these rules. Insurers which are assigned producers pursuant to these rules are required to: appoint such producers as agents in accordance with the procedures set forth in these rules; comply with the procedures governing the transfer of business by assigned producers; provide for the compensation of assigned producers in accordance with these rules; and comply with the procedures governing the termination of assigned producers.

The reproposed new rules provide different compliance requirements specifically based on business size. The rules exempt insurers with less than 1,000 in force exposures on December 31, 1983 and September 30, 1988. Further, the rules provide that insurers with less than 1,000 exposures at the end of the last quota period will not be assigned a producer whose book of business exceeds 15 percent (or greater than 25 percent in the case of insurers with more than 1,000 exposures) of the total private passenger automobile exposure of that insurer. Thus, the rules provide relief for insurers with a small book of business. In addition, the assignment of Association producers is tied to the amount of business written both presently and in the past. Accordingly, an insurer that writes a large amount of business will incur greater expense than an insurer that writes a small amount of business. Further, the Commissioner may excuse an insurer from its obligations under these rules if the insurer is in an unsafe or unsound condition. Finally, as previously noted, insurers may receive credit towards mandatory producer assignments pursuant to these rules which in turn, should mitigate against any additional costs imposed. The Department believes that these provisions should reduce any additional costs which may be imposed on small insurers through implementation of these rules.

Full text of the reproposal follows:

SUBCHAPTER 42. PRODUCER ASSIGNMENT PROGRAM

11:3-42.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17:33B-9c and provides for the assignment of qualified producers on an equitable basis to insurers writing private passenger automobile insurance in the voluntary market.

(b) This subchapter applies to all insurers licensed to transact private passenger automobile insurance in this State, unless otherwise exempt pursuant to this subchapter, and all qualified

producers who seek to be assigned to insurers pursuant to the procedures set forth in this subchapter.

(c) Producer assignments under the Program shall cease with any assignments made pursuant to the April 1, 1993 list of qualified producers. Notwithstanding the foregoing, the Commissioner may reactivate the assignment procedure in the event he or she determines that there are geographic areas in this State that lack sufficient representation for the placement of automobile insurance business in the voluntary market.

11:3-42.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Association" means the New Jersey Automobile Full Insurance Underwriting Association established pursuant to N.J.S.A. 17:30E-1 et seq.

"Automobile" is as defined in N.J.S.A. 17:30E-3b.

"Automobile insurance" is as defined in N.J.S.A. 17:30E-3c.

"Category B Association producer" means a producer who does not have a current affiliation with a voluntary market company for the purposes of placement of private passenger automobile insurance who:

1. Had such an affiliation with an insurer that was terminated by the insurer prior to December 31, 1980; or

2. Never had such an affiliation with a voluntary market company for the purposes of placement of private passenger automobile insurance.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Geographic area" means any one of the 27 rating territories in this State approved by the Commissioner for use in private passenger automobile rating systems.

"MTF" means the Market Transition Facility established pursuant to N.J.S.A. 17:33B-11.

"Program" means the Producer Assignment Program established pursuant to N.J.S.A. 17:33B-9c and this subchapter.

"Voluntary market insurer" means an insurer authorized to transact private passenger automobile insurance in this State.

11:3-42.3 List of qualified producers

Except for the first assignment made under this Program, the assignment of producers shall be made on a biannual basis subsequent to the conclusion of the quota periods established pursuant to N.J.S.A. 17:33B-11, commencing with the October 1, 1992 quota. The Commissioner shall annually, on October 1 and April 1, establish a list of producers who have been determined to be qualified for assignment to voluntary market insurers pursuant to this Program.

11:3-42.4 Eligible producers

(a) For the purpose of this subchapter, "eligible producer" is a producer who:

1. Is licensed in this State as a resident insurance producer;

2. Had a valid Association producer contract in force on September 30, 1990;

3. Does not have a current affiliation with a voluntary market insurer for the purposes of placement of private passenger automobile insurance, but who had such an affiliation that was terminated by the insurer between December 31, 1980 and December 31, 1992;

4. Is located in a rating territory that is determined by the Commissioner to be inadequately serviced, as defined in N.J.A.C. 11:3-42.5; and

5. Has derived not less than $7,500 in commission income from Association or MTF policies combined in calendar year 1990.

i. A producer may also use any voluntary market private passenger automobile insurance commission income he or she received during 1990 to meet the $7,500 threshold.

(b) For the purpose of this section, a producer who does not have a current affiliation with a voluntary market insurer for the purposes of placement of private passenger automobile insurance shall include the appointed representatives of insurers that have been:

1. Exempted from meeting the requirements of N.J.S.A. 17:33B-15, provided that the producer was appointed before the exemption order and wrote at least 10 policies for the insurer during the year preceeding the application for assignment;

2. Ordered by the Commissioner to cease the writing of automobile insurance; or

3. Permitted by the Commissioner to cease writing automobile insurance pursuant to a plan of orderly withdrawal approved pursuant to N.J.A.C. 11:2-29.

11:3-42.5 Designation of geographic areas

(a) For the purposes of the Program, the State shall be divided into geographic areas corresponding to the rating territories used by the Association/MTF to write private passenger automobile insurance. Each rating territory shall be designated as either adequately serviced or inadequately serviced. For the initial producer assignment to be made under this Program, the determination of whether a territory is inadequately serviced shall be as follows:

1. A territory shall be designated as adequately serviced if the proportion of voluntary market private passenger automobile non-fleet exposures to total private passenger non-fleet exposures in that territory meets or exceeds both the aggregate Statewide quota established pursuant to N.J.S.A. 17:30E-14B(2), for the quota period ending on September 30, 1990 and the aggregate Statewide quotas established pursuant to N.J.S.A. 17:33B-11c(5), for the quota periods ending March 31, 1991 and September 30, 1991.

2. A territory shall be designated as inadequately serviced if the proportion of voluntary market private passenger automobile non-fleet exposures to total private passenger non-fleet exposures in that territory is less than the aggregate Statewide quota established pursuant to N.J.S.A. 17:30E-14b(2), for the quota period ending on September 30, 1990 or pursuant to N.J.S.A. 17:33B-11(c)5, for the quota periods ending March 31, 1991, or September 30, 1991.

(b) For quota periods ending after September 30, 1991, the Commissioner shall review the status of each rating territory at the conclusion of each quota period established pursuant to N.J.S.A. 17:33B-11c(5). A rating territory shall be determined by the Commissioner to be inadequately serviced:

1. If the proportion of voluntary market private passenger automobile non-fleet exposures to total private passenger automobile non-fleet exposures in that territory is below the aggregate Statewide quota for the quota period; or

2. If the territory is adequately serviced based on the criteria established in (b)1 above, but the volume of exposures insured in the voluntary market was not achieved in the territory substantially through the voluntary writing of exposures but was achieved through the mandatory assignment of exposures pursuant to any mandatory depopulation plan established by the Commissioner.

(c) Notwithstanding the foregoing, the Commissioner, in his or her discretion, may find that specific areas within a rating territory are inadequately serviced although the territory as a whole has been determined to be adequately serviced. The Commissioner's determination shall set forth the basis for his or her finding in such instances.

(d) Except as may be otherwise permitted by the Commissioner, producers shall be deemed to be located and servicing business in a single rating territory for the purposes of this Program. The producer shall be assigned to the rating territory in which the producer's principal business office is located, as reflected by the records of the Department's licensing records.

(e) The Commissioner shall annually, on May 15 and November 15, establish a list of those rating territories or, if applicable, areas within rating territories that are determined to be inadequately serviced based on a review of the results of the immediately preceding quota periods, that is, April 1 and October 1, respectively. Notice thereof shall be provided to all Association producers by bulletin.

11:3-42.6 Application procedures

(a) Any producer who is eligible for assignment to a voluntary market insurer pursuant to this Program shall make application to

the Department on a form prescribed and furnished by the Department, incorporated herein by reference as Appendix A. The Department shall provide the form upon written request, within five working days of receipt of such request.

(b) All applications and accompanying documents shall be submitted to the Department. Applications premised on the May 15 list of inadequately serviced territories shall be filed with the Department no later than July 1 and applications premised on the November 15 list shall be filed no later than January 1.

(c) In the event an application is not fully completed, or the information provided is inadequate or required documentation is missing, the application shall be disapproved and the producer so notified, in writing, within 10 working days of receipt of the application by the Department. The producer shall be afforded a reasonable opportunity to cure any deficiencies in the application; provided, however, that such deficiencies are cured and a completed application is filed with the Department by the filing dates specified in (b) above.

(d) The Department shall review each application to determine whether the producer meets each of the criteria established by the Commissioner pursuant to N.J.S.A. 17:33B-9c and shall advise the applicant, in writing, as to whether he or she is qualified for assignment under this Program. Disapproval of an application shall be made as provided in N.J.A.C. 11:3-42.8.

(e) Notifications to producers applying pursuant to the May 15 list of inadequately serviced territories shall be issued by the Department on or before September 1; notifications premised on the November 15 list of inadequately serviced territories shall be issued by the Department on or before March 1.

(f) Completed applications and other information required to be submitted pursuant to this subchapter shall be submitted to the Department at the following address:

ARM Unit/PAP
Department of Insurance
CN 325
Trenton, New Jersey 08625

11:3-42.7 Review of applications

(a) In determining whether a producer is qualified for participation in this Program, the Department's review shall include, but need not be limited to, the following:

1. Any records concerning the termination of the producer's affiliation with any voluntary market insurer(s) to determine whether:

i. The producer was terminated on or after December 31, 1980 (as provided at N.J.S.A. 17:33B-9c(3));

ii. The producer has violated any of the insurance laws of this State or rules promulgated pursuant thereto; and

iii. The reason for termination adversely reflects on the producer's competency, efficiency and effectiveness in servicing insurance business or otherwise indicates that the producer should not be qualified for this Program due to unworthiness, bad faith, lack of integrity, financial irresponsibility, dishonesty or other criteria deemed relevant by the Commissioner;

2. Any records relating to the appointment of the producer to act as an Association or MTF producer, his or her performance as an Association or MTF producer, any bona fide complaints filed against the producer with the Association, the MTF or any servicing carrier of these entities and any corrective or disciplinary action taken by the Association or MTF with respect to the producer;

3. Any records of bona fide complaints filed against the producer with the Department or any administrative action instituted by the Department (that is, issuance of an Order to Show Cause, issuance of an Order pursuant to N.J.S.A. 17:22A-20d etc.) with respect to the producer that has resulted in the imposition of fines or suspension or revocation of license privileges, including the imposition of such sanctions based on a Consent Order; and

4. Upon disclosure on the application or any other document reviewed by the Department of such administrative actions, any records relating to administrative actions instituted by any licensing authority of this or any other state or the Federal government with respect to the producer that has resulted in the imposition of fines, or suspension or revocation of license privileges.

11:3-42.8 Producer qualification standards

(a) An application for qualification under this Program shall be disapproved if, based on the Department's review as set forth in N.J.A.C. 11:3-42.7:

1. The producer is determined not to meet the eligibility criteria set forth in N.J.A.C. 11:3-42.4;

2. The producer has failed to comply with insurance laws and regulations and/or the producer performance standards established by the Association Plan of Operation, at Part III Operating Principles, Section 4: Producer Performance Standards, subsection 1, Performance Standards—General, or the MTF Plan of Operation, at Part III, Operating Principles, Section 4: Producer Performance Standards, subsection 1, Performance Standards—General;

3. The producer's affiliation with any voluntary market insurer has been terminated for reasons that adversely reflect on the producer's competency, efficiency or effectiveness in servicing insurance business or that otherwise indicate that the producer should not be qualified for this Program due to unworthiness, bad faith, lack of integrity, dishonesty, financial irresponsibility or other criteria deemed relevant by the Commissioner. This standard shall apply to all terminations of affiliation, including, but not limited to, agency appointments, brokerage arrangements and limited insurance representative appointments, any termination of an appointment made pursuant to the Producer Voluntary Placement Plan and any termination of an assigned appointment made under this Program;

4. The producer failed to file a completed application with the ARM Unit within the Department as provided in N.J.A.C. 11:3-42.6(c);

5. The producer knowingly withheld material information on the application or any accompanying document or intentionally made or caused to be made any false, deceptive or fraudulent statement during the application process, or otherwise qualified or attempted to qualify for this Program by fraud or material misrepresentation; or

6. The producer has been excluded from the Producer Voluntary Placement Plan or has previously been excluded from the Producer Assignment Program as provided in N.J.A.C. 11:3-42.18.

(b) An otherwise eligible producer whose application has been disapproved may reapply for the Program in a subsequent period except where such disapproval is for cause. For the purpose of this provision, the term, "for cause," shall mean any willful and/or repeated violation of insurance laws or regulations, or Association or MTF performance standards, or any conduct that demonstrates unworthiness, lack of integrity, bad faith, dishonesty, financial irresponsibility or incompetency to transact business as an insurance producer.

(c) When the ARM Unit within the Department disapproves an application for assignment, the disapproval notice shall:

1. Include a written statement specifying the reasons for the rejection; and

2. Inform the producer of his or her ability to request a review of the disapproval by the Commissioner, within 10 days of receipt of the disapproval.

3. A request for review by the Commissioner shall be in writing and made within 10 days of receipt of the disapproval and shall be accompanied by all supporting documentation, if any, disputing with specificity, the reasons for disapproval. A response to this request may be made by the ARM Unit within five days thereafter.

4. The Commissioner shall issue a written decision with reasons upholding or reversing the decision of the ARM Unit within 30 days from receipt of the last written request or response, whichever is later.

11:3-42.9 Exemption from program

(a) The Program is intended to address the dual goals of protecting producers who have built businesses and developed expertise serving the residual market and of encouraging auto sales and service in inadequately served territories. Therefore, assignment of producers on an equitable basis should consider whether an insurer's own marketing system has, in practice, provided reasonable access

to persons in all areas of the State. When an insurer has demonstrably provided such access, it may be exempt from assignments under the Program.

1. Requests for an exemption on this basis must be supported by the following information:

i. For an insurer utilizing producers to transact private passenger automobile insurance in this State:

(1) A report showing the distribution of producers by territory within the State of New Jersey for the period between October 1, 1990 to the present. The report should specify the appointment dates of any newly appointed producer during the report period, as well as the termination date of any producer terminated during the report period;

(2) A narrative and supporting documentation demonstrating that the insurer was actively soliciting private passenger automobile insurance in inadequately serviced territories for the period between October 1, 1990 and April 1, 1992. The narrative and supporting documentation should also include data reflecting the results of the solicitation efforts;

(3) A report showing the number of new business applications for private passenger automobile insurance by territory submitted by each producer for the period from October 1, 1990 to the present. For the purposes of this report, applications rejected by the insurer should be included;

(4) A report showing the number of new business private passenger automobile insurance policies issued by the insurer by territory for the period from October 1, 1990 to the present; and

(5) Any other supplemental information that the insurer may consider relevant to the request for an exemption.

ii. For insurers who conduct business as direct writers:

(1) A narrative and supporting documentation showing that the insurer was actively soliciting private passenger automobile insurance in the inadequately serviced territories for the period from October 1, 1990 and to the present. The narrative and supporting documentation should also include data reflecting the results of the solicitation efforts;

(2) A report showing the number of requests for quotations and/or applications for private passenger automobile insurance by territory for the period from October 1, 1990 to the present. For the purposes of this report, requests for quotations denied and applications rejected by the insurer should be included;

(3) A report showing the number of new private passenger automobile insurance policies issued by the insurer by territory for the period between October 1, 1990 to the present; and

(4) Any other supplemental information that the insurer may consider relevant to its request for an exemption.

2. Requests for exemptions from this Program must be received by the Department no later than 45 days prior to the end of the quota period for which assignments are being made. Failure to submit a complete application by the due date may result in a denial of the insurer's request for exemption from assignments for that assignment period.

3. The review of requests for exemptions from this Program shall be conducted by the ARM Unit within the Department. The ARM Unit shall review the request and shall notify the insurer in writing as to its decision within 45 days of receipt of a complete exemption request.

4. When the ARM Unit rejects an exemption request, the notice of rejection shall:

i. Include a statement in writing specifying the reasons for the rejection; and

ii. Inform the insurer of the right to request a review of the rejection by the Commissioner, no later than seven days after receipt of the notice of rejection;

5. A request for review by the Commissioner shall be made in writing no later than seven days after receipt of the notice of rejection and shall be accompanied by all supporting documentation, if any, disputing, with specificity the reasons for rejection. A response to this request may be made by the ARM Unit within five days thereafter.

6. The Commissioner shall issue a written decision with reasons upholding or reversing the decision of the ARM Unit within 30 days from receipt of the last written request or response, whichever is later.

(b) An insurer may also be exempted from this Program:

1. As part of relief from insurer obligations under the Fair Automobile Insurance Reform Act having been granted, pursuant to the requirements of N.J.A.C. 11:2-35;

2. In accordance with a plan of orderly withdrawal from the State which has been approved pursuant to N.J.A.C. 11:2-29;

3. If the insurer had fewer than 1,000 voluntary private passenger automobile exposures in-force on December 31, 1983 and September 30, 1988; or

4. If the insurer has, as a condition of providing coverage, uniform membership requirements which have been filed and approved by the Department pursuant to N.J.S.A. 17:29A-46 and N.J.A.C. 11:3-35 and the insurer is not prohibited from using its membership requirements by N.J.S.A. 17:33B-26. Notwithstanding the foregoing, if the insurer is a member of a group that includes other insurers that are authorized to transact private passenger automobile insurance in this State, but do not have approved membership requirements as a condition of providing coverage, producer assignments shall be made to the group.

(c) An insurer that has been exempted from this Program pursuant to (b)1 or 2 above or qualifies for exemption under (b)3 or 4 above shall notify the Department at least 45 days prior to the promulgation of the lists of qualified producers.

11:3-42.10 Apportionment of producers; credits

(a) Each insurer authorized to transact the business of private passenger automobile insurance in this State shall be subject to the assignment of qualified producers pursuant to the procedures and requirements set forth in this Program. Producer assignments shall be apportioned among insurers based upon each insurer's apportionment share as determined for purposes of depopulation pursuant to N.J.S.A. 17:30E-14 and 17:33B-11(c)5, subject to any exemptions as set forth in N.J.A.C. 11:3-42.9.

(b) Any insurer that has, pursuant to the Producer Voluntary Placement Plan, appointed eligible Association producers as defined in N.J.A.C. 11:3-42.4 shall receive credit against any producer assignments to be made under this Program on a one-for-one basis. The one-for-one credit shall be premised on a calculation of the insurer's apportionment share of the total number of producers who otherwise would have been eligible for assignment under this Program in the absence of any voluntary agreements entered into by those companies subject to assignment.

1. In the event that an insurer appoints sufficient eligible Association producers to meet or exceed the insurer's apportionment share of such producers for that assignment period, the insurer shall not be subject to producer assignment during that assignment period and the excess shall be credited against any subsequent assignments made by the Commissioner.

2. The excess shall not be credited against subsequent assignments to the extent that the insurer has terminated any appointments of producers prior to the next assignment period.

3. Credits against future assignments shall apply irrespective of whether the territory where a producer is located continues to be designated as inadequately serviced pursuant to N.J.A.C. 11:3-42.5.

(c) Any insurer that has, pursuant to the Producer Voluntary Placement Plan, appointed Category B Association producers who are located in territories that have been determined by the Commissioner to be inadequately serviced pursuant to N.J.A.C. 11:3-42.5, shall receive credits against any producer assignments based on the credit allowance set forth in (d) below.

1. In the event that an insurer appoints sufficient Category B Association producers to meet or exceed the insurer's apportionment share of eligible producers for that assignment period, the insurer shall not be subject to producer assignment during that assignment period and the excess shall be credited against any subsequent assignments made by the Commissioner.

2. The excess shall not be credited against subsequent assignments to the extent that the insurer has terminated any producer appointments prior to the next assignment period.

3. Credits against future assignments shall apply irrespective of whether the territory where a producer is located continues to be designated as inadequately serviced pursuant to N.J.A.C. 11:3-42.5.

(d) The credit allowance specified in (c) above shall be calculated so as to ensure the Commissioner's ability to produce assignments for all or substantially all producers on each list of qualified producers as set forth in N.J.A.C. 11:3-42.3. The credit allowance shall be reviewed and adjusted, if necessary, on a periodic basis. For the initial implementation of this Program, an insurer shall receive one credit toward a producer assignment for every four Category B producers appointed who are located in inadequately serviced territories.

(e) In calculating any insurer's apportionment share of any producer assignments made pursuant to this Program, the following procedures shall govern:

1. The apportionment shares of producer assignments of any insurers that are subject to exemption under the Program, pursuant to N.J.A.C. 11:3-42.9, shall be calculated and such shares redistributed among the remaining carriers in the proportion that each of the remaining insurers' market shares bears to the total market share of all such insurers;

2. Credits against an insurer's apportionment share of producer assignments earned pursuant to (b) above shall be calculated and the producers redistributed among the remaining insurers in the proportion that each of the remaining insurers' producer assignments (after application of the one-for-one credit) bears to the total number of such assignments; and

3. Credits against an insurer's apportionment share of producer assignments earned pursuant to (c) above shall be calculated and the producers redistributed among the remaining insurers in the proportion that each of the remaining insurers' producer assignments (after application of any credits under (c) above) bears to the total number of such assignments.

(g) In calculating credits under this section, the Department shall utilize the number of voluntary agreements that are in force at the end of the April 1 and October 1 quota periods, as applicable. Any credits that are earned by an insurer for a given assignment period that are premised on an appointment that is subsequently terminated shall be removed and adjustments made to the insurer's apportionment share in the next assignment period.

11:3-42.11 Producer assignments

(a) Each insurer subject to the assignment of producers pursuant to this Program shall be notified by Order subsequent to the Commissioner's establishment of each list of qualified producers as set forth in N.J.A.C. 11:3-42.3. Except as provided in (a)1 and 2 below, qualified producers shall be assigned to the insurers subject to assignment on a random basis.

1. No insurer whose total private passenger automobile in-force exposures at the end of the last quota period is greater than 1,000 will be assigned a producer whose eligible book of business is greater than 25 percent of the total private passenger automobile exposures of that insurer.

2. No insurer whose total private passenger automobile in-force exposures at the end of the last quota period is less than 1,000 will be assigned a producer whose eligible book of business is greater than 15 percent of the total private passenger automobile exposures of that insurer.

3. The Department shall consider the total in-force exposures of the insurer at the end of the last quota period in making assignments under this Program.

11:3-42.12 Appointment

(a) Any producer assigned to an insurer under this Program shall be appointed by the insurer as an agent of the company pursuant to N.J.S.A. 17:22A-15 and notice thereof provided to the Department as provided in N.J.A.C. 11:17-2.9. Contracts between the insurer and the assigned producer(s) shall be executed no later than 30 days following issuance of the Order specified in N.J.A.C. 11:3-42.11.

1. With respect to insurers that are members of a group, the notice to the Department shall specify the member companies to which the producer is appointed as an agent. Where the group utilizes different member insurers for the purpose of writing standard and nonstandard risks, the producer shall be appointed as an agent for all such companies. Insurers that are members of a group are not required to appoint the producer as an agent of all the companies in the group provided that the producer is appointed to one or more companies that have approved standard and non-standard rating plans.

(b) Pursuant to N.J.S.A. 17:22-6.14a(1)e, an insurer may use an insurance marketing system that provides for its agents to be compensated on a salary basis without commission or provides for its agents to represent the company exclusively. Such an insurer may utilize this system for producers assigned to it under this Program or may appoint such producers as independent agents.

11:3-42.13 Transfer of MTF business

(a) The insurer shall offer the same or equivalent automobile insurance coverage that was afforded under the MTF to each MTF insured serviced by the producer who is determined by the insurer to qualify as an eligible person pursuant to N.J.A.C. 11:3-34. Where the insurer does not have rates and rules filed and approved by the Department for the same or equivalent coverage presently afforded the insured under the MTF policy, the insurer shall offer to the insured the next broadest coverage for which the insurer has rates and rules filed and approved by the Department. The insurer is expressly prohibited from offering less coverage to the insured than the coverage afforded to such insured under the MTF policy. Examples of coverages that may be offered is set forth in Appendix B to this subchapter, incorporated herein by reference. In determining whether the MTF insured qualifies as an eligible person, insurers shall comply with N.J.A.C. 11:3-8.4. An insurer also may determine to make an offer of coverage to an insured who does not qualify as an eligible person.

(b) The transfer of the producer's MTF policies to the assigned insurer shall be accomplished through completion by the producer of a new business application and a coverage selection form for the insured. Pursuant to mutual agreement between the insurer and the producer, the new business application may be unsigned. However, a coverage selection form signed by the insured shall be submitted to the insurer.

(c) An insurer receiving assignments under this Program may make independent agreements with the servicing carriers for the exchange of electronic information or other arrangements involving the transfer of policies from the MTF to the insurer. An outline of the terms of any agreement and any copies of any written material that will be sent to insureds must be submitted in advance of its implementation to the Department. The MTF shall have no responsibility to provide coverage for insureds as a result of the failure of the servicing carrier to perform under the terms of the independent agreement.

11:3-42.14 New business

The producer shall be authorized to solicit, negotiate and effect new contracts of automobile insurance in accordance with all applicable laws and regulations and the insurer's underwriting guidelines, consistent with procedures applicable to the insurer's other representatives.

11:3-42.15 Producer compensation; company rates

(a) Where an insurer determines to use its own rates for former MTF insureds transferred to the insurer and/or new business written through the producer, the contract shall provide for the producer to be compensated based on the insurer's current schedule of commissions or other formula used to provide compensation to its agents. Policies transferred from the MTF shall be considered as new business with respect to providing producer compensation, for the assigned insurer's initial policy period.

(b) Where an insurer's compensation schedule contemplates support services, such as office space, equipment or advertising, or other employee benefits, and such services or benefits are not provided to the producer, the compensation schedule shall be adjusted to reflect accurately the value of such services or benefits so that the producer shall receive compensation that is equivalent to the compensation paid to, or on behalf of, the company's agents who receive such services or benefits.

1. For the purpose of this provision, the term "agent" shall be construed to have the broadest possible meaning, including, but not limited to, exclusive agents or independent agents.

2. Where an insurer has more than one schedule of commissions for its agents, it shall negotiate in good faith with producers assigned pursuant to this Program to determine the commission to be paid.

(c) In the case of companies that are direct writers, expenses for a direct marketing department and related support staff shall be considered in determining the commission paid to the assigned producer under (a) above.

1. The commission agreed to by any direct writer and an assigned producer under (a) above shall be comparable to the compensation paid to independent agents by insurers that utilize such agents.

2. Where an insurer that is a direct writer also maintains, through a subsidiary company or otherwise, a mechanism to accept business from producers who are not the normal, exclusive agents of the direct writers, the commission schedule applicable to such producers shall be utilized consistent with (a) above.

11:3-42.16 Producer compensation; MTF rates

Where the insurer is authorized by law to use MTF rates, rules and forms for policies written through the producer, it shall pay the producer the same commission paid by the MTF.

11:3-42.17 Duration and terms of producer assignment

(a) Any termination of an appointment of a producer assigned to an insurer pursuant to this Program shall be prohibited for two years following the date of contract, except where such termination is for cause. A termination for cause must be based on the producer's insolvency, abandonment, gross and willful misconduct or failure to pay over to the companies monies due to the company after his or her receipt of written demand therefor, or after revocation of the agent's license by the Commissioner. In addition, an appointment may be terminated for cause if the producer violates the written underwriting guidelines of the insurer in such a manner or with such frequency as to substantially affect the company's ability to underwrite or provide coverage.

1. Insurers shall provide producers with at least 45 days written notice of a termination for cause. The notice of termination shall include a detailed written explanation of the reasons for termination. A copy of the notice shall also be sent to the Department.

2. A termination for cause shall result in the exclusion of the producer from further participation in the Program. Producers may contest a termination notice pursuant to the procedures in N.J.A.C. 11:3-42.18(d).

3. In the case of a termination for cause, the insurer may reassign the producer's book of business to another active agent of the company or service it directly.

(b) At the conclusion of the two year period, the producer and insurer shall negotiate in good faith to do one of the following:

1. Irrespective of the marketing system customarily used by the insurer, appoint the producer as an independent agent, the termination of which appointment is governed by N.J.S.A. 17:22-6.14a(1)(d);

2. Where the insurer, pursuant to N.J.S.A. 17:22-6.14a(e), uses an insurance marketing system that provides for its agents to be compensated on a salary basis without commission or provides for its agents to represent that company exclusively, the insurer may appoint the producer under this system; or

3. Buy out the producer by paying to him or her an amount equivalent to at least one year's commission based on the book of business at the end of the two year assignment period.

(c) If the insurer and the producer cannot reach an agreement under (b) above, the producer shall be deemed a terminated agent who is subject to the provisions of N.J.S.A. 17:22-6.14a(d) and (i), notwithstanding N.J.S.A. 17:22-6.14a(1)e or the mode of appointment of the producer under this Program (that is, exclusive agent or independent agent).

11:3-42.18 Exclusion from program

(a) Any producer who refuses an assignment under this Program, that provides for his or her appointment as the assigned company's agent on fair and equitable terms, shall be excluded from further participation in this Program.

(b) Any producer who is terminated within the two year period set forth in N.J.A.C. 11:3-42.16(a) above shall be excluded from further participation in this Program.

(c) Insurers shall immediately provide notice of any refusal of assignment as provided in (b) above, respectively, in writing, to the Department in the format set forth in Appendix C to this subchapter, incorporated herein by reference. A copy of the notice shall be simultaneously delivered to the affected producer.

(d) A producer who has received a notice of termination for cause or a Notice of Refusal of Appointment may file a written response with the Department. Such response shall be made within 10 days of the insurer's notice. The Commissioner shall issue a written decision with reasons within 30 days.

11:3-42.19 Initial implementation of program

For the initial implementation of this Program, in-force voluntary agreements that are established by insurers with eligible Association producers and Category B producers located in inadequately serviced territories between October 1, 1990 and February 29, 1992 shall be used to determine any credits under N.J.A.C. 11:3-42.10.

11:3-42.20 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

APPENDIX A

Date Stamp Application Number

PRODUCER ASSIGNMENT PROGRAM (PAP)
Producer Application

Producer License Reference #

Name of Applicant (must be same as on license)

Contact Person If Applicant is Corp. or Partnership

( ) Telephone Number

Main Business Address of Applicant—No. & Street (no Post Office Box #)

City Zip

Rating Territory of Main Business Address _____ SS or Tax ID # _____

Does the applicant have a valid New Jersey producer license? Yes ____ No ____

Did the applicant have a valid Association producer contract on 9/30/90? Yes ____ No ____

Does the applicant have a current appointment with a voluntary market insurer for the placement of automobile insurance? Yes ____ No ____

Did the applicant have an appointment with a voluntary market insurer for the placement of automobile insurance that was terminated by the insurer after 12/31/80? Yes____ No ____

If yes, list the insurers with the date and reason for termination below.

Insurer	Date	Reason for termination
Insurer	Date	Reason for termination
Insurer	Date	Reason for termination

Total commission income earned by applicant from JUA/MTF business in 1990? $_____

Total commission earned on voluntary market auto insurance policies, if any? $ _____
Attach copies of IRS 1099 forms.

If the answer to any of the questions below is YES, attach copies of relevant documents and explain in the Remarks section below. Add additional sheets if necessary.

Has the applicant or any officer, partner, director or owner of 5% or more have any unsatisfied judgments against them? Yes ____ No ____

Has the applicant or any officer, partner, director or owner of 5% or more ever been indicted or convicted of a crime, misdemeanor or disorderly persons offense in this State, other state or by the federal government? Yes ____ No ____

Has the applicant or any officer, partner, director or owner of 5% or more ever been the subject of any administrative action initiated by the Department of Insurance of this State or any other licensing authority of this or any other state, that resulted in the revocation or suspension of license privileges? Yes____ No ____

Certification—I/We hereby certify that:

1. I/We give the Department of Insurance permission to verify any information supplied with any federal, state or local government agency, insurance company, JUA or MTF.

2. All the information submitted on this application and all attachments are true and complete. I am/We are aware that submitting false information in connection with this application is grounds for exclusion from the Producer Assignment Program and may subject me/us to administrative penalties including revocation of license.

Signature of Applicant or Officer of Corporation Date

Print Name

Return to: NJ Department of Insurance
ARM Unit/PAP Applications
20 W. State Street CN 325
Trenton, NJ 08625

Remarks:

APPENDIX B

COVERAGE DETERMINATION EXAMPLES

The following examples are provided for illustration purposes only:

Example 1: The MTF policyholder presently has $25,000/$50,000/$10,000 split limits of liability coverage. However, the member company only writes combined single limit of liability coverage and only has rules and rates filed and approved by the Department for this type coverage. Therefore, the member company must offer the MTF policyholder a combined single limit of liability coverage which is equal to the bodily injury occurrence limit and the property damage occurrence limit added together or the next broadest available coverage (for example, $75,000, but in no event less than $60,000).

Example 2: The MTF policyholder presently has $25,000/$50,000/$10,000 split limits of liability coverage. The member company only writes combined single limit of liability coverage and offers $100,000 combined single limit of liability coverage as the minimum coverage to its voluntary insureds. However, the member company has rates and rules filed and approved by the Department for combined single limit of liability coverage for amounts less than $100,000. Therefore, the member company must offer the MTF policyholder a combined single limit of liability coverage which is equal to the bodily injury occurrence limit and the property damage occurrence limit added together or the next broadest available coverage, but less than $100,000 (for example, $75,000, but in no event less than $60,000).

Example 3: The MTF policyholder presently has $25,000/$50,000/$10,000 split limits of liability coverage. The member company only writes combined single limit of liability coverage and offers $100,000 combined single limit of liability coverage as the minimum coverage to its voluntary insureds. The member company does not have any rates and rules filed and approved by the Department for amounts of combined single limit of liability coverage less than $100,000. Therefore, the member company must offer the MTF policyholder $100,000 combined single limit of liability coverage.

Example 4: The MTF policyholder presently has $75,000 combined single limits of liability coverage. The member company writes both split limits and combined single limit of liability coverage and has rates and rules filed and approved by the Department for both types of coverage. Therefore, the member company must offer the MTF policyholder $75,000 combined single limit of liability coverage and not a split limits policy.

Example 5: The MTF policyholder presently has $100,000 combined single limit of liability coverage. The member company only writes split limits of liability coverage and only has rates and rules filed and approved by the Department for this type of coverage. Therefore, the member company must offer the MTF policyholder split limits of liability coverage with a bodily injury per person limit equal to the combined single limit of liability coverage or the next broadest available coverage (for example, $100,000/$300,000/$50,000). (Note: All conversions of combined single limit of liability coverage should be handled in the same manner, except a $35,000 combined single limits policy. In this particular case, the member company shall offer $15,000/$30,000/$5,000 split limits of liability coverage.)

APPENDIX C

PRODUCER ASSIGNMENT PROGRAM—REFUSAL OF PRODUCER APPOINTMENT

(Please print or type)

------- Company Information ----------

_____ _____

Name of Company or Group NAIC #

Address: _____

_____ _____

Company Contact Person Title

Phone No.: (____) _____ FAX No.: (____) _____

------- Producer Information ----------

_____ | | | | | | | | | |

Name of JUA/MIF Contractholder DOI Producer Reference No.

Contact Person: _____

Individual Licensee if above is Partnership or Corporation

_____

Main Business Address—No. and Street (P.O. Box not permitted)

_____ NJ _____ (____) _____

City Zip Phone

------- Refusal Information ----------

Date of Refusal of Appointment: Mo. ____ Day ____ Yr. ____

Comment: _____

_____

_____

_____

_____

CERTIFICATION

I certify that the above information is correct to the best of my knowledge, information and belief. I understand that if I have knowingly made any false statements I will be subject to penalties.

_____ _____

Signature of Company Representative Print Name

_____ _____

Title Date

(a)

DIVISION OF PROPERTY/LIABILITY
Commercial Lines Insurance
Proposed Readoption: N.J.A.C. 11:13

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.
Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e) and 17:29AA-1 et seq.
Proposal Number: PRN 1992-361.

Submit comments by September 16, 1992 to:

Verice M. Mason
Assistant Commissioner
Department of Insurance
Legislative and Regulatory Affairs
CN 325
20 West State Street
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), the Commissioner of Insurance ("Commissioner") proposes to readopt N.J.A.C. 11:13 which expires on November 12, 1992.

The Department finds that these rules continue to be necessary to implement and interpret the Commercial Lines Deregulation Act of 1982 ("Act"). The Act establishes a separate rating law for commercial lines of insurance and exempts certain lines of commercial insurance from the provisions of the existing property/liability rating law except as specifically provided in the Act. By establishing a separate rating law for commercial lines insurance, the Act affords insurers greater flexibility in the underwriting and rating of commercial risks while maintaining appropriate regulatory oversight by the Department of Insurance ("Department"). The Commissioner is empowered under the Act to promulgate rules and regulations in order to implement and enforce its provisions.

As required by the Executive Order, the Department has reviewed these rules and has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated.

This chapter includes rules related to different areas of commercial lines insurance. Subchapters concerning the following subjects are codified in this chapter:

1. General provisions, including the purpose, scope and definitions for this chapter;
2. Commercial lines filings, which provides requirements for rate, rule and policy form submissions;
3. Expense experience, which incorporates N.J.A.C. 11:4-10 into this chapter regarding the reporting of expense experience;
4. Special risks, which interprets the statutory definition of "special risks" and provides statistical reporting requirements;
5. Procedure for the regulation of consent to higher rate filings, which incorporates N.J.A.C. 11:4-7 into this chapter;
6. Commercial insurance rating plans, which establishes standards for rating plans that modify rates for specific risks; and
7. Commercial lines insurance policy form standards, which provides standards for the acceptance or disapproval of policy forms.

The Department has undertaken a review of these rules at several levels to determine their effectiveness and viability. This review has included the Division Property/Liability and the Division of Legislative and Regulatory Affairs.

Social Impact

The Department believes that these rules that implement the Commercial Insurance Deregulation Act of 1982 enhance the ability of commercial insureds and insurers to effectively negotiate contracts thereby stimulating competition and encouraging efficient rating and marketing practices.

These rules also set standards for individual premium risk modification plans filed by insurers of commercial risks and thus impact both insurers and insurance purchasers. Risk premium modification plans provide limited flexibility to vary the price of a policy based on the characteristics of a specific risk.

While recognizing that many commercial insurers do not require the same degree of regulatory protection afforded to individual insureds, the requirements of the Act and the rules proposed for readoption ensure that the rights of such insureds are adequately protected.

Economic Impact

The readoption of these rules will permit insurers to continue to price individual policies more accurately, within specified limits above and below their filed rates, based upon the actual risk undertaken. The readoption of these rules will continue market competition and promote both availability and lower premiums.

Insurance companies will incur no additional expenses because the proposed readoption does not change the current rules. The Department will not incur additional expenses in connection with the proposed readoption of the current rules.

The filing and statistical reporting requirements in Subchapters 2, 3, 4, and 5 impose some economic cost upon insurers. The Department believes that these costs, however, are necessary to provide for the limited amount of Department oversight required by the Act for commercial lines insurance. The Department believes that the costs imposed by these rules, which provide for the form and manner of submission to the Department of filings and information required by the Act to be submitted, are negligible compared to the volume of business to which they apply. All commercial lines insurers maintain staff personnel to fulfill such requirements.

The standards for commercial insurance rating plans in Subchapter 6 also impose some minimal economic costs upon insurers to comply with the filing requirements. These costs similarly are minimal when compared to the volume of commercial lines insurance business to which they apply, and are reasonable in consideration of the public purposes which they serve (see N.J.A.C. 11:13-6.1(b)). Because these standards are relatively new (having been adopted in December, 1990), the Department intends to review their market impact in calendar year 1993 when data becomes available for the first full year of their effect.

The standards for commercial insurance policy forms in Subchapter 7 are regulatory and do not impose any direct costs. These provisions advise insurers what policy forms are acceptable, or not acceptable, for filing and use in this State pursuant to N.J.S.A. 17:29AA-6.

Regulatory Flexibility Analysis

The proposed readoption of these rules will affect only commercial lines insurers.

If there are "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., in the commercial lines insurance industry, they can expect to incur no added costs because the proposed readoption does not change the current rules (see cost discussion in Economic Impact above).

To the extent that insurers qualify as "small businesses," they use the services of a rating organization for rate and form filings. Nevertheless, there may be insurers that independently file rates and forms that qualify as "small businesses" according to the statutory definition.

The rules for commercial lines rating plans make no distinction between plans filed by small businesses and those filed by other insurers. The filing requirements are minimal and are currently being met by insurers of all sizes that wish to provide the rate flexibility available through such plans.

Since the purpose of the rules regarding commercial policy forms is to establish minimum standards for policy forms used by all insurers, it would be inconsistent to establish different standards based upon company size.

Full text of the proposed readoption appears in the New Jersey Administrative Code at N.J.A.C. 11:13.

RULE ADOPTIONS

AGRICULTURE

(a)

STATE AGRICULTURE DEVELOPMENT COMMITTEE

Acquisition of Development Easements

Adopted Amendments: N.J.A.C. 2:76-3.12 and 4.11

Proposed: March 16, 1992 at 24 N.J.R. 893(b).
Adopted: July 23, 1992, by the State Agriculture Development Committee, Arthur R. Brown, Jr., Chairperson.
Filed: July 24, 1992 as R.1992 d.325, **with portions not adopted but still pending.**

Authority: N.J.S.A. 4:1C-5f.

Effective Date: August 17, 1992.
Expiration Date: July 31, 1994.

Summary of Agency Actions:

On May 21, 1992, the State Agriculture Development Committee, Arthur R. Brown, Jr., Chairperson, pursuant to the authority of N.J.S.A. 4:1C-5f and in accordance with the applicable provisions of the Administrative Procedure Act, adopted amendments to be cited as N.J.A.C. 2:76-3.12(a)2, 3, 6, 9, 12, 17; N.J.A.C. 2:76-3.12(c); N.J.A.C. 2:76-4.11(a)2, 3, 6, 9, 12, 17 and N.J.A.C. 2:76-4.11(c) concerning the creation of farmland preservation programs and the creation of municipally approved farmland preservation programs as proposed in the Notice published in the New Jersey Register, March 16, 1992, at 24 N.J.R. 893(b).

In addition, the adopted amendments result in the recodification of several paragraphs without change in text. The proposed amendment to N.J.A.C. 2:76-3.12(a)13iv and 2:76-4.11(a)13iv are not hereby adopted but remain open for further study and review by the State Agriculture Development Committee.

Summary of Public Comment and Agency Response:

COMMENT: The Burlington County Agriculture Development Board supports the amendments as proposed with regard to identifying any pre-existing nonagricultural development occurring on the premises as cited at N.J.A.C. 2:76-3.12(a)2 and 4.11(a)2, but suggests that the SADC clarify whether the pre-existing nonagricultural use can continue to be used by a successive owner of the property, as has been suggested. It should be made clear that the restriction runs with the land until abandonment of the use occurs.

The Atlantic County Agriculture Development Board indicated that it is not aware of any abuses under the present rules; therefore, the Board feels the proposed policies are not needed.

The New Jersey Farm Bureau expressed some reservation about the non-conforming use amendments for structures that are essential to the farm business that may need expansion. It suggested that the rule is flexible enough in its definition of "farm structure" so that it is inclusive of all buildings needed for the farm business.

RESPONSE: In response to the Burlington County Agriculture Development Board's concern, the Committee feels that the proposed amendment does not require any further clarification. Pursuant to N.J.A.C. 2:76-3.12(a)18 and 4.11(a)18, the word "Grantor" shall mean any and all persons who lawfully succeed to the rights and responsibilities of the Grantor, including, but not limited to, the Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns. In addition, N.J.A.C. 2:76-3.12(a) and 4.11(a) already provide that the restrictions run with the land. The abandonment of the non-agricultural use is the critical factor whether it is done by the initial Grantor or successor.

In response to the Atlantic County Agriculture Development Board's comment, the proposed rule amendment is for the purpose of allowing a nonagricultural use which existed on the Premises at the time of the Grantor's submission of petition to the board to continue under certain conditions. Without this base line information, it becomes difficult to monitor the farm in the future to ensure compliance with the deed restrictions.

In response to the New Jersey Farm Bureau's comment, the landowner has the ability to construct and expand any building that is for an agricultural purpose without board and Committee review and approval. The proposed rule amendment only pertains to any new structures or the expansion of pre-existing structures for nonagricultural uses.

COMMENT: The Burlington County Agriculture Development Board supports the clarification which prohibits the use of deed restricted land for clearly nonagricultural recreational activities (ball fields, golf courses, etc.) as cited at N.J.A.C. 2:76-3.12(a)9 and 4.11(a)9. However, the board would recommend that the SADC consider such periodic activities as a horse show or farm equipment auction to be agricultural activities which are in compliance with the existing deed restriction. Such activities encourage investment in agriculture and create an opportunity for the agricultural community to provide a direct public benefit and service.

RESPONSE: The Board and Committee reserves the right to evaluate each recreational activity for compliance with the deed restrictions based on its own merits. The County Agriculture Development Board and Committee must use its discretion when evaluating recreational activities which are used to derive income on the Premises to ensure compliance with the deed restrictions. Any recreational activities that are used to derive income which do not interfere with the use of the land for agricultural production and only utilize the premises in its existing condition would be permitted under the deed restrictions.

COMMENT: The Burlington CADB does not endorse the proposed rule amendment as cited at N.J.A.C. 2:76-3.12(a)13 and 4.11(a)13, and feels that exclusion of the Grantor's children is prejudicial and arbitrary. In a threatened agricultural climate such as that of New Jersey, it does not seem appropriate to discourage the participation of family members, primarily children, from living on an agricultural operation if they are employed full time on the Premises. The Burlington CADB therefore recommends that the SADC reconsider this rule change to allow the Grantor to house his descendants in agricultural labor housing as long as the descendant is employed on the Premises year round, on a full-time basis.

A similar concern was expressed by the Hunterdon County Agriculture Development Board which stated that family members who live and work on the farm should not be discriminated against and should be treated the same as non-family members who also live and work on the farm.

The New Jersey Farm Bureau commented that the labor housing unit question when it involves farm family members can get complicated, especially in view of residual dwelling site opportunity allowances.

The Atlantic County Agriculture Development Board indicated that it is not aware of any abuses under the present rules; therefore, the Board feels that the proposed rules are not needed.

RESPONSE: The State Agriculture Development Committee has decided not to adopt this portion of the proposal at this time. The proposed amendment will remain open pending further study and review.

Full text of the adopted amendments follows:

2:76-3.12 Deed restrictions

(a) The following deed restrictions shall be agreed to by the board and the landowner(s) when a farmland preservation program is adopted and shall run with the land:

"Grantor promises that the Premises shall at all times for the term of the agreement be owned, used and conveyed subject to:

"1. (No change.)

"2. Grantor certifies that at the time of petitioning the Grantee to enter into a farmland preservation program the nonagricultural uses indicated on attached Schedule (C) existed on the Premises. All other nonagricultural uses are prohibited except as expressly provided in this agreement.

"3. All nonagricultural uses existing on the Premises at the time of the landowner's petition to the Grantee as set forth in Section 2 above may be continued and any structure may be restored or repaired in the event of partial destruction thereof, subject to the following:

i. No new structures or the expansion of pre-existing structures for nonagricultural use are permitted;

ii. No change in the pre-existing nonagricultural use is permitted;

iii. No expansion of the pre-existing nonagricultural use is permitted; and

iv. In the event that the Grantor abandons the pre-existing non-agricultural use, the right of the Grantor to continue the use is extinguished.

Recodify 2. and 3. as 4. and 5. (No change in text.)

"6. No sand, gravel, loam, rock, or other minerals shall be deposited on or removed from the Premises excepting only those materials required for the agricultural purpose for which the land is being used. Grantor retains and reserves all oil, gas, and other mineral rights in the land underlying the Premises, provided that any prospective drilling and/or mining will be done by slant from adjacent property or in any other manner which will not materially affect the agricultural operation.

Recodify 5. and 6. as 7. and 8. (No change in text.)

"9. Grantor may use the Premises to derive income from certain recreational activities such as hunting, fishing, cross country skiing and ecological tours, only if such activities do not interfere with the actual use of the land for agricultural production and that the activities only utilize the Premises in its existing condition. Other recreational activities from which income is derived and which alter the Premises, such as golf courses and athletic fields, are prohibited.

Recodify 8. and 9. as 10. and 11. (No change in text.)

"12. At the time of this conveyance, Grantor has (_____) existing single family residential building(s) on the Premises and (_____) residential buildings used for agricultural labor purposes. Grantor may use, maintain, and improve existing buildings on the Premises for agricultural, residential and recreational uses subject to the following conditions:

i.-iii. (No change.)

"13. Grantor may construct any new buildings for agricultural purposes. The construction of any new buildings which shall serve as a residential use, regardless of its purpose, shall be prohibited except as follows:

i.-iii. (No change.)

iv. The above exceptions shall not be permitted unless jointly approved in writing by the Grantee and the Committee. Approval for such exceptions shall only be granted upon the determination that the proposed construction would have a positive impact on the continued use of the Premises for agricultural production.

Recodify 12.-14. as 14.-16. (No change in text.)

"17. Grantor, Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns grants the Committee the first right and option to purchase the Premises in fee simple absolute in accordance with the provisions of N.J.S.A. 4:1C-1 et seq., as amended by P.L. 1989, c.28 and P.L. 1989, c.310. Grantor, Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns, agree to give the Committee written notice, by certified mail, that a contract of sale has been executed for the property. The notice shall set forth the terms and conditions of the executed contract of sale and shall have attached a copy of that contract. The notice of executed contract of sale shall also include any other information required by the Committee by regulation. The Committee may exercise its first right and option to purchase the Premises in fee simple absolute by complying with the provisions of N.J.S.A. 4:1C-1 et seq., as amended by P.L. 1989, c.28 and P.L. 1989, c.310.

Recodify 16.-19. as 18.-21. (No change in text.)

(b) (No change.)

(c) The deed restrictions contained in (a) above shall be liberally construed to effectuate the purpose and intent of the Farmland Preservation Bond Act, P.L. 1981, c.276, as amended by P.L. 1987, c.240, the Open Space Preservation Bond Act of 1989, P.L. 1989, c.183 and the Agriculture Retention and Development Act, N.J.S.A. 4:1C-11 et seq., P.L. 1983, c.32, as amended.

2:76-4.11 Deed restrictions

(a) The following deed restrictions shall be agreed to by the board and the landowner(s) when a municipally approved farmland preservation program is adopted and shall run with the land:

"Grantor promises that the Premises shall at all times for the term of the agreement be owned, used and conveyed subject to:

"1. (No change.)

"2. Grantor certifies that at the time of petitioning the Grantee to enter into a farmland preservation program the nonagricultural uses indicated on attached Schedule (C) existed on the Premises. All other nonagricultural uses are prohibited except as expressly provided in this agreement.

"3. All nonagricultural uses existing on the Premises at the time of the landowner's petition to the Grantee as set forth in Section 2 above may be continued and any structure may be restored or repaired in the event of partial destruction thereof, subject to the following:

i. No new structures or the expansion of pre-existing structures for nonagricultural use are permitted;

ii. No change in the pre-existing nonagricultural use is permitted;

iii. No expansion of the pre-existing nonagricultural use is permitted; and

iv. In the event that the Grantor abandons the pre-existing non-agricultural use, the right of the Grantor to continue the use is extinguished.

Recodify 2. and 3. as 4. and 5. (No change in text.)

"6. No sand, gravel, loam, rock, or other minerals shall be deposited on or removed from the Premises excepting only those materials required for the agricultural purpose for which the land is being used. Grantor retains and reserves all oil, gas, and other mineral rights in the land underlying the Premises, provided that any prospective drilling and/or mining will be done by slant from adjacent property or in any other manner which will not materially affect the agricultural operation.

Recodify 5. and 6. as 7. and 8. (No change in text.)

"9. Grantor may use the Premises to derive income from certain recreational activities such as hunting, fishing, cross country skiing and ecological tours, only if such activities do not interfere with the actual use of the land for agricultural production and that the activities only utilize the Premises in its existing condition. Other recreational activities from which income is derived and which alter the Premises, such as golf courses and athletic fields, are prohibited.

Recodify 8. and 9. as 10. and 11. (No change in text.)

"12. At the time of this conveyance, Grantor has (_____) existing single family residential building(s) on the Premises and (_____) residential buildings used for agricultural labor purposes. Grantor may use, maintain, and improve existing buildings on the Premises for agricultural, residential and recreational uses subject to the following conditions:

i.-iii. (No change.)

"13. Grantor may construct any new buildings for agricultural purposes. The construction of any new building which shall serve as a residential use, regardless of its purpose, shall be prohibited except as follows:

i.-iii. (No change.)

iv. The above exceptions shall not be permitted unless jointly approved in writing by the Grantee and the Committee. Approval for such exceptions shall only be granted upon the determination that the proposed construction would have a positive impact on the continued use of the Premises for agricultural production.

Recodify 12.-14. as 14.-16. (No change in text.)

"17. Grantor, Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns grants the Committee the first right and option to purchase the Premises in fee simple absolute in accordance with the provisions of N.J.S.A. 4:1C-1 et seq., as amended by P.L. 1989, c.28 and P.L. 1989, c.310. Grantor, Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns, agree to give the Committee written notice, by certified mail, that a contract of sale has been executed for the property. The notice shall set forth the terms and conditions of the executed contract of sale and shall have attached a copy of that contract. The notice of executed contract of sale shall also include any other information required by the Committee by regulation. The Committee may exercise its first right and option to purchase the Premises in fee simple absolute by complying with the provisions of N.J.S.A. 4:1C-1 et seq., as amended by P.L. 1989, c.28 and P.L. 1989, c.310.

Recodify 16.-19. as 18.-21. (No change in text.)

(b) (No change.)

(c) The deed restrictions contained in (a) above shall be liberally construed to effectuate the purpose and intent of the Farmland Preservation Bond Act, P.L. 1981, c.276, as amended by P.L. 1987, c.240, the Open Space Preservation Bond Act of 1989, P.L. 1989, c.183 and the Agriculture Retention and Development Act, N.J.S.A. 4:1C-11 et seq., P.L. 1983, c.32, as amended.

(a)

STATE AGRICULTURE DEVELOPMENT COMMITTEE

Acquisition of Development Easements

Adopted Amendment: N.J.A.C. 2:76-6.15

Proposed: March 16, 1992, at 24 N.J.R. 896(a).

Adopted: July 23, 1992 by the State Agriculture Development Committee, Arthur R. Brown, Chairperson.

Filed: July 24, 1992 as R.1992 d.324, **with a portion not adopted but still pending.**

Authority: N.J.S.A. 4:1C-5f.

Effective Date: August 17, 1992.

Expiration Date: July 31, 1994.

Summary of Agency Action:

On May 21, 1992, the State Agriculture Development Committee, Arthur R. Brown, Jr., Chairperson, pursuant to the authority of N.J.S.A. 4:1C-5f and in accordance with the applicable provisions of the Administrative Procedure Act, adopted amendments to be cited as N.J.A.C. 2:76-6.15(a)1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14ii, 15, 16, 17, 18, 19, 20, 21 and 22 concerning the acquisition of development easements as proposed in the Notice published in the New Jersey Register, March 16, 1992, at 24 N.J.R. 896(a).

In addition, the adopted amendments result in the recodification of several paragraphs without change in text.

The proposed amendment to N.J.A.C. 2:76-6.15(a)14i is not hereby adopted but remains open for further study and review by the State Agriculture Development Committee.

Summary of Public Comment and Agency Response:

COMMENT: The Burlington County Agriculture Development Board supports the amendments as proposed with regard to identifying any pre-existing nonagricultural development occurring on the premises as cited at N.J.A.C. 2:76-6.15(a)3, but suggests that the State Agriculture Development Committee (SADC) clarify whether the pre-existing non-agricultural use can continue to be used by a successive owner of the property, as has been suggested. It should be made clear that the restriction runs with the land until abandonment of the use occurs.

The Atlantic County Agriculture Development Board indicated that it is not aware of any abuses under the present rules; therefore, the Board feels the proposed policies are not needed.

The New Jersey Farm Bureau expressed some reservation about the non-conforming use amendments for structures that are essential to the farm business that may need expansion. It suggested that the rule is flexible enough in its definition of "farm structure" so that it is inclusive of all buildings needed for the farm business.

RESPONSE: In response to the Burlington County Agriculture Development Board's concern, the Committee feels that the proposed amendment does not require any further clarification. Pursuant to N.J.A.C. 2:76-6.15(a)20, the word "Grantor" shall mean any and all persons who lawfully succeed to the rights and responsibilities of the Grantor, including, but not limited to, the Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns. In addition, N.J.A.C. 2:76-6.15(a)18 already provides that the restrictions run with the land. The abandonment of the nonagricultural use is the critical factor whether it is done by the initial Grantor or successor.

In response to the Atlantic County Agriculture Development Board's comment, the proposed rule amendment is for the purpose of allowing a nonagricultural use which existed on the Premises at the time of the Grantor's application to the board to continue under certain conditions. Without this base line information, it becomes difficult to monitor the farm in the future to ensure compliance with the deed restrictions.

In response to the New Jersey Farm Bureau's comment, the landowner has the ability to construct and expand any building that is for an agricultural purpose without board and Committee review and approval. The proposed rule amendment only pertains to any new structures or the expansion of pre-existing structures for nonagricultural uses.

COMMENT: The Burlington County Agriculture Development Board supports the clarification which prohibits the use of deed restricted land for clearly nonagricultural recreational activities (ball fields, golf courses, etc.) as cited at N.J.A.C. 2:76-6.15(a)9. However, the board would recommend that the SADC consider such periodic activities as a horse show or farm equipment auction to be agricultural activities which are in compliance with the existing deed restriction. Such activities encourage investment in agriculture and create an opportunity for the agricultural community to provide a direct public benefit and service.

RESPONSE: The Board and Committee reserves the right to evaluate each recreational activity for compliance with the deed restrictions based on its own merits. The County Agriculture Development Board and Committee must use its discretion when evaluating recreational activities which are used to derive income on the Premises to ensure compliance with the deed restrictions. Any recreational activities that are used to derive income which do not interfere with the use of the land for agricultural production and only utilize the premises in its existing condition would be permitted under the deed restrictions.

COMMENT: The Burlington CADB does not endorse the proposed rule amendment as cited at N.J.A.C. 2:76-6.15(a)14, and feels that exclusion of the Grantor's children is prejudicial and arbitrary. In a threatened agricultural climate such as that of New Jersey, it does not seem appropriate to discourage the participation of family members, primarily children, from living on an agricultural operation if they are employed full time on the Premises. The Burlington CADB therefore recommends that the SADC reconsider this rule change to allow the Grantor to house his descendants in agricultural labor housing as long as the descendant is employed on the Premises year round, on a full-time basis.

A similar concern was expressed by the Hunterdon County Agriculture Development Board which stated that family members who live and work on the farm should not be discriminated against and should be treated the same as non-family members who also live and work on the farm.

The New Jersey Farm Bureau commented that the labor housing unit question when it involves farm family members can get complicated, especially in view of residual dwelling site opportunity allowances.

The Atlantic County Agriculture Development Board indicated that it is not aware of any abuses under the present rules; therefore, the Board feels that the proposed rules are not needed.

RESPONSE: The State Agriculture Development Committee has decided not to adopt this portion of the proposal at this time. The proposed amendment will remain open pending further study and review.

Full text of the adopted amendment follows:

2:76-6.15 Deed restrictions

(a) The following statement shall be attached to and recorded with the deed of the land and shall run with the land: "Grantor promises that the Premises shall be owned, used and conveyed subject to:

"1. Any development of the Premises for non-agricultural purposes is expressly prohibited.

"2. The Premises shall be retained for agricultural use and production in compliance with N.J.S.A. 4:1C-11 et seq., P.L.1983, c.32, and all other rules promulgated by the State Agriculture Development Committee, (hereinafter Committee). Agricultural use shall mean the use of the Premises for common farmsite activities including, but not limited to production, harvesting, storage, grading, packaging, processing and the wholesale and retail marketing of crops, plants, animals and other related commodities and the use and application of techniques and methods of soil preparation and management, fertilization, weed, disease and pest control, disposal of farm waste, irrigation, drainage and water management, and grazing.

"3. Grantor certifies that at the time of the application to sell the development easement to the Grantee the nonagricultural uses indicated on attached Schedule (B) existed on the Premises. All other nonagricultural uses are prohibited except as expressly provided in this Deed of Easement.

"4. All nonagricultural uses, if any, existing on the Premises at the time of the landowner's application to the Grantee as set forth

in Section 3 above may be continued and any structure may be restored or repaired in the event of partial destruction thereof, subject to the following:

i. No new structures or the expansion of pre-existing structures for nonagricultural use are permitted;

ii. No change in the pre-existing nonagricultural use is permitted.

iii. No expansion of the pre-existing nonagricultural use is permitted; and

iv. In the event that the Grantor abandons the pre-existing non-agricultural use, the right of the Grantor to continue the use is extinguished.

"5. No sand, gravel, loam, rock, or other minerals shall be deposited on or removed from the Premises excepting only those materials required for the agricultural purpose for which the land is being used. Grantor retains and reserves all oil, gas, and other mineral rights in the land underlying the Premises, provided that any prospective drilling and/or mining will be done by slant from adjacent property or in any other manner which will not materially affect the agricultural operation.

"6. (No change in text.)

"7. No activity shall be permitted on the Premises which would be detrimental to drainage, flood control, water conservation, erosion control, or soil conservation, nor shall any other activity be permitted which would be detrimental to the continued agricultural use of the Premises.

"8. Grantee and Committee and their agents shall be permitted access to, and to enter upon, the Premises at all reasonable times, but solely for the purpose of inspection in order to enforce and assure compliance with the terms and conditions of this Deed of Easement. Grantee agrees to give Grantor, at least 24 hours advance notice of its intention to enter the Premises, and further, to limit such times of entry to the daylight hours on regular business days of the week.

"9. Grantor may use the Premises to derive income from certain recreational activities such as hunting, fishing, cross country skiing and ecological tours, only if such activities do not interfere with the actual use of the land for agricultural production and that the activities only utilize the Premises in its existing condition. Other recreational activities from which income is derived and which alter the Premises, such as golf courses and athletic fields, are prohibited.

"10. Nothing shall be construed to convey a right to the public of access to or use of the Premises except as stated in this Deed of Easement or as otherwise provided by law.

"11. Nothing shall impose upon the Grantor any duty to maintain the Premises in any particular state, or condition, except as provided for in this Deed of Easement.

"12. Nothing in this Deed of Easement shall be deemed to restrict the right of Grantor to maintain all roads and trails existing upon the Premises as of the date of this Deed of Easement. Grantor shall be permitted to construct, improve or reconstruct any roadway necessary to service crops, bogs, agricultural buildings, or reservoirs as may be necessary.

"13. (No change in text.)

"14. Grantor may construct any new buildings for agricultural purposes. The construction of any new buildings for residential use, regardless of its purpose, shall be prohibited except as follows:

i. To provide structures for housing of agricultural labor employed on the Premises but only with the approval of the Grantee and the Committee. If Grantee and the Committee grant approval for the construction of agricultural labor housing, such housing shall not be used as a residence for Grantor; and

ii. To construct a single family residential building anywhere on the Premises in order to replace any single family residential building in existence at the time of conveyance of this Deed of Easement but only with the approval of the Grantee and Committee.

"15. The land and its buildings which are affected may be sold collectively or individually for continued agricultural use as defined in Section 2 of this Deed of Easement. However, no subdivision of the land shall be permitted without the joint approval in writing of the Grantee and the Committee. In order for the Grantor to receive approval, the Grantee and Committee must find that the subdivision shall be for an agricultural purpose and result in agriculturally viable parcels. Subdivision means any division of the Premises, for any purpose, subsequent to the effective date of this Deed of Easement.

"16. In the event of any violation of the terms and conditions of this Deed of Easement, Grantee or the Committee may institute, in the name of the State of New Jersey, any proceedings to enforce these terms and conditions including the institution of suit to enjoin such violations and to require restoration of the Premises to its prior condition. Grantee or the Committee do not waive or forfeit the right to take any other legal action necessary to insure compliance with the terms, conditions, and purpose of this Deed of Easement by a prior failure to act.

"17. This Deed of Easement imposes no obligation or restriction on the Grantor's use of the Premises except as specifically set forth in this Deed of Easement.

"18. This Deed of Easement is binding upon the Grantor, the Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns and the Grantee; it shall be construed as a restriction running with the land and shall be binding upon any person to whom title to the Premises is transferred as well as upon the heirs, executors, administrators, personal or legal representatives, successors, and assigns of all such persons.

"19. Throughout this Deed of Easement, the singular shall include the plural, and the masculine shall include the feminine, unless the text indicates otherwise.

"20. The word 'Grantor' shall mean any and all persons who lawfully succeed to the rights and responsibilities of the Grantor, including but not limited to the Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns.

"21. Wherever in this Deed of Easement any party shall be designated or referred to by name or general reference, such designation shall have the same effect as if the words, 'heirs, executors, administrators, personal or legal representatives, successors and assigns' have been inserted after each and every designation.

"22. Grantor, Grantor's heirs, executors, administrators, personal or legal representatives, successors and assigns further transfers and conveys to Grantee all of the non-agricultural development rights and development credits appurtenant to the lands and Premises described herein. Nothing contained herein shall preclude the conveyance or retention of said rights by the Grantee as may be permitted by the laws of the State of New Jersey in the future. In the event that the law permits the conveyance of said development rights, Grantee agrees to reimburse the Committee (_____) percent of the value of the development rights as determined at the time of the subsequent conveyance."

(b)-(d) (No change.)

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Capital Requirements, Depository Institutions

Adopted New Rules: N.J.A.C. 3:4

Proposed: May 4, 1992 at 24 N.J.R. 1665(a).
Adopted: July 27, 1992 by Jeff Connor, Commissioner, Department of Banking.
Filed: July 27, 1992 as R.1992 d.326, **without change.**

Authority: N.J.S.A. 17:1-8.1.

Effective Date: August 17, 1992.
Expiration Date: August 17, 1997.

Summary of Public Comments and Agency Responses:

The Department received comments from the following persons:

1. Ronald D. Watson, Chief Executive Officer, Custodial Trust Company.

2. James R. Silkensen, Executive Vice President, New Jersey Savings League.

3. John F. Kuntz, Executive Vice President and General Counsel, The Howard Savings Bank.

A **summary** of the comments received and responses of the Department follows:

COMMENT: It is important that the Department, as the primary regulator of New Jersey state-chartered depository institutions, be afforded enforcement and supervisory mechanisms over depository institutions subject to its supervision similar to those maintained by federal regulators of depository institutions. However, the standards set forth in the proposed rule for defining an unsafe condition and an unsafe and unsound manner are overly rigid and do not give the Commissioner adequate discretion. There may be facts and circumstances upon which the Commissioner could choose to make a determination that an under-capitalized depository institution is not, for example, in an unsafe condition.

RESPONSE: The Department generally views a depository institution with a ratio of Tier 1 capital to total assets of less than two percent to be in an unsafe condition. However, this does not mean that the Commissioner is without discretion once this level is attained. As the commenter notes, the rule permits the Commissioner to enter into a written agreement with the depository whereby the depository agrees to increase its capital ratio and take other action as may be necessary. In addition, the Commissioner is authorized, but not directed, to take possession of the property and business of a depository which is in an unsafe or unsound condition to transact business. See N.J.S.A. 17:9A-269 and 17:12B-179.

Accordingly, since the Commissioner already has discretion, no change is made based on this comment.

COMMENT: Seizing a well-run financial institution that is making progress on its capital plan merely because it has not been given an adequate period of time to achieve more stringent capital requirements of the State would be imprudent, not to mention expensive, for New Jersey, the FDIC and taxpayers. Further, the authority to seize institutions with less than 2 percent capital should be exercised with great caution and in close cooperation with federal authorities.

RESPONSE: As noted above, the Department has discretion once it is determined under this rule that an institution is in an unsafe condition. The Department agrees that seizing under-capitalized institutions should be initiated cautiously and in cooperation with federal regulators, and will continue to exercise this caution after adoption of this rule.

COMMENT: The Department of Banking may currently rely on the FDIC and OTS capital guidelines to enforce a minimum leverage ratio, where appropriate, in supervising financial institutions. However, if the leverage ratio is phased out by federal supervisors over the next couple of years, it would be inconvenient for the Department of Banking to be obliged by its own regulations to enforce such ratios.

RESPONSE: The Department will review these capital standards as changes in the federal standards are proposed or adopted by Congress or federal regulators. Should the Department deem it necessary to change the capital requirements, the Administrative Procedures Act allows such changes to be made without undue delay.

Full text of the adopted new rules follows:

CHAPTER 4
DEPOSITORY INSTITUTIONS

SUBCHAPTER 1. CAPITAL REQUIREMENTS

3:4-1.1 Definitions

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

"Bank" shall have the meaning ascribed to it in N.J.S.A. 17:9A-1.

"Capital stock association" shall have the meaning ascribed to it in N.J.S.A. 17:12B-244.

"Capital stock savings bank" shall have the meaning ascribed to it in N.J.S.A. 17:9A-8.1.

"Classified assets" means assets, or portions thereof, which have a well defined weakness or weaknesses attributable to the unfavorable record of the obligor, insufficiency of security, or other factors noted in the examiners comments.

"Depository institution" shall mean a bank, savings bank, capital stock savings bank, capital stock association or mutual association.

"Mutual association" shall have the meaning ascribed to it in N.J.S.A. 17:12B-5.

"Qualifying capital" shall have the same meanings ascribed to it in Appendix A to 12 C.F.R. Part 325.

"Risk weighted assets" for a bank and savings bank shall have the meaning ascribed to it in Appendix A to 12 C.F.R. Part 325, and for a savings and loan association shall have the meaning ascribed to it in 12 C.F.R. 567.6.

"Savings bank" shall have the meaning ascribed to it in N.J.S.A. 17:9A-1(13).

"Tier 1 capital" shall have the meaning ascribed to it in 12 C.F.R. §325.2(m).

"Total assets" shall have the meaning ascribed to it in 12 C.F.R. §325.2(n).

3:4-1.2 Minimum leverage capital requirement

(a) The minimum leverage capital for a depository institution shall be a ratio of Tier 1 capital to total assets of four percent.

(b) Notwithstanding (a) above, the Commissioner may establish for a depository institution a minimum ratio of Tier 1 capital to total assets of more than four percent based on the following factors:

1. The financial history and condition of a depository institution, and its future earnings prospects;
2. The managerial resources of the depository institution;
3. The funding and liquidity of the depository institution;
4. The interest-rate risk exposure of the depository institution;
5. The concentration of assets of the depository institution; and/or
6. The volume of assets classified as substandard, doubtful or loss, or subject to special mention.

3:4-1.3 Minimum risk-based capital requirement

A depository institution shall maintain qualifying capital of at least eight percent of its risk weighted assets. At least four percent of this qualifying capital shall be in the form of Tier 1 capital.

3:4-1.4 Unsafe operations

(a) A depository institution which has leverage capital and/or risk-based capital below the minimum required levels shall be deemed to be operating in an unsafe or unsound mannner for purposes of N.J.S.A. 17:9A-266 et seq., and N.J.S.A. 17:12B-177 et seq.

(b) A depository institution which has entered into and is in compliance with a written agreement with the Department of Banking or has submitted to the Department of Banking and is in compliance with a plan approved by the Department of Banking to increase its capital ratios to such levels as the Department deems appropriate and to take such other action as may be necessary for the depository institution to be operated so as not to be engaged in such an unsafe or unsound practice will not be deemed to be engaged in an unsafe or unsound practice on account of its capital ratios.

(c) Notwithstanding (a) above, the Department of Banking is not precluded from taking any authorized action against a depository institution with capital above the minimum requirements if the specific circumstances deem such action to be appropriate.

3:4-1.5 Unsafe condition

(a) A depository institution which has a ratio of Tier 1 capital to total assets of less than two percent shall be deemed to be in an unsafe condition for purposes of N.J.S.A. 17:9A-269 or N.J.S.A. 17:12B-179.

(b) A depository institution which has entered into and is in compliance with a written agreement with the Department of Banking to increase its capital ratios to such levels as the Department deems appropriate and to take such other action as may be necessary for the depository institution to be operated in a safe and sound manner will not be deemed to be an unsafe condition on account of its capital ratio.

(c) Notwithstanding (a) above, the Department of Banking is not precluded from taking action against a depository institution which has a ratio of Tier 1 capital to total assets equal to or greater than two percent if the depository institution is otherwise in an unsafe condition, or such action is otherwise authorized.

(a)

DIVISION OF REGULATORY AFFAIRS

Debt Adjustment and Credit Counseling

Adopted Readoption with Amendments: N.J.A.C. 3:25

Proposed: June 15, 1992 at 24 N.J.R. 2106(a).
Adopted: July 21, 1992 by Jeff Connor, Commissioner, Department of Banking.
Filed: July 23, 1992 as R.1992 d.323, **without change.**

Authority: N.J.S.A. 17:1-8.1, 17:1-8.9, 17:16G-4, 5 and 6.

Effective Date: July 23, 1992, Readoption; August 17, 1992, Amendments and New Rules.
Expiration Date: July 23, 1997.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption may be found in the New Jersey Administrative Code at N.J.A.C. 3:25.

Full text of the adopted amendments and new rules follows:

SUBCHAPTER 1. DEBT ADJUSTMENT AND CREDIT COUNSELING FEES

3:25-1.1 Definitions

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

"Act" means P.L.1979, c.16.

"Billing cycle" means the period between successive billing dates, when the client is charged by the licensee. For the purpose of determining the maximum amount of the fees which may be charged, it is assumed that the length of the billing period is approximately 30 days. If the billing cycle is substantially longer or shorter than 30 days, the amount of the maximum fee which may be charged shall be adjusted accordingly.

...

"Commissioner" means the Commissioner of Banking.

...

"Debt adjustment" means either acting or offering to act for a consideration as an intermediary between a debtor and his creditors for the purpose of settling, compounding, or otherwise altering the terms of payment of any debts of the debtor, or, to that end, receiving money or other property from a debtor, or on behalf of the debtor, for payment to, or distribution among, the creditors of the debtor, but shall not include the activities of an attorney-at-law of this State who is not principally engaged as a debt adjuster, a person who is a regular full-time employee of a debtor and who acts as an adjuster of his or her employer's debts, a person acting pursuant by any order or judgment of court, or pursuant to authority conferred by any law of this State or the United States, a person which is a creditor of the debtor or an agent of one or more creditors of the debtor and whose services in adjusting the debtor's debts are rendered without cost to the debtor, or a person who at the request of a debtor arranges for or makes a loan to the debtor and who at the authorization of the debtor acts as an adjuster of the debtor's debts in the disbursement of the proceeds of the loan without compensation for the services rendered in adjusting those debts.

"Debtor" means an individual debtor or two or more individuals who are jointly and severally indebted.

"Department" means the Department of Banking.

"Licensee" means an agency licensed to provide debt adjustment and credit counseling services pursuant to N.J.S.A 17:16G-2.

"Office" shall include a principal office and a branch office.

3:25-1.2 Debt adjustment fees

The maximum fee that may be charged by a licensee to a client for debt adjustment services is $25.00 per billing cycle.

3:25-1.3 Credit counseling fees

The maximum fee that may be charged by a licensee to a client for credit counseling services is $60.00 per billing cycle.

3:25-1.4 Prior notice

With respect to the fees that may be charged pursuant to this subchapter, it is the responsibility of the licensee to provide to the client in writing, prior to providing any debt adjustment or consumer credit counseling service, a statement of the fees to be charged.

SUBCHAPTER 2. OFFICES, LICENSING, BONDS, INVESTIGATIONS, EXAMINATIONS

3:25-2.1 Principal and branch offices

(a) A licensee shall establish a place of business in this State which shall be designated as the principal office. The license for the principal office shall be prominently displayed in the public area of the office.

(b) In addition to the principal office, an applicant or licensee may establish a branch office or offices elsewhere in this State for the conduct of debt adjusting and credit counseling activities. The license for the branch office shall be prominently displayed in the public area of the office.

(c) An applicant shall apply for a principal office license and may apply for a branch office license by making application to the Department. A licensee may apply for a branch office license by making application to the Department. Such application shall be made on forms as prescribed by the Commissioner and shall include, but shall not be limited to, the name of the applicant or licensee, the location of the proposed principal or branch office, the license fee for each office, and proof of bond in the amount set forth in N.J.A.C. 3:25-2.3. The Commissioner shall issue the license upon determining that the applicant is qualified to be licensed and possesses the necessary financial resources to sustain its operation.

(d) No licensee shall engage in debt adjusting or credit counseling activities at an office until it has received a license for that office.

3:25-2.2 License fees

Each licensee shall pay to the Department a biennial license fee of not more than $500.00 for each office it maintains. The fee shall be due on January 1 of each even numbered calendar year. When the initial license or certificate is issued in the second year of the biennial period, the fee shall be an amount equal to one-half the fee for the biennial period.

3:25-2.3 Bond

(a) A licensee shall maintain a bond in an amount not less than $50,000 for each principal office and $25,000 for each branch office from a surety company authorized to do business in this State. The bond shall run to the State, pro rata, for its benefit and for the benefit of all consumers injured by the wrongful act, omission, default, fraud or misrepresentation of the licensee in the course of activity as a licensee. The bond shall not be payable for claims made by business creditors. No bond shall comply with this section unless it contains a provision that it shall not be cancelled for any cause unless notice of intention to cancel is filed with the Department at least 30 days before the day upon which cancellation shall take effect.

(b) Those persons who hold a license pursuant to the Act on August 17, 1992 shall not be required to comply with this section until October 16, 1992.

3:25-2.4 Refusal to issue, revocation and suspension of licenses

(a) The Commissioner may revoke or suspend a license if, after notice and hearing conducted in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, the Commissioner determines that the licensee:

1. Has violated any provision of the Act or any order rule or regulation issued pursuant to the Act;

2. Has failed to pay any fee, penalty, or other lawful levy imposed by the Commissioner;

3. Has withheld information or made a material misstatement in an application for a license or in any other submission to the Department;

4. Has been convicted of an offense involving breach of trust, moral turpitude or fraudulent or dishonest dealing, or has had a

final judgment entered against him or her in a civil action upon grounds of fraud, misrepresentation or deceit;

5. Is associating with, or has associated with, any person who has been convicted of an offense involving breach of trust, moral turpitude or fraudulent or dishonest dealing, or who has had a final judgment entered against him or her in a civil action upon grounds of fraud, misrepresentation or deceit;

6. Has become insolvent or has acted in a way that indicates that the licensee's debt adjustment and credit counseling business would not be operated in a financially responsible manner;

7. Has demonstrated unworthiness, incompetence, bad faith or dishonesty in transacting business or otherwise; or

8. Has engaged in any other conduct which would be deemed by the Commissioner to be grounds to deny a license.

(b) The Commissioner may refuse to issue a license for any reason for which he or she could revoke or refuse to renew a license.

3:25-2.5 Right of investigation and examination

The Commissioner may make such investigations and examinations of any licensee or other person as he or she deems necessary to determine compliance with the Act, regulations issued pursuant to the Act, or orders. For such purposes, he or she may examine, or compel by subpoena, the production of all relevant books, records, and other documents and materials relative to an examination or investigation. The costs of examination shall be borne by the licensee.

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Administration Chapter
Basic Requirements for Recipients and Providers
Adopted Repeal and New Rules: N.J.A.C. 10:49

Proposed: May 4, 1992 at 24 N.J.R. 1728(b).
Adopted: July 13, 1992 by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: July 14, 1992 as R.1992 d.317, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).
Authority: N.J.S.A. 30:4D-1; Section 1901-1930 of the Social Security Act, codified as 42 U.S.C. 1396 et seq; Title 42 C.F.R.
Effective Date: August 17, 1992.
Expiration Date: August 17, 1997.

Summary of Public Comments and Agency Responses:

There were two comments submitted from associations that represent nursing facilities. One commenter was Leonard Fishman, Esq., representing the New Jersey Association of Non-Profit Homes for the Aging (NJANPHA). The second commenter was James E. Cunningham, President, New Jersey Association of Health Care Facilities.

Both commenters had a similar request that the proposed regulations (N.J.A.C. 10:49-7.3(c) and (e)) governing third party liability (TPL) be amended to mandate Medicaid payment in full of the Medicare co-insurance for Medicare/Medicaid patients in nursing homes.

Both commenters stated that their objections to this limitation concerning payments to nursing homes, citing a recent U.S. Court of Appeals, Second Circuit, decision (*New York City Health & Hospital Corp. v. Perales,* Dkt. No. 91-6123, 2nd. Cir. February 3, 1992) which indicates that States must pay the Medicare cost-sharing amounts for Qualified Medicare Beneficiaries who are dually eligible to receive benefits under both programs. Additionally, they state that the Medicare rate includes payment for additional items for which Medicaid pays separately to other providers.

The agency's response is that N.J.A.C. 10:49-7.3(e)1i states that for dual Medicare/Medicaid eligibles, the program shall supplement Medicare payments to providers to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid program in the absence of other coverage. This is based upon the statutory authority (N.J.S.A. 30:4D-7) in the New Jersey Medical Assistance and Health Services Act which empowers the Commissioner to adopt fee schedules with regard to medical assistance benefits. This is not countermanded by a decision in a U.S. Court of Appeals for a jurisdiction that does not include New Jersey, which is in the Third Circuit.

Mr. Fishman also commented on N.J.A.C. 10:49-13.2(b) which defines "final audit," for the purposes of N.J.S.A. 30:4D-7m only, as the point in the audit process when the Division issues the provider an audit report specifically designated as the final audit. The definition of final audits important because N.J.S.A. 30:4D-7m requires interest payments on any amount found by final audit to be owing to a provider if not paid within 45 days of the final audit. The commenter contends that the definition of final audit in N.J.A.C. 10:49-13.2(b) would defeat the purpose of N.J.S.A. 30:4D-7m since the Division could avoid interest by delaying issuance of the report designated "final audit" until the check is drawn for the amount owed to the provider. Instead, they suggest that the Division use an "objective standard" to define "final audit."

The Division's position is that the concern of the NJANPHA regarding the definition of "final audit" in N.J.A.C. 10:49-13.2(b) as it relates to N.J.S.A. 30:4D-7m regarding interest owing to a nursing facility provider for a net final audited underpayment amount is of no practical significance. N.J.A.C. 10:63-1.23 provides that the final audited per diem rates cannot exceed the prospective rates originally paid tor a provider. Consequently, audits of nursing facilities cannot result in the determination of an underpayment requiring additional reimbursement to a provider for which interest need be calculated. Furthermore, it should be emphasized, that even if it was possible for there to be a recognized underpayment based on audit, the issue of interest in that situation would be almost entirely hypothetical, since, as stated in the interest section of the State Medicaid statute, N.J.S.A. 30:4D-7m: "This subsection shall not apply until federal financial participation is available for such payments;". For the above stated reasons, the Division regards the current wording of N.J.A.C. 10:49-13.2(b) as adequate.

Summary of Changes Between Proposal and Adoption:

The Department and the Division are making the following changes upon adoption which are not in violation of N.J.A.C. 1:30-4.3. Some of the changes are necessary to insure that the text of the Administration Chapter, N.J.A.C. 10:49, is consistent with existing Federal and/or State law or regulations. These changes will be discussed in more detail than those which are corrections to language, terminology, or nomenclature.

N.J.A.C. 10:49-3.2(g): The word "not" has to be inserted to indicate that the Division cannot enter into a provider agreement with a suspended or excluded provider. The language in the proposed new rule is similar to the existing text of N.J.A.C. 10:49-1.17(a)26 which contains a prohibition of non-participation if the provider is suspended or excluded from Title XVIII (Medicare), Title XIX (Medicaid) or Title XX of the Federal Social Security Act. Both the existing text and this adopted text are based upon 1902(a)39 of the Social Security Act, 42 U.S.C. 1396a.

N.J.A.C. 10:49-19.10(e): The word "if" must be deleted and the word "of" inserted to be consistent with Federal law, 1903(m)(5)(A)(B) of the Social Security Act, 42 U.S.C. 1396B(m)(5)(A)(B).

N.J.A.C. 10:49-10.4 and 10.8: There are three corrections in the subchapter concerning hearings. The word "adequately" was changed to "adequate" for grammatical reasons. The word "discounted" was changed to "discontinued" to be consistent with Federal regulations (42 C.F.R. 230) which describes the conditions under which Medicaid benefits can be continued during the pendency of the hearing. If the claimant's whereabouts are unknown, Medicaid benefits would be "discontinued" (N.J.A.C. 10:49-10.4(a)2 and (e)).

The Division is also amending N.J.A.C. 10:49-10.8 to clearly indicate in the text of the Administration Chapter that while all hearings are governed by the Uniform Administrative Procedure Rules promulgated by the Office of Administrative Law (OAL) (N.J.A.C. 1:1), the special OAL Hearing Rules in N.J.A.C. 1:10B apply to recipient hearings, not provider hearings. The language in the adopted text of N.J.A.C. 10:49-10.8 will now parallel the existing OAL text of N.J.A.C. 1:10B-1.1.

N.J.A.C. 10:49-21.2(a)4 and 5: With respect to eligibility requirements governing the Pharmaceutical Assistance to the Aged and Disabled Programs (PAAD), the "or" must be deleted and replaced with the word "and." The PAAD statute prohibits a person from qualifying for this state-funded pharmaceutical program if said person is receiving Medicaid (Title XIX) or has their own private health insurance policy which is equal to, or better than, PAAD.

The Division believes that these changes discussed above are not sufficiently substantive to require republication because they do not enlarge or curtail who or what will be affected nor will the changes affect what is being prescribed, proscribed or mandated. The rationale for this statement is that all changes are necessary to make the adopted text of N.J.A.C. 10:49 consistent with existing Federal and/or State laws and/or regulations previously cited.

The following changes are technical changes of a minor nature which do not change the nature, scope or impact of this rule being submitted for adoption. The changes are listed for the record.

Citation—Nature of Correction

N.J.A.C. 10:49-2.6—Telephone number corrected.

N.J.A.C. 10:49-2.10—The word "care" is being deleted. The word "case"is being added to be consistent with the first sentence (see N.J.A.C. 10:49-2.10(b)2).

The word "needed" is being deleted and the word "needy" is being added next to program category 15 (Aged) to be consistent with program Category 25 (Disabled) (see N.J.A.C. 10:49-2.10(c)).

N.J.A.C. 10:49-2.14—The phrase "for covered health" services is being deleted to avoid redundancy.

N.J.A.C. 10:49-9.4—It is necessary to recodify the second subsection (b) as (c) to avoid duplication.

N.J.A.C. 10:49-19.1—The Federal regulatory citation needs to be changed to 42 CFR 447.362.

N.J.A.C. 10:49-19.3—The section captioned "Benefits" has to be recodified from N.J.A.C. 10:49-19.4 (in the proposed text) to N.J.A.C. 10:49-19.3 in this adopted text to insure sequential numbering.

In addition, the word "active" must be deleted and the word "acute" added to indicate the appropriate level of care. The adopted text will now clearly indicate that in a prepaid health program, services are not available in an inpatient psychiatric institution that is not an acute care hospital to individuals under age 65 and over age 21 (see N.J.A.C. 10:49-19.3(d)7 in the adopted text).

N.J.A.C. 10:49-20.2—The word "unity" is being deleted and replaced with the word "entity" for clarification.

N.J.A.C. 10:49-23.1—Form 6, which is FD-152, not FD-172, is being printed in the adoption and corrected in the introduction. Form 14 is being revised to read Garden State Health Plan conditions for membership.

Form 17 had been revised and a new form provided. The Suburban Essex MDO has been closed and is deleted from the list. Both the Morris and Bergen MDO's have new telephone numbers.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

CHAPTER 49
ADMINISTRATION

SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.1 Scope and purpose

The Division of Medical Assistance and Health Services, under the Department of Human Services, administers the New Jersey Medicaid Program and other special programs. This chapter provides general and specific information about the regular Medicaid Program; special Medicaid services or programs (such as HealthStart, Prepaid Health Plans, and Waivered Programs); and other special (State) funded programs.

10:49-1.2 The Medicaid Program: definitions, organizations, services and eligibility

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

"Medicaid" means medical assistance provided to certain persons with low income and limited resources as authorized under Title XIX (Medicaid) of the Social Security Act.

"County welfare agency" means that agency of county government which is charged with the responsibility for determining eligibility for public assistance programs including Aid to Families with Dependent Children, the Food Stamp Program, and Medicaid. Depending on the county, the county welfare agency might be identified as the board of social services, the welfare board, the division of welfare, or the division of social services.

"Fiscal Agent" means an entity that processes and adjudicates provider claims on behalf of the New Jersey Medicaid Program, other Special Programs, and the Pharmaceutical Assistance to the Aged and Disabled Program.

"Provider" means any individual, partnership, association, corporation, institution, or any other public or private entity, agency, or business concern, meeting applicable requirements and standards for participation in the New Jersey Medicaid Program, other Special Programs and the Pharmaceutical Assistance to the Aged and Disabled Program, and where applicable, holding a current valid license, and lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D-1 et seq. and amendments thereto.

"Recipient" means a person who is a resident of the State of New Jersey and is determined to need medical care and services under N.J.S.A. 30:4D-1 et seq. and amendments thereto, and falls within the eligibility criteria set forth therein.

(b) Regarding the organization of the Division of Medical Assistance and Health Services, the Department of Human Services is the single State agency for receipt of Federal funds under Title XIX (Medicaid) of the Social Security Act. The Division of Medical Assistance and Health Services, Department of Human Services, administers the New Jersey Medicaid Program through its Central Office and through Medicaid District Offices (MDO) located throughout the State of New Jersey. A listing of the MDOs is provided in the chapter Appendix.

1. The Program is jointly financed by the Federal and State governments and administered by the State. The New Jersey Medicaid Program is conducted according to the Medicaid State Plan approved by the Secretary, United States Department of Health and Human Services.

(c) Regarding Medicaid Program services and eligibility, the New Jersey Medicaid Program became effective January 1, 1970 (P.L. 1968, c.413; codified as N.J.S.A. 30:4D-1 et seq.). The Program originally provided a broad array of medical services for individuals (aged, or blind, or disabled, or specified members of families with dependent children) categorically eligible for public assistance under the Social Security Act. Since then Medicaid coverage has been extended to the following:

1. Individuals who qualify under the Medically Needy provisions, codified as N.J.S.A. 30:4D-6(g);

2. Pregnant women and children (up to the age of six) whose income is less than 133 per cent of the Federal poverty level, codifed as N.J.S.A. 30:4D-3(i)(9). These individuals are determined by the County Welfare Agency to be eligible for the New Jersey Care ... Special Medicaid Programs;

3. Pregnant women and children (up to the age of one) whose income is less than 185 percent of the Federal poverty level, codified as N.J.S.A. 30:4D-3(i)(13); and

4. Individuals 65 years of age and older, or individuals who are blind or disabled (pursuant to Federal regulations either 42 CFR 435.530 et seq. or 42 CFR 455.540 et seq.) whose income cannot exceed 100 percent of the Federal poverty level adjusted for family size. These individuals are determined by the county welfare agency to be eligible for the New Jersey Care ... Special Medicaid Programs, codified as N.J.S.A. 30:4D-3i(11).

10:49-1.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(a) EPSDT is a Federally mandated comprehensive child health program for Medicaid recipients from birth through 20 years of age. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) codified EPSDT. Accordingly, the term "EPSDT Services" means the following:

1. EPSDT Screening Services;
2. Vision Services;
3. Dental Services;
4. Hearing Services; and
5. Such necessary health care diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

(b) A physician, independent clinic, or hospital outpatient department may provide EPSDT screening services.

10:49-1.4 HealthStart

HealthStart is a program to provide comprehensive maternity care services for all pregnant women (including those determined to be presumptively eligible) and child health care services for children (through two years of age) who are eligible for Medicaid benefits. Detailed information about this program is included in the Physician Services Manual or N.J.A.C. 10:54, Independent Clinic Services Manual or N.J.A.C. 10:66, Nurse-Midwifery Services Manual or N.J.A.C. 10:58 and the Hospital Services Manual or N.J.A.C. 10:52.

10:49-1.5 Prepaid health plans

"Prepaid health plan" means an entity that provides medical services to enrolled Medicaid eligibles under a contract with the Medicaid agency on the basis of prepaid capitation fees but does not necessarily qualify as an HMO. For policies and procedures concerning prepaid health care services see N.J.A.C. 10:49-19. For a description of the State operated HMO, the Garden State Health Plan, see N.J.A.C. 10:49-20.

10:49-1.6 Waivered programs

(a) The Division of Medical Assistance and Health Services also administers Respite and the following Home and Community-Based Services Waivers: Community Care Program for the Elderly and Disabled (CCPED); Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Medicaid Model Waivers I, II, and III); and AIDS Community Care Alternatives Program (ACCAP). An overview of these programs is provided at N.J.A.C. 10:49-17.

(b) The Division also provides oversight to the Division of Developmental Disabilities in its administration of its Home and Community-Based Services Waiver for developmentally disabled individuals.

10:49-1.7 State-funded programs

(a) In addition to the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services also administers the following four State-funded programs:

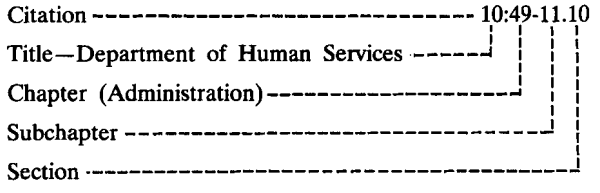
1. Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), see N.J.A.C. 10:49-21;
2. Lifeline Programs (utility assistance programs), see N.J.A.C. 10:49-22;
3. Hearing Aid Assistance for the Aged and Disabled, see N.J.A.C. 10:49-23; and
4. The Home Care Expansion Program, see N.J.A.C. 10:49-18.

10:49-1.8 Overview of provider manuals

(a) There are 19 New Jersey Medicaid provider manuals. Each is designed for use by a specific type provider that provides services to Medicaid recipients. Each manual is written in accordance with Federal and State laws, rules, and regulations, with the intent to ensure that such laws, rules, and regulations are uniformly applied.

(b) Each Medicaid provider manual consists of two chapters, broken down into subchapters. The first chapter is referred to as N.J.A.C. 10:49 (Administration) and outlines the general administrative policies of the New Jersey Medicaid Program and other special programs. The second chapter of each manual specifies the rules and regulations relevant to the specific provider-type and the services provided. Following the second chapter of the manuals is the Fiscal Agent Billing Supplement.

(c) Codification of manual material follows that of the New Jersey Administrative Code (N.J.A.C.). The citation for a particular section of the provider manual reflects the same material under the same citation in the N.J.A.C. The following is an example of a citation in the N.J.A.C. or a provider manual:



(d) There is an individual New Jersey Medicaid provider manual for each of the following services. These services are listed in the New Jersey Administrative Code (N.J.A.C.) under Title 10 (Department of Human Services) Chapters 10:50 through 10:68, and 10:73, as follows:

1. 10:50—Transportation Services Manual
2. 10:51—Pharmacy Services Manual
3. 10:52—Hospital Services Manual
4. 10:53—(Reserved)
5. 10:54—Physician Services Manual
6. 10:55—Prosthetic and Orthotic Services Manual
7. 10:56—Dental Services Manual
8. 10:57—Podiatry Services Manual
9. 10:58—Nurse-Midwifery Services Manual
10. 10:59—Medical Supplier Services Manual
11. 10:60—Home Care Services Manual
12. 10:61—Independent Clinical Laboratory Services Manual
13. 10:62—Vision Care Services Manual
14. 10:63—Long Term Care Services Manual
15. 10:64—Hearing Aid Services Manual
16. 10:65—Medical Day Care Services Manual
17. 10:66—Independent Clinic Services Manual
18. 10:67—Psychological Services Manual
19. 10:68—Chiropractic Services Manual
20. 10:73—Case Management Services Manual

(e) Regarding manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the New Jersey Medicaid Program. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. Newsletters should be filed at the back of the manual and replacement pages should be added to the manual in accordance with instructions provided. Manual revisions shall be substantially made through the rulemaking process, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(f) Regarding provider responsibility, this manual and all subsequent updates are distributed as a guide to assist providers in their participation in the New Jersey Medicaid Program. The provider is ultimately responsible for knowing and abiding by current laws and regulations pertaining to this Program.

SUBCHAPTER 2. NEW JERSEY MEDICAID RECIPIENTS

10:49-2.1 Who is eligible for Medicaid?

Medicaid recipients are divided into two categories: those eligible for all services under the regular New Jersey Medicaid Program (see N.J.A.C. 10:49-2.2); and those eligible for a limited range of services under the Medically Needy Program (see N.J.A.C. 10:49-2.3).

10:49-2.2 Persons eligible under the regular New Jersey Medicaid Program

(a) The following groups are eligible for medical and health services covered under the regular New Jersey Medicaid Program when provided in conjunction with specific Program requirements as outlined in the second chapter of each Provider Services Manual. The list is not all-inclusive.

1. Persons who are eligible to receive Supplemental Security Income (SSI) payments as determined by the Social Security Administration and those persons who meet the SSI standards but apply for the Medicaid Only program through the county welfare agency. Those persons are the aged (65 and over), the blind, and the disabled;
2. A person who qualifies under the Supplemental Security Income (SSI) Program as the "ineligible spouse" of an SSI recipient determined by the Social Security Administration;
3. Children and caretaker relatives eligible for and receiving Aid to Families with Dependent Children (AFDC);
4. Deemed recipients of AFDC including:

i. Persons denied AFDC solely because the payment would be less than $10.00;

ii. Persons whose AFDC payment is reduced to zero ($0.00) because of an over-payment recovery; and

iii. For a period of four months, persons losing AFDC because of the receipt of child or spousal support;

5. For a period of up to 12 months from the first month of ineligibility, persons losing eligibility for AFDC as a result of earnings or hours of employment, or the receipt of New Jersey Unemployment or Temporary Disability Insurance benefits;

6. Persons ineligible for AFDC because of requirements that do not apply under Medicaid;

7. For a period of one year, a child born to a woman who is a Medicaid recipient, so long as the woman remains eligible for Medicaid, or would remain eligible if pregnant;

8. Persons for whom adoption assistance agreements are in effect pursuant to Section 473 of the Social Security Act (42 U.S.C. 673) or for whom foster or adoption assistance is paid under Title IV-E of the Act;

9. Persons ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Medicaid;

10. Persons receiving only mandatory State supplemental payments administered by the Social Security Administration;

11. Certain former recipients of Supplemental Security Income (SSI) who would still be eligible for SSI except for entitlement to or increase in the amount of Social Security benefits;

12. Persons eligible for but not receiving AFDC or an optional State benefit;

13. Children under the age of 21 years who meet the income and resource requirements for AFDC but do not qualify as dependent children;

14. Persons who are in institutions for at least 30 consecutive days and who are eligible under a special income level (the Medicaid "cap") that is higher than the income level for a non-institutionalized SSI or State supplement recipient;

15. Pregnant women and children up to the age of one whose income is below 185 percent of the Federal poverty level, and children up to the age of six whose income is below 133 percent of the Federal poverty level, codified as 42 U.S.C. 1396a, or 1902 (1) of the Social Security Act.

16. Aged, blind, and disabled persons whose income is below 100 percent of the Federal poverty level and whose assets are within 200 percent of the SSI asset limits;

17. For a period of 60 days, women who have applied for Medicaid benefits before the last day of pregnancy and who are eligible for Medicaid on the last day of pregnancy;

18. Persons 65 years of age or older who do not meet the eligibility standards of the categorically needy or medically needy and who are eligible for the Medical Assistance to the Aged Continuance (MAA) program. (No new applications are accepted for this coverage); and

19. Refugees who are eligible under the Refugee Resettlement program.

10:49-2.3 Persons eligible under the Medically Needy Program

(a) A Medicaid recipient under the Medically Needy Program is limited to those medical services listed in N.J.A.C. 10:49-5.3. Services shall be provided in conjunction with specific Program requirements as outlined in the second chapter of the applicable Provider Services Manual.

(b) To be determined Medically Needy under the Medicaid Program, it is necessary for the person to meet categorical eligibility requirements, have income and/or resources in excess of the categorical standards, and have insufficient funds to meet his or her medical expenses. Medically Needy persons shall be in one of the following groups:

1. Pregnant women;

2. Needy children (under 21 years of age); or

3. The aged (65 years of age or older), the blind or the disabled.

(c) There are special income and resource levels established for the Medically Needy. If a person meets one of the categories listed in (b) above and has income and/or resources above categorical program levels but less than or equal to the Medically Needy income and resource levels, he or she shall be determined as Medically Needy eligible. However, if a person meets one of the categories listed in (b) above and meets the Medically Needy resource level but has income which exceeds the Medically Needy income level, eligibility may be established through the "spend-down" process.

1. "Spend-down" is the process whereby a person may apply incurred medical expenses to offset income above the Medically Needy income level, and thereby adjust his or her income to meet the Medically Needy income limit.

(d) Medically Needy eligibility for all groups, including the aged, blind and disabled, shall be determined by the county welfare agency for both the retroactive and prospective period.

1. Each Medically Needy applicant/recipient shall reapply for benefits every six months. Eligibility may be established the first day of that six-month period or on any date during the six-month period that spend-down is met.

2. Eligibility shall be verified by providers on each visit by reviewing the Medicaid Eligibility Identification Card (MEI) (FD-73/178) (see N.J.A.C. 10:49-2.13—Validation Form). For those cards issued for the month within the six month period in which the spend-down is met, the card will reflect the date that eligibility begins after the spend-down is met.

(e) Claims for Medically Needy covered services provided during an eligible period may be submitted to the Program for reimbursement using standard Medicaid procedures. Services provided prior to the effective date of eligibility shall be the client's liability, except for certain "special" claims.

1. "Special" claims are claims for Medically Needy covered services that were not used to meet the spend-down and were rendered between the first of the month in which eligibility is established and the date of eligibility that appears on the Medicaid Eligibility Identification Card.

2. The county welfare agency shall identify "special" claims which may be reimbursed under the Program and shall provide a Medically Needy Claim Transmittal (Form FD-311, see Appendix, N.J.A.C. 10:49). Such claims shall be submitted hard copy with Form FD-311 attached.

10:49-2.4 Eligibility process (variations to routine procedure)

There are variations to the routine procedure for determining Medicaid eligibility. These variations are relevant to applying for eligibility for a newborn infant or for an inpatient upon admission to a hospital (see N.J.A.C. 10:49-2.5); to determining presumptive eligibility for pregnant women (see N.J.A.C. 10:49-2.6); and to determining retroactive eligibility (see N.J.A.C. 10:49-2.7).

10:49-2.5 Applying for Medicaid eligibility for a newborn infant or for an inpatient upon admission to a hospital

(a) There are limited variations to the eligibility process for a newborn infant of a woman who is a Medicaid recipient. The policy and procedures follow:

1. Although both the mother and newborn infant may be Medicaid recipients on the date of delivery, the newborn infant is not immediately assigned a Person Number (see N.J.A.C. 10:49-2.10). In order to expedite payment to any provider before this number is assigned, the provider is permitted to bill for services provided to the newborn using the mother's HSP (Medicaid) Case Number and Person Number on the claim form.

i. Immediately after the birth of a newborn infant, the hospital shall submit a "Public Assistance Inquiry" (Form PA-1C, see Appendix, N.J.A.C. 10:49) to the county welfare agency. This will facilitate the assignment of a Person Number and addition of the newborn's name to the Medicaid eligibility file. The PA-1C Form shall include the date of birth of the newborn and the signature of the mother.

2. The period for which newborn services may be billed under the mother's HSP (Medicaid) Case Number and Person Number shall extend from the date of birth until the last day of the month in which a 60 day time frame ends, or until the newborn is assigned his or her own Person Number, whichever happens first.

Example: If a newborn's date of birth is January 5th, the 60 day period ends March 6th. Claims may be submitted through March 31st using the mother's HSP (Medicaid) Case Number and Person Number, provided the newborn has not been assigned his or her own Person Number in the meantime. Claims for services provided

to the newborn after March 31st would be processed only if the required information about the newborn is used (Person Number, name, age, sex, etc.).

3. The newborn's Person Number shall be used as soon as it is available to the provider. The practitioner or any other type of provider shall request the newborn's Person Number from the mother at each encounter.

4. Billing instructions for services provided a newborn infant under his or her mother's HSP (Medicaid) Case Number and Person Number are provided in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual, as applicable.

(b) The following procedures shall apply when application is made for Medicaid eligibility for an inpatient upon admission to a hospital:

1. A Hospital may submit a "Public Assistance Inquiry" (Form PA-1C, see Appendix, N.J.A.C. 10:49) when an individual is admitted to the facility and financial or medical indigency is a factor in the coverage of care. Under this arrangement, if the patient is determined to be eligible for Medicaid, the effective date of eligibility is the date of the hospital inquiry.

i. A PA-1C Form should be directed to either the Social Security Administration District Office in the area where the hospital is located or the county welfare agency as follows:

(1) The Social Security Administration is responsible for establishing Medicaid eligibility for the aged (persons 65 years and over), for the blind, and for the disabled who apply for Supplemental Security Income (SSI).

(2) The county welfare agency is responsible for establishing Medicaid eligibility for the individual who applies for Aid to Families with Dependent Children (AFDC), or for the individual who is aged, blind, or disabled and applies for "Medicaid Only," or for any individual who applies for New Jersey Care ... Special Medicaid Programs.

2. Before preparing a PA-1C Form, the hospital shall screen the patient to determine the following:

i. Whether or not the patient is already eligible for Medicaid;

ii. Whether or not the patient has health insurance to cover the cost of hospital care and treatment; and

iii. Whether or not the person has sufficient income and/or resources to meet the cost of hospital care.

3. In the event that the date of the Medicaid eligibility which was established by the Social Security Administration or the county welfare agency is later than the date of admission, the recipient may apply directly to the New Jersey Medicaid Program for retroactive Medicaid payment of unpaid bills for allowable medical services within the three month period prior to the month of application (see N.J.A.C. 10:49-2.7).

10:49-2.6 Presumptive eligibility

(a) "Presumptive eligibility" means an expedited process whereby selected certified HealthStart Comprehensive Maternity Care providers make preliminary Medicaid eligibility determinations on behalf of pregnant women (see HealthStart in applicable Provider Services Manuals). This is a preliminary process to determine presumptive eligibility prior to the determination of Medicaid eligibility or ineligibility by the county welfare agency.

1. Approved HealthStart Maternity Care providers (independent clinics and hospital outpatient departments) may determine presumptive eligibility for pregnant women who require ambulatory prenatal services from Medicaid participating providers.

(b) A presumptively eligible pregnant woman is entitled to all Medicaid covered services with the exception of inpatient hospital and nursing facility care services. Although Medicaid HealthStart services must be provided only by a HealthStart provider, other Medicaid covered services may be provided to a presumptively eligible pregnant woman by any appropriate Medicaid provider.

(c) A presumptively eligible pregnant woman is eligible for a period of time which will end:

1. If the woman has not filed an application with the county welfare agency, on or before the last day of the month subsequent to the date of the presumptive eligibility determination; or

2. If the woman has filed an application with the county welfare agency, on the last day of the month subsequent to the month in which she was determined presumptively eligible, or on the day eligibility or ineligibility for Medicaid benefits is determined by the county welfare agency.

(d) A presumptively eligible pregnant woman is identified by the two messages which appear on the "Medicaid Eligibility Identification Card" (Form FD-73/178) (see Appendix, N.J.A.C. 10:49). One message is above the woman's name on the upper left side: **PRESUMPTIVELY ELIGIBLE PREGNANT WOMAN.** The second message appears in the message box on the upper right hand corner: **PROVIDERS ONLY:** CALL 1-800-328-0065 TO VERIFY ELIGIBILITY **BEFORE PROVIDING SERVICES.** This card is the only document acceptable for the identification of a presumptively eligible pregnant woman.

1. As part of the presumptive eligibility process, a presumptively eligible pregnant woman will be given an FD-334 Form, Certification of Presumptive Eligibility (see Appendix, N.J.A.C. 10:49). This is not valid proof of eligibility for Medicaid and should not be used by the provider for presumptive eligibility purposes. A request for reimbursement based solely upon the presentation of the FD-334 form does not guarantee payment.

2. Even with the identification through the MEI card, each time a service is rendered the provider shall verify the presumptive eligibility status of a pregnant woman, prior to the delivery of ambulatory services, by calling the toll free telephone number, 1-800-*[323]**328*-0065, during normal business hours (Monday through Friday, 8:30 A.M.-4:30 P.M.) or as soon as possible if the services are delivered other than during normal business hours.

3. When the provider requests verification for presumptive eligibility, he or she is required to provide the individual's name and HSP (Medicaid) Case Number, including the Person Number, to the operator.

4. The operator will advise the provider of the presumptive eligibility status on the date service is delivered and furnish him or her with an authorization number. The authorization number documents the verification of the Mediciad presumptive eligibility status for the provider.

5. Payment for services rendered without presumptive eligibility verification may be denied if the provider did not secure the required authorization number which verified the eligibility status, as noted in (d)4 above.

10:49-2.7 Medicaid Retroactive Eligibility

(a) Any person applying for Medicaid benefits shall be asked if he or she has unpaid medical bills incurred within the three-month period immediately prior to the month of application for Medicaid. Except for a Medically Needy applicant (see N.J.A.C. 10:49-2.3(e)), an individual indicating that there are such bills, may complete an FD-74 Form, Application for Payment of Unpaid Medical Bills (see Appendix, N.J.A.C. 10:49) and forward the application with all outstanding unpaid medical bills to the Medicaid Retroactive Eligibility Unit, Division of Medical Assistance and Health Services, CN-712-10, Trenton, New Jersey 08625.

1. An application for retroactive eligibility may be obtained by the applicant, or his or her authorized agent, from the county welfare agency, the Medicaid District Office, the Social Security Administration District Office, or from the Retroactive Eligibility Unit, Division of Medical Assistance and Health Services. The application shall be submitted within six months from the date of application for public assistance.

(b) If the New Jersey Medicaid Program determines that the person was eligible for Medicaid at the time the service was provided, providers shall be notified directly that the unpaid bills for any service covered by the New Jersey Medicaid Program may be reimbursable in accordance with standard Medicaid reimbursement procedures.

1. The provider shall then complete the appropriate Medicaid claim form and submit it to the Retroactive Eligibility Unit for consideration and authorization of payment.

2. For any Medically Needy recipient, a retroactive eligibility determination shall be completed by the county welfare agency (see N.J.A.C. 10:49-2.3, Persons eligible under the Medically Needy Program).

10:49-2.8 Verification of eligibility for Medicaid services

(a) Each Medicaid recipient, except Nursing Facility recipients, has an HSP (Medicaid) Case Number printed on a Medicaid form that validates eligibility. The recipient shall present this form to the provider, as a proof of Medicaid eligibility, every time a service is to be provided. See N.J.A.C. 10:49-2.10 for a description and information about the HSP (Medicaid) Case Number and see N.J.A.C. 10:49-2.11 for information about the Medicaid forms that are used to validate eligibility. The Recipient Eligibility Verification System (REVS) can be used, in some instances, as an alternative to viewing a form used to validate eligibility (see N.J.A.C. 10:49-2.9).

1. When extended plans of treatment have been approved, it is especially important to review the validation of eligibility form each time a service is provided.

i. Medical authorization or approval of a service by the Division shall not be construed as a guarantee that a person is eligible for the Medicaid Program.

ii. There shall be no reimbursement for services performed after termination of eligibility except as noted in N.J.A.C. 10:49-5.4(a)9.

10:49-2.9 Recipient Eligibility Verification System (REVS)

In the event a recipient is unable to produce a form that validates Medicaid eligibility (see N.J.A.C. 10:49-2.11) and the recipient's HSP (Medicaid) Case Number is known, the provider can verify eligibility by calling the Unisys Recipient Eligibility Verification System (REVS). REVS is accessed by dialing 1-800-676-6562 (or 587-1955 in the local Trenton area). Complete instructions for using REVS can be found in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

10:49-2.10 HSP (Medicaid) Case Number

(a) An HSP (Medicaid) Case Number consists of 12 digits, which includes a two-digit Person Number. The components of an HSP (Medicaid) Case Number as it is initially assigned to a recipient follows.

(b) The first two digits usually designate the county of residence as follows.

01 Atlantic	08 Gloucester	15 Ocean
02 Bergen	09 Hudson	16 Passaic
03 Burlington	10 Hunterdon	17 Salem
04 Camden	11 Mercer	18 Somerset
05 Cape May	12 Middlesex	19 Sussex
06 Cumberland	13 Monmouth	20 Union
07 Essex	14 Morris	21 Warren

1. For some adult recipients (that is, the Medicaid Only Program and New Jersey Care . . . Special Medicaid Programs for Aged, Blind, and Disabled) the first two digits of the HSP (Medicaid) Case Number designate the county of residence where eligibility was originally determined but not necessarily the location where the recipient is currently residing. In these instances, when the recipient moves to another county, the recipient retains the HSP (Medicaid) Case Number of the original county of application. However, the eligibility identification card will indicate the current address.

2. For recipients in certain State or county facilities, the first two digits of the HSP (Medicaid) Case Number designate the facility where the recipient resides. In a few unique situations the first two digits designate a special State program. The following list identifies the first two digits used to identify a State or county facility or a special State program. Following the name of the facility and enclosed in parentheses, is the Medicaid District Office serving that facility. For those facilities below marked by an asterisk(*), it should be noted that when the first two digits of an HSP (Medicaid) *[Care]* ***Case*** Number are used to identify more than one facility, a specific series of numbers for the fifth through tenth digit shall be used to designate the second or third facility as well as to designate the sequential identification number of the Medicaid recipient.

i. Identification of State and County Psychiatric Facilities

31—Greystone Park Psychiatric Hospital (Morris MDO)

32—Trenton Psychiatric Hospital (Mercer MDO)

*32—(300,000 series) Forensic Psychiatric Hospital (Mercer MDO)

*32—(600,000 series) Senator Garrett W. Hagedorn Center for Geriatrics—Psychiatric Section (Hunterdon MDO)

33—Marlboro Psychiatric Hospital (Monmouth MDO)

34—Ancora Psychiatric Hospital (Camden MDO)

36—Arthur Brisbane Child Treatment Center (Psychiatric Hospital) (Monmouth MDO)

37—Bergen Pines Psychiatric Center (Bergen MDO)

38—Essex County Hospital Center—Cedar Grove (Essex—Suburban MDO)

39—Camden County Psychiatric Hospital (Camden MDO)

ii. Identification of Intermediate Care Facilities/Mental Retardation

*34—(800,000 series) Ancora Development Center (Camden MDO).

35—North Princeton Development Center (Hunterdon MDO)

41—Vineland Developmental Center (Cumberland MDO)

42—North Jersey Developmental Center (Totowa) (Passaic MDO)

43—Greenbrook Regional Center (Hunterdon MDO)

44—Woodbine Developmental Center (Cumberland MDO)

45—New Lisbon Developmental Center (Burlington MDO)

46—E. R. Johnstone Training and Research Center (Middlesex MDO)

47—Woodbridge Developmental Center (Middlesex MDO)

48—Hunterdon Developmental Center (Hunterdon MDO)

iii. 51—Soldiers Homes (Unit Dose Drugs) (MDO in county in which home is located)

iv. 90—Division of Developmental Disabilities Community Care Services (Waiver and Non-Waiver) and Special Residential Services, Statewide. (MDO in county in which the recipient resides.)

(c) The third and fourth of the 12-digit HSP (Medicaid) Case Number designate the category under which a person was determined eligible for the New Jersey Medicaid Program. For some adult recipients (that is, the Medicaid Only Program and New Jersey Care . . . Special Medicaid Programs for Aged, Blind, and Disabled) the third and fourth digits of the HSP (Medicaid) Case Number will not change from Program 20 and 25 (meaning the individual is disabled and under 65 years of age) to 10 and 15 (meaning the individual is aged—65 years of age or older) when recipients reach age 65.

10—Aged—SSI related (65 years of age or older)

15—Aged—Medically *[Needed]* ***Needy*** 65 years of age or older)

20—Disabled—SSI related (under 65 years of age)

25—Disabled—Medically Needy (under 65 years of age)

30—Aid to Families with Dependent Children (AFDC). New Jersey Care . . . Special Medicaid Programs for pregnant women and children are included in this category.

35—Medically Needy (children and pregnant women)

50—Blind—SSI related

55—Blind—Medically Needy

60—Children (If first two digits are 01 to 21, the individual is under supervision of the Division of Youth and Family Services. If the first two digits are greater than 21, the individual is institutionalized under the Institutional Services Section of the Division of Medical Assistance and Health Services).

70—Medical Assistance for Aged—A New Jersey State Program

80—Refugee Program

(d) The fifth through tenth digits of the HSP (Medicaid) Case Number designate the sequential identification number of the Medicaid recipient.

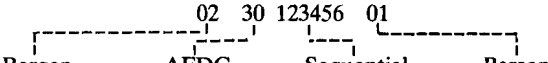
(e) The eleventh and twelfth digits of the HSP (Medicaid) Case Number designate the specific Person Number assigned to each recipient.

01–04 Adult (any age)

06–09 Adult (any age)

05 Pregnant Women
10–19 Ineligible Spouse
20–39 Children under 19
40–49 Medicaid Special (Children under 21 but not under 19)

(f) For example, an adult Medicaid recipient (caretaker/parent) from Bergen County receiving assistance under Aid to Families with Dependent Children (AFDC) Program could have the following HSP (Medicaid) Case Number:



10:49-2.11 Forms that validate Medicaid eligibility

(a) A New Jersey Medicaid provider may verify a person's Medicaid eligibility by means of one of the following four forms:

1. Department of Human Services—"Medicaid-ID" (FD-152) (see N.J.A.C. 10:49-2.12);
2. "Medicaid Eligibility Identification Card" (FD-73/178) (see N.J.A.C. 10:49-2.13);
3. "Validation for Health Services Program" (DYFS 16-36) (see N.J.A.C. 10:49-2.14); or
4. "Validation of Eligibility" (FD-34) (see N.J.A.C. 10:49-2.15).

10:49-2.12 Validation Form (FD-152) "Department of Human Services Medicaid-ID"

(a) The validation Form FD-152 (see Appendix, N.J.A.C. 10:49) is issued monthly to persons eligible for Aid to Families with Dependent Children (AFDC) and to persons eligible under the Refugee and Community Medicaid Only programs. The form indicates that the persons are currently eligible for coverage for the month shown on the form-"VALID ONLY FOR THE MONTH OF _____". The validation form shall be retained by the Medicaid recipient to whom it is issued.

1. This form is the indicator of Medicaid eligibility for the Medicaid recipient(s) listed on the form.

i. Any Medicaid recipient enrolled in an HMO shall also be required to show his or her HMO ID Card.

2. Providers shall enter the name, HSP (Medicaid) Case Number, including the Person Number, exactly as it appears on Form FD-152 when requesting authorization for services or submitting a claim form.

3. One of the following three messages may be printed on the FD-152 form issued by the County Welfare Agency. Only one message will appear on the form. If more than one applies, however, the message printed is chosen in the order of priority listed below. Providers shall be requested to take the specific action for the message which appears.

i. Message One: "HMO-CHECK GSHP ID CARD". This recipient and all members of his or her family listed on the Medicaid ID Card are enrolled in the Garden State Health Plan, a State-operated health maintenance organization. Each family member chooses a primary care physician known as a physician case manager. To obtain service, this recipient shall also present the Garden State Health Plan Identification Card. This gold colored card lists each family member and the name and telephone number of the member's physician case manager. The member's physician case manager shall either authorize or personally provide all medical services. (See N.J.A.C. 10:49-20, Garden State Health Plan.)

ii. Message Two: "RESTRICTED USE HMO-CALL (NUMBER LISTED)" or "HMO COVERAGE—CHECK HMO ID CARD". This recipient (and any member of his or her family on the AFDC grant) is enrolled in a Health Maintenance Organization (HMO). The provider shall call the telephone number listed on either the FD-152 validation card or on the HMO ID Card to determine whether the service or the item he or she is being asked to provide is provided by the HMO. If a provider provides a service available through the HMO, reimbursement will be denied by the New Jersey Medicaid Program, except in medical emergencies.

iii. Message Three: "OTHER COVERAGE"—There will be an asterisk (*) before the name of the recipient(s) covered by another health insurer. The provider shall determine the insurer and the policy number (see N.J.A.C. 10:49-7.3, Third party liability).

10:49-2.13 Validation Form (FD-73/178) Medicaid Eligibility Identification Card (MEI Card)

(a) The MEI Card, Validation Form FD-73/178 (see Appendix, N.J.A.C. 10:49) is issued monthly or quarterly as indicated in (a)1 and 2 below.

1. The MEI Card is issued monthly to:

i. Persons (aged, blind and disabled) determined by the Social Security Administration to be eligible for Supplemental Security Income (SSI) and their spouses, if eligible as an essential person;

ii. Persons determined by the county welfare agency to be eligible for the New Jersey Care ... Special Medicaid Programs and the Medically Needy Program; and

iii. Recipients in the Special Status Program (see (e)2 below); and

2. The MEI card is issued quarterly for children (Medicaid recipients) under the supervision of the Division of Youth and Family Services (DYFS).

(b) The MEI Card usually identifies eligibility for only one recipient. However, several special programs list all eligible persons in the family; for example, for New Jersey Care ... Special Medicaid Programs all Medicaid recipients in the family are listed on the MEI card; the Special Status Program also identifies all recipients in the family on the MEI card.

1. When the MEI Card is issued to the Medically Needy, more than one recipient may be listed with a service code indicated next to each name.

(c) The information on the MEI Card includes an address, date of birth, Social Security Account Number and the availability of any third-party health insurance; however, for the Medically Needy Program, the date of birth and Social Security Account Number are omitted and the words "Medically Needy" are printed in this space.

1. If the Medicaid recipient has health insurance, the name of the other insurer will be printed together with a corresponding policy number. Additionally, Medicare coverage and the HIC (Medicare) Number will be printed on the MEI Card for all Medicare/ Medicaid recipients.

(d) The MEI Card is valid only when signed by the Medicaid recipient or his or her representative payee/legal guardian.

(e) A message printed on the MEI card will indicate the cardholder's enrollment in any waivered or special programs such as Home and Community-Based Services Waivers (see N.J.A.C. 10:49-17); Home Care Expansion Program (see N.J.A.C. 10:49-18); and Garden State Health Plan (see 10:49-20).

1. The MEI Card for Garden State Health Plan members will have the printed message: "HMO-Check-GSHP ID Card" under the section "Additional Health Insurance." To obtain service, this recipient shall also present the Garden State Health Plan Identification Card. This gold colored card lists the recipient and the name and telephone number of the recipient's physician case manager. All medical services shall be either provided by or authorized by the recipient's physician case manager prior to rendering a service.

2. The MEI Card for the Medicaid "Special Status Program" either restricts the Medicaid recipient(s) listed on the MEI Card to a single provider, except in a medical emergency, or warns providers that the recipient's card has been used by an unauthorized person or persons, or for an unauthorized purpose. If a warning card is issued, a message will be printed on the card alerting the provider to ask the Medicaid recipient for additional identification or to take other appropriate action. (See N.J.A.C. 10:49-14.2, Sanctions—Special Status Program).

3. The MEI Card issued for the Medically Needy Program will have the following message printed on the top of the card: "Medically Needy Eligible, Check Provider Manual for Authorized Services." It is important for the provider to always review the eligibility dates and to be aware that eligibility is not always established for an entire month. Coverage may begin on any day during the month. Also, a provider shall always review the "service code" for each Medically Needy recipient. The service code will enable the provider to de-

termine which services are available to each Medically Needy recipient (see N.J.A.C. 10:49-2.3 and 10:49-5.3 for service exceptions). The service codes for the three groups under Medically Needy are:

(A) Group A—Pregnant women
(B) Group B—Needy children
(C) Group C—Aged, blind and disabled.

10:49-2.14 Validation Form (DYFS-16-36)
Validation for Health Services Program (Medicaid)

(a) The DYFS-16-36 Validation Form (see Appendix, N.J.A.C. 10:49) is issued by the Division of Youth and Family Services (DYFS) to certain eligible children (Medicaid recipients). This form indicates eligibility for covered health *[for covered health]* services during the months shown on the form itself.

1. The validation form shall be retained by the recipient to whom it is issued.

2. The form is the indicator of eligibility for this group of children.

i. Any Medicaid recipient enrolled in a HMO shall also be required to show his or her HMO ID Card.

ii. The HSP (Medicaid) Case Number shall be entered exactly as it appears on the validation form on all requests for authorization of services and when submitting claim forms.

10:49-2.15 Validation Form (FD-34)
Validation of Eligibility

(a) The FD-34 Form, Validation of Eligibility (see Appendix, N.J.A.C. 10:49), identifies a Medicaid recipient who resides in a State or county institution.

1. The validation form shall be prepared and completed by the authorized Medicaid representative at the State or county institution. It is valid for the calendar month it is issued (up to a period of 31 days) to a Medicaid recipient (patient/resident) in a State or county governmental psychiatric hospital or an intermediate care facility/mental retardation, and is used to obtain Medicaid covered services outside of the institutional setting. The form shall be returned with the Medicaid resident.

2. Form FD-34 requires the signature, title, and telephone number of the authorized representative at the institution.

3. The Medicaid resident or patient of a State or county institution receiving covered health services in the community is identified by the 12-digit HSP (Medicaid) Case Number in which the first two digits identifies the institution. (See N.J.A.C. 10:49-2.10 (b)2).

(b) The New Jersey Medicaid Program has designated specific Medicaid District Offices to handle prior authorization requests for services for patients/residents from each institution and family care residents who are under the jurisdiction of the Division of Developmental Disabilities. If the patient/resident's HSP (Medicaid) Case Number begins with any of the following numbers, providers shall contact the Medicaid District Office (MDO) indicated (for MDO Directory, see Appendix at N.J.A.C. 10:49).

31—Morris MDO
32—Mercer MDO
32—Hunterdon MDO (Applicable only to 600,000 series)
33—Monmouth MDO
34—Camden MDO
35—Hunterdon MDO
36—Monmouth MDO
37—Bergen MDO
37—Hudson MDO (Applicable only to 600,000 series)
38—Essex—Suburban MDO
39—Camden MDO
41—Cumberland MDO
42—Passaic MDO
43—Hunterdon MDO
44—Cumberland MDO
45—Burlington MDO
46—Burlington MDO
47—Middlesex MDO
48—Hunterdon MDO
90—MDO in county in which recipient resides.

10:49-2.16 Medicaid application

(a) If a person has not applied for benefits, is unable to pay for services provided, and appears to meet the requirements for eligibility for the New Jersey Medicaid Program, the provider shall encourage the person, or his or her representative, to apply for benefits:

1. To the county welfare agency for programs such as Aid to Families with Dependent Children; Medicaid Only; New Jersey Care . . . Special Medicaid Programs for pregnant women, children, and the aged, blind, or disabled; or for Medically Needy;

2. To the Social Security Administration for Supplemental Security Income benefits for the aged, blind, and disabled; or

3. In certain cases, to the New Jersey Division of Youth and Family Services, Department of Human Services.

(b) If it is not known which agency is responsible for determining eligibility or which program might be applicable, the Medicaid District Office will be able to provide guidance in this matter (for MDO Directory, see Appendix N.J.A.C. 10:49).

(c) All providers are encouraged to refer pregnant women who may be eligible for Medicaid to a provider authorized to determine presumptive eligibility. The names and addresses of these providers may be obtained by calling the HOT LINE at 1-800-321-BABY.

SUBCHAPTER 3. PROVIDER PARTICIPATION

10:49-3.1 Provider types eligible to participate

(a) The following provider types are eligible to participate as Medicaid providers:

1. Chiropractors and/or chiropractic groups;
2. Clinics (independent outpatient health care facilities);
3. Clinical laboratories;
4. Dentists and/or dentist groups;
5. Hearing aid dealers;
6. Health maintenance organizations;
7. Home health agencies;
8. Homemaker agencies;
9. Hospices;
10. Hospitals;
i. General;
ii. Psychiatric; and
iii. Special;
11. Nursing facilities, including intermediate care facilities for the mentally retarded;
12. Medical suppliers;
13. Medical day care centers;
14. Nurse-midwives;
15. Opticians;
16. Optometrists;
17. Orthotists;
18. Pharmacies;
19. Physicians and/or physician groups;
20. Podiatrists and/or podiatrist groups;
21. Prosthetists;
22. Psychologists and/or psychologist groups;
23. Residential treatment facilities;
24. Transportation providers; and
25. State and county agencies that have agreed to provide personal care assistant services.

10:49-3.2 Enrollment process

(a) Providers shall be required to complete a Medicaid Provider Application and sign a Provider Agreement (see Appendix, 10:49) or a specialized agreement, and/or such other documentation as the Program may require, depending on the nature of the services provided.

1. Policies and rules pertaining to shared health care facilities are outlined in N.J.A.C. 10:49-4.

(b) All Medicaid providers other than an individual practitioner and/or group of practitioners shall be required to complete Form HCFA-1513, Ownership and Control Interest Disclosure Statement (see Appendix N.J.A.C. 10:49) at the time of application or reapplication. Providers prior to 1973 were not required to utilize

provider agreement forms; however, they shall comply with all applicable State and Federal Medicaid laws, policies, rules and regulations.

1. As a condition of continued participation in the New Jersey Medicaid Program, a provider may, from time to time, be required to:

i. Complete a provider application form and sign a provider participation agreement; and/or

ii. Complete a Form HCFA 1513, Ownership and Control Interest Disclosure Statement. This requirement shall not be applicable to individual practitioners(s) or groups of practitioners.

2. The New Jersey Medicaid Program shall terminate any existing agreement or contract if the provider fails to disclose information required by (b)1ii above.

3. Enrollment documentation requested by the New Jersey Medicaid Program shall be furnished within 35 calendar days of the date of the written request.

(c) An out-of-State provider shall have a current, approved provider agreement with the New Jersey Medicaid Program and hold a current, valid certification and/or license from the appropriate agency under the laws of the respective state in which the provider is located.

(d) A provider application to enroll may be requested from the Fiscal Agent of the New Jersey Medicaid Program. An appropriate Medicaid Program enrollment package will be mailed to the requesting provider. The enrollment application must be completed in full and returned to the Fiscal Agent, along with all the necessary attachments.

1. The applicant's eligibility to participate in the New Jersey Medicaid Program will be confirmed in writing. A New Jersey Medicaid provider number will be assigned and returned to the applicant along with the appropriate Medicaid Program Provider Manual.

2. If the application is denied, the applicant will receive a notification which explains the decision to deny and the applicant's right to appeal the decision (see N.J.A.C. 10:49-10).

(e) If the applicant is found to be currently enrolled (for example, an inactive provider who now wants to actively participate), the applicant will be assigned an appropriate Medicaid provider number and the provider's existing record on the Provider Master File will be reactivated.

(f) The Division may refuse to enter into a provider participation agreement with any applicant who has been suspended, debarred, disqualified, or excluded by the Medicaid Program of another state.

(g) The Division shall ***not*** enter into a provider participation agreement with an applicant who has been suspended or excluded from participation in the delivery of medical care or services under Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant Act (Title XX) of the Federal Social Security Act, by the Secretary of the United States Department of Health and Human Services.

10:49-3.3 Providers with multi-locations

(a) The New Jersey Medicaid Program requires that all providers (except independent clinical laboratories, nursing facilities, and pharmacies) applying to participate in the Program or presently participating in the Program, identify each and every branch or satellite location from which they shall provide services to Medicaid recipients.

(b) Each separate location shall meet all required standards for participation in the New Jersey Medicaid Program and shall be uniquely identified, if approved for participation. Services rendered to Medicaid recipients at an unapproved satellite shall not be billed and will not be paid under the approved parent organization's provider number.

(c) Billing through a central location for approved multi-location providers shall be allowed; however, providers shall utilize the preaddressed claims for each office location as the claims reflect the proper address and provider number for that location. Selection of central or localized billing shall be left to providers, who shall state their preference on the application.

10:49-3.4 Medicaid Provider Billing Number

(a) Each Medicaid provider is assigned a Medicaid Provider Billing Number. The seven digit provider billing number is required on all Medicaid claim forms as a condition of payment.

(b) Certain Medicaid providers are also assigned an individual Medicaid Provider Services Number which must also appear on certain claim forms as detailed in the Medicaid Fiscal Agent Billing Supplement.

(c) Providers who, for billing purposes, need a referring practitioner's individual Medicaid Provider Services Number shall contact that practitioner to obtain the number. A practitioner who does not participate in the Medicaid Program will not have a Medicaid Provider Services Number. In the absence of the referring practitioner's individual Medicaid Provider Services Number, providers must enter seven fives (5's) for non-participating out-of-State providers or seven sixes (6's) for non-participating in-State providers to indicate non-participation in the New Jersey Medicaid program.

1. Each Medicaid participating practitioner (that is, physician, certified nurse mid-wife, chiropractor, dentist, optometrist, podiatrist, or psychologist) shall supply his or her individual Medicaid Provider Services Number to other providers when referring a Medicaid recipient for services.

(d) A shared health care facility (SHCF) (see N.J.A.C. 10:49-4.1) is assigned a registration code (Shared Health Care Facility Number), which must appear on a claim form submitted to the Medicaid Fiscal Agent by every member of the SHCF. In addition, each practitioner rendering a service in a shared health care facility must indicate his or her Medicaid Provider Billing Number and individual Medicaid Provider Services Number on the claim form (see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

SUBCHAPTER 4. PROVIDERS' ROLE IN A SHARED HEALTH CARE FACILITY

10:49-4.1 Definitions

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

"Department" means the Department of Human Services.

"Discipline" means a branch of instruction or learning such as medicine, dentistry, chiropractic, and so forth.

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

"Patient" means anyone eligible to receive benefits from the Program.

"Program" means the New Jersey Medicaid Program.

"Provider" means any individual, partnership, association, corporation, institution or any other public or private entity, agency or business concern, meeting applicable requirements and standards for participation in the New Jersey Medicaid Program, and where applicable, holding a current valid license, and lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D-1 et seq. and amendments thereto.

"Purveyor" means any person, firm, corporation or other entity other than a provider who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users or providers within the shared health care facility any medical supplies, equipment and/or services for which reimbursement under the Program is received, including, but not limited to, clinical laboratory services or supplies; diagnostic radiology services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment, and which amount to $10,000 per year.

"Shared health care facility" (SHCF) means four or more providers, two or more of whom are practicing within different specialties and/or disciplines, either independently or in association with each other, within a single structure; and

1. Two or more of whom share any of the following:
i. Common waiting areas;
ii. Examining rooms;
iii. Treatment rooms;
iv. Equipment;
v. Supporting staff;
vi. Common records; and
2. One or more of whom receives payment on a fee-for-service basis, and where the gross Medicaid income for the facility meets or exceeds $80,000 per year.

"Specialty" means a health care practice within a discipline such as pediatrics, obstetrics/gynecology, orthodontics, periodontics, and so forth.

10:49-4.2 Scope

(a) This subchapter shall apply to shared health care facilities as defined herein and to providers located in a specific health care facility.

(b) This subchapter shall apply to purveyors, whether or not located in a building which houses a shared health care facility.

(c) Nothing in this subchapter shall apply to an association of health care providers delivering health services on other than a fee-for-service basis.

(d) This subchapter shall not apply to hospitals participating in the Medicaid Program.

10:49-4.3 Registration of shared health care facilities

(a) No shared health care facility shall be operated under the Program unless it has been registered with the Division. The Office of Program Integrity Administration, CN-712, Trenton, New Jersey 08625 is responsible for registration.

1. Providers within the shared health care facility shall designate one provider member who shall be responsible for registration:

i. Said responsibility and liability by the designated provider, shall be limited to timely filing of accurate reports required under this section.

(b) Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to:

1. The name of the owner or owners of the facility;

2. The name, residence address and professional license number of every provider and purveyor working in the shared health care facility;

3. The name, residence address and curriculum vitae of the individual designated to asssume responsibility for the central coordination and management of the shared health care facility's activities, if so designated;

4. The owner, lessor or lessee shall furnish to the Division a copy of the lease agreement upon request;

5. The name of any person, firm or corporation providing administrative, clerical or billing services to providers in shared health care facilities, other than employees of providers; and

6. The name and address of lessor of any space or equipment in the shared health care facility.

(c) The registrant shall re-register on the June 1 next following initial registration, and annually thereafter on June 1.

(d) The Division shall be notified, in writing, within 30 days of any change in:

1. The owner or owners of the facility;

2. The termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility's activities. The Division shall also be notified within 30 days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility; and

3. Any addition or termination of any provider or purveyor in the shared health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

10:49-4.4 Prohibited practices; administrative requirements

(a) The Division shall not enter into any agreement of Medicaid participation, nor shall any payment be made to any provider in a shared health care facility where the rental fee for the letting of space or supportive professional or clerical services to a provider in a shared health care facility is calculated in whole or in part, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located.

(b) No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for:

1. Recommending or procuring goods, services or equipment of such purveyor or provider to any other person;

2. Directing patronage or clientele to such purveyor or provider; or

3. Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

(c) Patient referral rules require that:

1. No provider in a shared health care facility or person employed in such facility shall refer a patient to another provider located in such a facility, unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

2. Every provider practicing in a shared health care facility who treats a patient referred to him or her by another provider practicing in the same facility shall communicate in writing to the referring provider, the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record; and

3. The claim submitted to the Program by the provider to whom such patient has been referred shall contain the full name and individual Medicaid Provider Services Number of the referring provider, and shall identify the medical problem that necessitated the referral.

(d) Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the Program may be obtained at any pharmacy of the recipient's choice.

(e) No purveyor or provider other than a physician, dentist, podiatrist, optometrist or chiropractor, who maintains a business in the building in which a shared health care facility is located, shall maintain a door or window opening into the offices or waiting room of the shared health care facility.

(f) All provider claims submitted for services rendered at a shared health care facility shall contain the registration code (SHCF Number) of the facility at which the service was performed. The individual Medicaid Provider Services Number of the practitioner rendering the service must also be entered on the claim form. The practitioner who rendered the service or his or her authorized representative must sign and date the claim form.

(g) The requirements set forth in the Medicaid Program Provider Services Manuals for each respective discipline shall apply to services rendered at a shared health care facility.

(h) It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred.

10:49-4.5 Quality of care requirements

(a) To ensure quality, continuity and proper coordination of medical care, each shared health care facility shall:

1. Where feasible, designate an individual who, on a full-time basis, shall coordinate and manage the facility's activities;

2. Devise an appropriate means of insuring that patients shall be scheduled to return for appropriate follow-up care and shall be treated by a provider familiar with patient's medical history;

3. Post conspicuously the names and scheduled office hours of all providers practicing in the facility;

4. Maintain proper records. Such records shall contain at least the following information:

i. The full name, address and Medicaid Number of the patient;

ii. The dates of all visits to all providers in the shared health care facility;

iii. The chief complaint for each visit to each provider in the shared health care facility;

iv. Pertinent history and all physical examinations rendered by each provider in the shared health care facility;

v. Diagnostic impressions for each visit to any provider in the shared health care facility;

vi. All medications prescribed at each visit by any provider in the shared health care facility who is qualified to issue prescriptions;

vii. The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility;

viii. All x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health care facility;

ix. The results of all x-ray, laboratory work and electrocardiograms ordered as in (a)4viii above;

x. All referrals by providers in the shared health care facility to other medical providers and the reason for such referrals, and date of referral; and

xi. A statement as to whether or not the patient is expected to return for further treatment.

5. The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

SUBCHAPTER 5. SERVICES COVERED BY MEDICAID PROGRAM

10:49-5.1 Requirements for provision of services

(a) The services listed in N.J.A.C. 10:49-5.2 are available to recipients eligible for the regular New Jersey Medicaid Program. Services available to Medically Needy recipients are listed in N.J.A.C. 10:49-5.3. The services listed in N.J.A.C. 10:49-5.2 and 5.3 shall be provided in conjunction with Program requirements specifically outlined in the second chapter of each Provider Services Manual.

1. Any service limitations imposed will be consistent with the medical necessity of the patient's condition as determined by the attending physician or other practitioner and in accordance with standards generally recognized by health professionals and promulgated through the New Jersey Medicaid Program. Some services require authorization from the Program before the services are provided (see N.J.A.C. 10:49-6, Authorization Required).

10:49-5.2 Services available to recipients eligible for the regular Medicaid Program

(a) The services listed below, in alphabetical order, are available to recipients eligible for the regular Medicaid Program:

1. Case management services (Mental Health Program);

2. Chiropractic services;

3. Christian Science Sanatoria care and services (see Hospital Services Manual);

4. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, etc.);

5. Dental services;

6. Early and Periodic Screening, Diagnosis, and Treatment for recipients under age 21 (EPSDT): A preventative health care program for recipients under age 21 designed for early detection, diagnosis and treatment of correctable abnormalities. This program supplements the general medical services otherwise available;

7. Family planning services;

8. HealthStart maternity and pediatric care services include packages of comprehensive medical and health support services provided by independent clinics; hospital outpatient departments; local health departments meeting New Jersey Department of Health's improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49-1.4 for applicable Provider Services Manuals regarding HealthStart services, and requirements for provider participation);

9. Hearing aid services;

10. Home care services (home health care and personal care assistant services);

11. Hospice room and board services in a nursing facility (available to dually eligible Medicare/Medicaid recipients);

12. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals;

iii. Psychiatric hospitals (inpatient): Limited to persons age 65 or older and children 21 years of age and under; and

iv. Inpatient psychiatric programs for children 21 years of age and under;

13. Hospital services—outpatient;

14. Laboratory (clinical);

15. Medical day care services;

16. Medical supplies and equipment;

17. Mental health services;

18. Nursing facility services, including intermediate care facilities for the mentally retarded;

19. Nurse-midwifery services;

20. Optometric services;

21. Optical appliances;

22. Pharmaceutical services;

23. Physician services;

24. Podiatric services;

25. Prosthetic and orthotic devices;

26. Radiological services;

27. Rehabilitative services (Payments are made to eligible Medicaid providers only. No payment is made to privately practicing therapists);

i. Physical therapy, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;

ii. Occupational therapy, as provided by a home health agency, independent clinic, nursing facility, or hospital outpatient department;

iii. Speech-language pathology services, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office; and

iv. Audiology services provided in the office of a licensed specialist in otology or otolaryngology, or as part of independent clinic or hospital outpatient services; and

28. Transportation services which include ambulance, invalid coach, livery, and other transportation provided by independent clinics or through arrangements with a county welfare agency.

10:49-5.3 Services available to recipients eligible for the medically needy program

(a) Regular Medicaid services are available to Medically Needy recipients except for the following services which are not available or are only available to certain eligible Medically Needy groups: (See the service code next to the recipient's name on the Medicaid Eligibility Identification Card to ascertain the Medically Needy group under which the recipient's eligibility was established; that is, Group A—pregnant women, Group B—needy children, and Group C—aged, blind and disabled.)

1. Chiropractic services are available only to pregnant women (Group A).

2. EPSDT services are not available to any Medically Needy group.

3. Hospital services (inpatient) are available only to pregnant women (Group A).

4. Nursing facility services are not available to any Medically Needy group.

5. Medical day care services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

6. Pharmaceutical services are available only to pregnant women and needy children (Groups A and B).

7. Podiatric services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

8. Rehabilitative services are not available for reimbursement when provided through a hospital or nursing facility, except to pregnant women as part of their inpatient hospital services.

9. Case management services for the mentally ill are available to Medically Needy pregnant women only.

10:49-5.4 Services not covered by Medicaid Program

(a) Listed below are some general services and items excluded from payment under the New Jersey Medicaid Program. There are additional specific exclusions and limitations detailed in the second chapter of each Provider Services Manual. Payment is not made for the following:

1. Any service, admission, or item, which is not medically required for diagnosis or treatment of a disease, injury, or condition;

2. Services provided to all persons without charge shall not be billed to the Medicaid Program when provided for a Medicaid recipient. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health, New Jersey Heart Association, First Aid Rescue Squads, and so forth) shall be utilized to the fullest extent possible;

3. Any service or items furnished in connection with elective cosmetic procedures;

i. There are certain exceptions to this rule, but the exceptions require prior authorization. A written certification of medical necessity and a treatment plan shall be submitted by the physician to the appropriate Medicaid District Office for consideration;

4. Private duty nursing services (except for recipients under EPSDT);

5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;

6. Services provided outside the United States and territories;

7. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid recipient claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages;

8. That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;

9. Services or items furnished prior to or after the period for which the recipient presents evidence of eligibility for coverage.

i. Payment is made for inpatient hospital services (excluding governmental psychiatric hospitals) when ineligibility occurs after admission to hospital as an inpatient. Payment is also made for certain services that were authorized and initiated before loss of eligibility such as dental, vision care, prosthetics and orthotics, and durable medical equipment. Also, see "Retroactive Eligibility" at N.J.A.C. 10:49-2.7(c);

10. Any services or items furnished for which the provider does not normally charge;

11. Any admission, service, or item, requiring prior authorization, where authorization has not been obtained or has been denied (see N.J.A.C. 10:49-6, Authorizations Required);

12. Services furnished by an immediate relative or member of the Medicaid recipient's household;

13. Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code utilized by the billing provider, as specified in the Provider Services Manual;

i. Final payment shall be made in accordance with a review of those services actually documented in the provider's health care record. Further, the medical necessity for the services must be apparent and the quality of care must be acceptable as determined upon review by an appropriate and qualified health professional consultant.

ii. All such determinations will be based on rules and regulations of the New Jersey Medicaid Program, the minimum requirements described in the appropriate New Jersey Medicaid Provider Services Manual, to include those elements required to be documented in the provider's records according to the procedure code(s) utilized for payment, and on accepted professional standards. (See N.J.A.C. 10:49-9.5, Provider Certification and Recordkeeping.)

iii. Any other evidence of the performance of services shall be admissible for the purpose of proving that services were rendered only if the evidence is found to be clear and convincing. "Clear and convincing evidence" of the performance of services includes, but is not limited to, office records, hospital records, nurses notes, appointment diaries, and recipient statements.

iv. Therefore, any difference between the amount paid to the provider based on the claim submitted and the Division's value of the procedure as determined by the Division's evaluation, may be recouped by the Division of Medical Assistance and Health Services;

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid recipient whose Medicaid Eligibility Identification Card (FD-73/178) has a printed message restricting the recipient to another provider of the same service(s). (See N.J.A.C. 10:49-2.13(e)2, Special Status Program); and

15. Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or recipient income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Division. If upon audit, financial records or other acceptable evidence are unavailable for these purposes:

i. All reported costs for which financial records or other acceptable evidence are unavailable for review upon audit are deemed to be non-allowable; and/or

ii. Recipient income shall be presumed to equal the maximum income allowable for a Medicaid recipient for those recipients whose records relating to income are completely unavailable.

iii. The Division shall seek recovery of any resulting overpayments.

SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID PROGRAM

10:49-6.1 Prior and retroactive authorization (general)

(a) Under the Program, payment for certain services shall require prior authorization except in an emergency. It is the responsibility of the provider to obtain prior authorization before furnishing or rendering a service. Specific instructions are detailed in the appropriate Provider Services Manuals.

1. Prior authorization should not be construed as a guarantee that a person is eligible for the New Jersey Medicaid Program. At the time the serivce is to be provided, it is the provider's responsibility to verify eligibility.

2. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the recipient significant or intractable pain. Services provided for a medical emergency are exempt from prior authorization. Any service classified as a medical emergency that would have been subject to prior authorization had it not been so classified, must be supported by a practitioner's statement which describes the nature of the emergency, including relevant clinical information, and must state why the emergency services rendered were considered to be immediately necessary. To simply state that an emergency did exist is not sufficient.

3. In addition to services that must be prior authorized under the previous subsections, a provider may be required to submit some or all services for prior authorization if in the judgment of the Director the provider has engaged in conduct which would constitute good cause for suspension, debarment or disqualification under

N.J.A.C. 10:49-11.1(d). Prior authorization under this subsection may be imposed prior to a hearing under the same conditions applicable to suspensions under N.J.A.C. 10:49-11.1(j), except that the approval of the Attorney General shall not be necessary.

(b) Retroactive authorization may be granted under certain circumstances provided that the service is a part of continuing recipient care and, on the basis of medical judgment, would have been authorized at the time the service was rendered. Each case is considered on its own merit. Retroactive authorization is an exceptional measure granted only under the following unusual circumstances:

1. "Other coverage" (Medicare, Third-Party liability, other insurance, etc.) has denied or made only partial payment of a claim for services or items requiring prior authorization and it would have been unreasonable to expect the provider to have requested authorization prior to rendering the service;

2. Retroactive determination of eligibility;

3. An "administrative emergency" existed because communication between the provider and the staff of the New Jersey Medicaid Program could not be established (for example, during a weekend, holiday or evening) and provision of the service should not have been delayed. This differs from a medical emergency in that the recipient's condition would not be impaired if the service was not provided (see example below). In such instances, the request for retroactive authorization, including an explanation of the circumstances as well as the medical documentation supporting the services, shall be submitted to the Medicaid District Office or Central Office, as appropriate, within five calendar days after the service was provided or initiated. If verbal authorization was obtained, confirming written documentation shall follow.

Example: A physician orders a Medicaid recipient home from the hospital on a Friday evening. The recipient requires an electrical hospital bed, but the Medical Supplier is unable to contact the Medicaid District Office to obtain prior authorization. It is advantageous to the Medicaid Program, the hospital and the patient to discharge the recipient and not wait until authorization for the bed is requested on Monday; or

4. In situations not covered by (b)1, 2, and 3 above, the New Jersey Medicaid Program follows the doctrine of reasonableness which asks, "Is it reasonable to conclude that the situation presented warrants waiver of procedural rules?"

10:49-6.2 Out-of-State medical care and services

(a) Services provided outside the United States and territories are not covered by the New Jersey Medicaid Program.

(b) Any covered service that requires prior authorization as a prerequisite for reimbursement to New Jersey Medicaid providers shall also require prior authorization if it is to be provided in any other state.

1. Services which require prior authorization are described in the specific Medicaid Provider Services Manual.

(c) Prior authorization shall be required for all inpatient and outpatient hospital services provided outside the State of New Jersey except in the following situations:

1. Care provided in an emergency;

2. Interstate hospital transfers; and

3. Care provided to Medicaid recipients residing out-of-State at the discretion of the New Jersey Department of Human Services.

SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

10:49-7.1 General provisions

(a) The following information outlines the rules of the New Jersey Medicaid Program that the provider shall adhere to when submitting a claim and requesting payment for services provided to a New Jersey Medicaid recipient. (To identify a Medicaid recipient see N.J.A.C. 10:49-2.)

1. Each Provider Services Manual has information relevant to basis of payment for services and items of payment provided that is usually found in the second chapter of each manual.

(b) In addition to information in this subchapter about submitting claims for payment, a Fiscal Agent Billing Supplement is included following the second chapter of each Provider Services Manual. Included in the Supplement are prior authorization forms and instructions; information for the proper completion and submission of claim forms; the procedure to follow when claims are rejected and returned to the provider by the Fiscal Agent during the adjudication process; third party liability verification, procedure for submitting crossover claims, and examples of timely submission of claims; electronic media claims (EMC) submission; Remittance Advice statements; procedure for Electronic Funds Transfer (EFT); adjustments for overpayment and underpayment of claims, and adjustments by Medicare; procedure to follow when a claim is paid in error (voids); procedure for inquiries about claims; procedure for ordering forms; information about provider services; and item-by-item instructions for completing the claim form and other forms.

1. The Fiscal Agent Billing Supplement is not published in the New Jersey Administrative Code (N.J.A.C.) but is referenced as an appendix and is thus not a legal description of the New Jersey Medicaid Program's rules. Should there be any conflict between the Fiscal Agent Billing Supplement and the pertinent laws or rules governing the Medicaid Program, the latter takes precedence.

10:49-7.2 Timeliness of claim submission and inquiry

(a) A claim is defined as a request for payment from the New Jersey Medicaid Program for a Medicaid-reimbursable service provided to a Medicaid recipient. The claim may be submitted hard copy or by means of an approved method of automated data exchange. In order for a Medicaid claim to be considered for reimbursement, all appropriate documentation shall be included with the claim form.

1. It is the responsibility of the provider to ensure that each Medicaid claim submitted by that provider is received by the New Jersey Medicaid Program's Fiscal Agent within the time periods indicated in this section.

i. The New Jersey Medicaid Program shall not reimburse for a claim received outside the prescribed time periods. This policy also applies to inquiries concering a claim or claim related information received outside the prescribed time periods.

ii. For retroactive eligibility cases, a claim associated with a retroactive eligibility application will be considered as received on the date of receipt of the application on behalf of the applicant. For information about retroactive eligibility, see 10:49-2.7.

(b) An institutional claim is a claim submitted by a hospital; home health agency; nursing facility; intermediate care facility/mental retardation; residential treatment center; or governmental psychiatric hospital. The time requirements for submitting an institutional claim is as follows:

1. For claims submitted by home health agencies and hospitals (excluding governmental psychiatric hospitals), a claim for payment of a service provided to any Medicaid recipient shall be received by the New Jersey Medicaid Fiscal Agent within:

i. One year of the date of discharge on an inpatient hospital claim;

ii. One year of the date of service entered on an outpatient hospital claim or home health claim;

iii. One year of the earliest date of service entered on an outpatient hospital claim form or home health claim, if the claim carries more than one date of service; or

iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

2. For claims submitted by a nursing facility; intermediate care facility/mental retardation; residential treatment center; or government psychiatric hospital, a claim for payment for services shall be received by the Fiscal Agent no later than one year after the "from date of service" on the claim form.

(c) A non-institutional claim is a claim submitted by all providers except a hospital, home health agency, nursing facility, intermediate care facility/mental retardation, residential treatment center, or governmental psychiatric hospital. The time requirements for submitting a non-institutional claim is as follows:

1. A claim for payment of a non-institutional service provided to any Medicaid recipient shall be received by the New Jersey Medicaid Fiscal Agent within:

i. One year of the date of service;

ii. One year of the earliest date of service entered on the claim form if the claim form carries more than one date of service;

iii. One year (365 days) of the dispensing date on a pharmacy claim form; or

iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

(d) The time requirements for submitting a combination Medicare/Medicaid claim are as follows (Under Federal regulations, this applies only to Medicare/Medicaid claims and does not extend to claims involving any other third party insurance.):

1. A combination Medicare/Medicaid claim is defined as a request for payment from the New Jersey Medicaid Program for a medical service provided to any Medicare/Medicaid recipient.

i. The claim form shall contain both the HSP (Medicaid) Case Number and the Medicare HIC Number.

2. A combination Medicare/Medicaid claim shall be received by the Medicare Intermediary/Carrier within the applicable Medicaid timely submission period (see (b) and (c) above) to be considered for further payment by the New Jersey Medicaid Program.

i. The provider shall continue to have one year from the date of service for a claim to be received by the Medicaid Fiscal Agent. A claim received by the Medicaid Fiscal Agent after Medicare adjudication and within one year from the date of service shall be considered timely submitted.

ii. For combination Medicare/Medicaid claims received by the Medicare Intermediary/Carrier within the applicable Medicaid timely submission period and where Medicare adjudication occurs beyond the one year of the date of service, the provider shall submit a claim to be received by the Medicaid Fiscal Agent within 90 days of the date of the Medicare adjudication.

iii. For Medicare/Medicaid claims where the Medicare adjudication occurs within one year from the date of service, but less than 90 days remain within the timely filing period, the provider shall submit the claim to be received by Medicaid within the one year timely filing period or 90 days, whichever is later.

iv. A combination Medicare/Medicaid claim received outside the applicable Medicaid timely submission period shall not be reimbursed by the New Jersey Medicaid Program.

3. In most cases, when a recipient is eligible for both Medicare and Medicaid, a Medicare/Medicaid claim will cross over from the Medicare Carrier/Intermediary to the Medicaid Fiscal Agent. The provider is requested to allow 45 days from Medicare adjudication for the Medicaid Program to receive and process crossover claims. Failure to allow the 45 days for the transition from Medicare to Medicaid may result in payment delays due to duplicate claim errors. There are instances, however, where claims will not cross over from Medicare to Medicaid. In those instances, or when a Medicare/Medicaid crossover is not reflected on the provider's Medicaid Remittance Advise within 45 days of the Medicare Explanation of Benefits (EOB), the provider shall follow the billing instructions in the Fiscal Agent Billing Supplement following the second chapter of the Provider Services Manual.

(e) If additional information is required in order to process a claim, the provider shall supply the information as soon as possible, but not more than 90 days after the end of the applicable timely submission period.

(f) Regarding an adjudicated claim inquiry, a provider may inquire about a claim that has been paid or denied but shall make the inquiry within 90 days of the date of adjudication as indicated on the Remittance Advice Statement.

(g) Regarding a non-adjudicated claim inquiry, a provider may inquire about the status of a claim for which neither payment nor denial has been received. The inquiry may be made at any time after the claim is received, but not more than 90 days after the end of the applicable timely submission period.

(h) Claims may be paid beyond 12 months of the date of receipt with Federal financial participation (FFP) in the following situations:

1. When the claim invoice or retroactive adjustment is paid to a provider reimbursed under a retrospective payment system;

2. For a Medicare/Medicaid claim, timely filed, Medicaid payment may be made for services within six months after the Program or provider receives notice of the Medicare claim disposition for a timely filed Medicare/Medicaid claim;

3. For claims from providers under investigation for fraud or abuse; or

4. For claims associated with administrative or legal actions pursuant to a hearing action or agency corrective action mandate, whether for an eligible individual or for all those eligibles affected in a similar manner.

10:49-7.3 Third party liability (TPL) benefits

(a) "Third party liability" (TPL) exists when any person, institution, corporation, insurance company, absent parent, Medicare program, public, private, or governmental entity is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the cost of medical assistance payable under this act.

1. It is a violation of section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid recipient because of a third party's potential liability to pay for services.

(b) Medicaid benefits are last-payment benefits. All TPL, for example, health insurance, Medicare, CHAMPUS, prepaid health plans, workers' compensation and auto insurance, shall, if available, be used first and to the fullest extent in meeting the cost of the medical needs of the Medicaid recipient, subject to (h) below.

(c) The New Jersey Medicaid Program will supplement the amount paid by a third party, but the combined total paid to the provider shall not exceed the total amount payable under the Program in the absence of any TPL. The following exceptions should be noted:

1. Medicare: The Program will make payment in the full amount of the Medicare deductible and co-insurance for certain inpatient hospital services (see (e)1i(1) below).

2. Contracting practitioners: No Program payments shall be made when the third party calls for a contracting or participating practitioner to accept the TPL as payment in full.

(d) Medicaid participating providers are prohibited from billing Medicaid recipients for any amount, except:

1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.) if the recipient elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized; or

2. For payments made to the recipient by a third party on claims submitted to the third party by the provider.

(e) When a Medicaid recipient has other health insurance, the Program requires that such benefits be used first and to the fullest extent, subject to the exceptions in (h) below. Supplementation may be made by the Program, but the combined total paid shall not exceed the amount payable under the Program in the absence of other coverage. The Program shall not supplement coverage services rendered by a participating or contracting practitioner with any private health coverage program where the private plan calls for the practitioner to accept that plan's payment as payment in full. When other health insurance is involved, supplementation claims shall not be filed with the Program unless accompanied by a statement of payment, Explanation of Benefits (EOB), or denial from the other carrier. Attachment of such information will expedite Medicaid claim processing.

1. Medicare is a health insurance program which covers certain aged and disabled persons. When rendering Medicare-covered services to any Medicaid recipient, providers shall inquire about Medicare eligibility especially if the third digit of the HSP (Medicaid) Case Number is a 1, 2, 5, or 7. Medicaid supplementation of available Medicare benefits shall be as follows:

i. Medicare (Title XVIII): For any Medicaid recipient who is covered under Medicare, responsibility for payment by the New

Jersey Medicaid Program shall be limited to the unsatisfied deductible and/or co-insurance to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid Program in the absence of other coverage. The following exceptions should be noted:

(1) The Program shall pay the full amount of any unsatisfied Medicare deductible and/or co-insurance for inpatient hospital services billable to the Program in accordance with Chapter 83, P.L. 1978 (that is, inpatient hospital services subject to payment by the Program according to the New Jersey DRG reimbursement methodology).

(f) When a Medicaid recipient has benefits available, such as those described above or from any other liable third party, an approved Medicaid provider shall be authorized to sign an insurance claim form for the Commissioner, based on the third party assignment of rights, in order to receive direct payment from the insurer. This is done pursuant to N.J.S.A. 30:4D-7.1(c). The following language shall be used by the provider when completing insurance claim forms: "(signature of authorized provider), Assignee for the Commissioner, New Jersey Department of Human Services."

(g) When recovery of benefits is sought by the Medicaid Program from a liable third-party, the Commissioner shall authorize the Director or his designee(s) to sign the recovery demand.

(h) TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid payment in any of the following circumstances:

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;

2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Program;

3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay; or

4. The claim involves a service for which HCFA has granted a waiver of the TPL cost avoidance requirements in accordance with 42 C.F.R. 433.139(e). Waivers have been granted for:

i. Pharmacy services; and

ii. Services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR and Vineland Special Hospital.

(i) In those situations where an insurance payment is received from another payer after Medicaid has been billed and has made payment, the provider must reimburse the Medicaid payment to the Medicaid Program and not the Medicaid recipient. Reimbursement must be made immediately to comply with Federal regulations. To initiate the process, providers must submit an Adjustment/Void Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

(j) Regardless of the status of a provider's claim with other third parties, all claims for Medicaid reimbursement must be received by the Medicaid Fiscal Agent within the time frames specified in N.J.A.C. 10:49-7.2, Timeliness of claim submission.

(k) Any individual who undertakes to legally represent any Medicaid recipient in an action for damages against any third party when medical expenses have been paid by the Division shall be required to give written notice to the Division within 20 days of filing or commencing the action.

1. The term "legal representative" shall include, but not be limited to, an attorney, administrator/administratrix, executor/executrix, conservator, guardian or guardian ad litem.

10:49-7.4 Prohibition of payment to factors

(a) A "factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or deduction of a portion of the accounts receivable.

(b) Payment for any covered services furnished to any Medicaid recipient by an approved provider may not be made to or through a factor, either directly or by power-of-attorney.

10:49-7.5 Use of service bureau and/or management agency

(a) Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payment in the name of the provider if the agent's compensation for this service is:

1. Related to the cost of processing the billing;

2. Not related on a percentage or other basis to the amount that is billed or collected; and

3. Not dependent upon the collection of the payment.

(b) If a participating provider wishes to designate a business agent to perform management, clerical and/or other services related to the claims payment process, approval is required from the New Jersey Medicaid Program.

(c) In order to obtain approval the provider/agent shall submit a copy of the signed agreement and power-of-attorney, if any, between the provider and the agent which shall contain a detailed statement of the powers and duties of the agent (including the power to sign Medicaid claim forms on behalf of the provider and the compensation arrangement) to Provider Enrollment, New Jersey Medicaid Program.

(d) Approval shall be obtained for each provider/agent agreement. Approval of an agent agreement with one provider does not confer an automatic approval of any additional provider/agent agreement.

(e) Standard Medicaid hard-copy claim forms shall be used unless the provider has been authorized for electronic media claims submission; however, in some instances hard-copy claims are required. These instances are detailed, as applicable, in the appropriate Provider Services Manual.

1. If standard Medicaid claim forms are not utilized, the provider/agent shall obtain approval from the New Jersey Medicaid Program.

2. In order to obtain approval, the provider/agent shall submit a printer's prototype of an exact replica of the Medicaid claim form and the programming instructions for completion of the form to the Fiscal Agent.

3. The provider/agent shall assume the entire cost of printing duplicate forms at all times.

(f) The New Jersey Medicaid Program in approving any provider/agent agreement, assumes no responsibility for the performance of the provider or agent. In the event that any error of the provider/agent requires special programming to be made by the Medicaid Fiscal Agent in order to have claims paid correctly, the provider/agent shall assume the entire cost of the special program.

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

10:49-8.1 Fiscal Agent

The State of New Jersey uses a fiscal agent for the processing of claims and payment to providers for all health services.

10:49-8.2 Claim payment

(a) The Fiscal Agent will process claims daily and produce provider payments and associated Remittance Advice (RA) statements once each week. The RA is the provider's account statement and reflects the status of all claims currently entered into the Medicaid Management Information System. Provider payments in the form of checks and electronic funds transfers will be released following approval by the New Jersey Medicaid Program.

1. The Remittance Advice (RA) is the major vehicle for communicating to the provider the status of all Medicaid claims received by the Fiscal Agent. All of the provider's claims are processed and supporting records are updated during each payment cycle. RA statements are generated as a result of a payment cycle. All claims processed (entered into the Medicaid Management Information System) fall into one of three classifications: paid; suspended; or denied.

i. A claim that is correctly completed for a covered service provided to a Medicaid recipient by an approved provider will be paid. The claim will appear on the RA Claims Status page, or pages, along with all other claims for which a provider is being paid in that payment cycle. If the amount differs from the billed charges, an explanation will appear on the RA.

ii. Suspended claims are those claims held for review by the Fiscal Agent. The review will result in a claim being paid, denied, or additional information being requested. If additional information is required, a Claim Correction Form (CCF) will be forwarded to the provider. (Additional billing information is provided in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

iii. Reasons for denial of a claim will be provided on the RA in the form of a code.

(1) Messages explaining all codes reflected on the Remittance Advice will be printed on a separate page.

(b) A unique 13 digit Internal Control Number (ICN) is assigned to each Medicaid claim received by the Fiscal Agent. The ICN is reflected on the RA and can be used to track the status of a claim. For more information about the ICN, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

(c) For each claim processed in a payment cycle, the ICN, recipient name, dates of service and other claim information is printed on the RA. On the line immediately below this information, a code is printed representing a denial reason, suspense reasons, and payment reduction reasons, if any. The only type of claim status that will not have a code is one that is paid as billed. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. For more information about Remittance Advice see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

10:49-8.3 Adjustments following payment of claims

(a) If a claim is incorrectly paid and the provider receives an overpayment or underpayment, the provider shall notify the Fiscal Agent in writing. (For the procedure to follow, see Fiscal Agent Billing Supplement, Adjustment/Void Form, following the second chapter of each Provider Services Manual).

(b) On occasion, a claim will be paid that should not have been paid; for example, a duplicate payment. If a claim is paid in error, the provider shall notify the Fiscal Agent by requesting that the claim be voided. (For the procedure to follow, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.)

(c) Any adjustment made by Medicare will not cross over to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider shall notify the Fiscal Agent. (For the procedure to follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

10:49-8.4 Claims payment by direct deposit (electronic funds transfer (EFT))

(a) Through electronic funds transfer, a provider has the option of receiving claims payment automatically as a direct deposit to his or her checking account.

1. To enroll in the EFT payment program, the provider must complete an EFT Enrollment Request/Authorization form. A voided check displaying the provider's account number must accompany the complete authorization form. The enrollment form must be signed by the provider or an authorized official such as the business manager, owner, or facility administrator. Any change to the EFT information (for example, a change of account number, ownership, or authorized official) requires the completion of a new EFT Enrollment Request/Authorization form. (For detailed instructions about enrollment in the EFT payment program, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

10:49-8.5 Outstanding checks

(a) After Medicaid checks are outstanding for a period of six months, a follow-up letter shall be sent to the payee. This procedure shall only apply to checks of $5.00 or more.

(b) All Medicaid checks remaining outstanding after 12 months shall be cancelled in monthly lots rather than check by check. Listings of cancelled checks shall be in sufficient detail to identify providers and amounts of payment. These records shall be retained for audit.

SUBCHAPTER 9. PROVIDER AND RECIPIENT'S RIGHTS AND RESPONSIBILITIES; ADMINISTRATIVE PROCESS

10:49-9.1 Civil rights

Federal regulations require that services provided to any Medicaid recipient shall be given without discrimination on the basis of race, color, national origin, or handicap. Therefore, payments shall be limited to providers of service who are in compliance with the nondiscrimination requirements of Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

10:49-9.2 Observance of religious belief

(a) Nothing in the Medicaid Program shall be construed to require any recipient to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his or her parent or guardian objects thereto on religious grounds, except as specified in (b) below.

(b) If a physical examination is necessary to establish eligibility based on disability or blindness, the Medicaid Program may not find an individual eligible for Medicaid unless he or she undergoes the examination.

10:49-9.3 Free choice by recipient and provider

(a) The concept of freedom of choice shall apply to both provider and recipient.

1. A Medicaid recipient shall be free to choose providers of service who meet Program standards and who elect to participate in the Medicaid Program. The Medicaid District Office shall assist any recipient in obtaining services if the recipient cannot locate a provider. Exception: see N.J.A.C. 10:49-14.2, Special Status Programs.

2. A provider who accepts a recipient for care shall accept the Program's policies and reimbursement for all covered services and/or items provided or delivered during that period when, by mutual agreement, the recipient is under the provider's care. In the provision of professional services, the provider shall be bound by the code of ethics governing his or her profession.

10:49-9.4 Confidentiality of records

(a) All information concerning applicants and recipients acquired under this Program shall be confidential and shall not be released without the written consent of the individual or his or her authorized representative. If, because of an emergency situation, time does not permit obtaining consent before release, the Program shall notify the individual, his or her family, or authorized representative, immediately after releasing the information.

(b) The restriction on the disclosure of information shall not preclude the release of statistical or summary data or information in which applicants or recipients are not, and cannot be, identified; nor shall it preclude the exchange of information among providers furnishing services, Fiscal Agent of the Program, and State or local government agencies, for purposes directly connected with administration of the Program. Disclosure without the consent of the applicant or recipient shall be limited to purposes directly connected with the administration of the Program in accordance with Federal and State law and regulations.

1. Purposes directly connected with the administration of the Program shall include, but are not limited to:

i. Establishing eligibility;

ii. Determining the amount of medical assistance;

iii. Providing services for recipients; and

iv. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Program.

*[(b)]**(c)* The type of information about applicants and recipients that shall be safeguarded by the Program includes, but is not limited to:

1. Name and address;

2. Medical services provided;

3. Social and economic conditions or circumstances;

4. Program evaluations of personal information;
5. Medical data, including diagnosis and past history of disease or disability;
6. Any information received for verifying income eligibility and amount of medical assistance payments. Income information received from SSA or the Internal Revenue Service shall be safeguarded according to the requirements of the agency that furnished the data; and
7. Any information received in connection with the identification of legally liable third party resources as required under applicable Federal Regulations (42 C.F.R. 433.138).

10:49-9.5 Provider certification and recordkeeping

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by Program regulations); and all providers shall certify that the information furnished on the claim form is true, accurate, and complete.

1. All claim forms for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the fiscal agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.
i. The following signature types are unacceptable:
(1) Initials instead of signature;
(2) Stamped signature; and
(3) Automated (machine-generated) signature.

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided;
2. To furnish information for such services as the Program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore are in accordance with the regulations of the New Jersey Medicaid Program;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with Program regulations; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid recipient or to others on his behalf.

10:49-9.6 Patient's (recipient) certification

(a) A recipient's certification, authorization to release information and payment request, shall, under ordinary circumstances, be signed after the services identified on the claim form are provided and before a claim for payment is submitted by the provider. The recipient is:

1. Certifying that the service(s) covered by a claim has been received;
2. Requesting payment for those services made on his or her behalf; and
3. Authorizing any holder of medical or other information to release to New Jersey Medicaid or its authorized agents any information needed for this or a related claim.

(b) A provider who is submitting claims via an approved electronic media claims submission shall request a waiver to obtain the recipient or representative's certification on the standard Patient Certification (Form FD-197) which the provider shall keep on file for each service rendered and shall make available upon request to representatives of the New Jersey Medicaid Program. Initials instead of a signature are unacceptable on the Patient Certification Form.

1. If a signed Patient Certification Form is not on file for each service, Medicaid reimbursement for the service shall be subject to recoupment.

(c) A provider who is submitting a hard-copy Medicaid claim form shall, under ordinary circumstances, obtain the recipient's certification on the Medicaid hard-copy claim form (appropriate to the provider), unless a waiver is requested to use the standard Medicaid Patient Certification (Form FD-197, see Appendix, N.J.A.C. 10:49). A waiver application may be obtained from the Fiscal Agent.

(d) For certain providers, an individualized certification form, as indicated in the specific service chapter of the appropriate provider manual, may be used in place of the standard Medicaid Patient Certification (Form FD-197).

(e) A Medicaid hard-copy claim form or a Patient Certification Form shall be completed by a provider before it is presented to the recipient for signature. A Medicaid recipient may not sign a blank Medicaid hard-copy claim or a Patient Certification Form prior to receiving services or as a condition for receiving services.

(f) When the recipient's signature is unobtainable, the following procedures may be used:

1. An illiterate recipient may make his or her mark (x), and the mark shall be witnessed by another person who signs his or her name and address on the Patient Certification Form (FD-197) or on the Medicaid hard-copy claim form.
2. If a recipient is physically or mentally incapable of signing, or is deceased, the form(s) may be signed on his or her behalf by:
i. A parent;
ii. A legal guardian;
iii. A relation;
iv. A friend;
v. An individual provider;
vi. A representative of an institution providing care or support;
vii. A representative of a governmental agency providing assistance; or
viii. An administrator or executor.
3. A brief explanation of the reason the recipient was not personally able to sign the form(s) and the relationship of the signee to the recipient shall be noted directly on the Medicaid hard-copy claim form or the Patient Certification Form (FD-197).

10:49-9.7 Integrity of the Medicaid Program

The New Jersey Medicaid Program, in order to maintain the integrity of the Program, strictly prohibits its employees from accepting gifts or gratuities of any kind and of any value from individuals, representatives of provider organizations or institutions who provide services and are reimbursed through the Program. This includes the prohibition of offers of special employment, consultation fees and all other gratuities by a provider, individual or facility.

10:49-9.8 Fraud and abuse

The New Jersey Medicaid Program shall employ methods to identify situations in which a question of fraud and/or abuse in the Program may exist. The Division shall refer to law enforcement officials situations in which there is valid reason to suspect that fraud has or may have been committed.

10:49-9.9 Informing individuals of their rights

(a) All claimants shall be informed of the following, in writing, at the time of application and at the time of any action affecting their claim:

1. Of their right to a fair hearing;
2. Of the method by which they may obtain a hearing;
3. That they may be represented by legal counsel or by a relative, friend, or other spokesperson, or they may represent themselves; and
4. Of legal services within the community from which they may receive legal aid.

10:49-9.10 Provisions for appeals; fair hearings

(a) Pursuant to N.J.A.C. 10:49-10, Fair Hearings, both providers and Medicaid recipients with the New Jersey Medicaid Program shall have the right to file for fair hearings.

(b) A provider may be granted a hearing because of the denial of a prior authorization request or issues involving the provider's status; for example, termination, debarment, suspension, and so forth, as described in N.J.A.C. 10:49-11.1, or issues arising out of the claims payment process.

(c) A Medicaid recipient may be granted a hearing because his or her claim for medical assistance is denied or is not acted upon with reasonable promptness, or because the recipient is aggrieved by any other agency action resulting in non-eligibility, denial, termination, reduction or suspension of such assistance.

(d) In order to obtain a fair hearing, the provider or the recipient shall submit a request in writing to the Fair Hearing Unit, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625, outlining the reason for the request.

(e) Any nursing facility whose certification or Medicaid Provider Agreement is denied, terminated, or not renewed, may request a hearing in accordance with the appeals procedure described in the Nursing Facilities Services Manual.

SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS

10:49-10.1 Definitions

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

"Applicant" means any person who has made application for purpose of becoming a "qualified applicant."

"Claimant," when used within these rules, means applicant, qualified applicant or recipient as defined in this section.

"Department" means the Department of Human Services, the single State agency responsible for administering the New Jersey Medicaid Program and other special programs through the Division of Medical Assistance and Health Services.

"Notice" means an announcement of a policy decision by the Title XIX agency that may adversely affect the Medicaid recipient.

"Provider" means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D-1 et seq. and amendments thereto, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

"Qualified applicant" means any person who is determined to be eligible to receive benefits in accordance with N.J.S.A. 30:4D-1 et seq. and amendments thereto.

"Recipient" means a person who is a resident of this State and is determined to need medical care and services under N.J.S.A. 30:40-1 et seq. and amendments thereto, and falls within the eligibility criteria set forth therein.

10:49-10.2 Notices

(a) The Department/Division may print a notice of prospective policy changes affecting Medicaid recipients generally in one or more newspapers in New Jersey.

1. This public notice will be accompanied by a proposed rulemaking on the subject of the notice in the New Jersey Register.

2. The public notice may precede or be subsequent to the Register publication.

3. The Department of Human Services may proceed to adopt the regulatory changes pursuant to N.J.S.A. 52:14B-4 without providing further notice.

10:49-10.3 Opportunity for fair hearing

(a) An opportunity for a fair hearing may be granted to any provider requesting a hearing on any valid complaint or issue arising out of the claims payment process.

1. Such issues shall include, but not be limited to, denials of prior authorization and denial of claims submitted for payment.

2. Such requests for hearing shall be made in writing within 20 days from the date of the notice of the agency action giving rise to said complaint or issue.

3. For claim denial or payment adjustment, the 20 days' notice starts from the date in the right hand corner of the Remittance Advice Claims Status returned to providers with the Remittance Advice cover page (see Fiscal Agent Billing Supplement following the second chapter of each Providers Services Manual regarding the Remittance Advice cover page and Claims Status explanations and examples). Providers should include a photocopy of the applicable Claims Status page, highlighting the recipient and applicable edit code(s) when submitting a hearing request.

(b) An opportunity for fair hearing shall be granted to all claimants requesting a hearing because their claims for medical assistance are denied or are not acted upon with reasonable promptness, or because they believe the agency has erroneously terminated, reduced or suspended their assistance. The agency need not grant a hearing if the sole issue is one of a Federal or State law requiring an automatic termination, reduction or suspension of assistance affecting some or all claimants. Under this requirement:

1. A request for hearing shall be defined as any clear expression (submitted in writing) by claimants (or someone authorized to act on behalf of claimants) to the effect that they desire the opportunity to present their case to higher authority;

2. The freedom to make such a request shall not be limited or interfered with in any way, and departmental emphasis shall be on helping claimants to submit and process their case if needed;

3. Claimants shall have 20 days from the date of notice of departmental action in which to request a hearing;

4. The fair hearing shall include consideration of:

i. Any departmental action, or failure to act with reasonable promptness, on a claim for medical assistance, which includes undue delay in reaching a decision on eligibility, suspension of assistance or denial of such assistance in whole or in part;

ii. Department decision regarding:

(1) Eligibility for medical assistance in both initial and subsequent determinations;

(2) Amount of medical assistance or change in such assistance;

5. The Department may respond to a series of individual requests for fair hearings by arranging for a single group hearing. A consolidation of cases by the Department may be allowed only in cases which the sole issue involved is one of federal or State law or policy;

6. In all group hearings, whether initiated by the Department or by claimants, the policies governing fair hearings shall be followed. Thus, each individual claimant shall be permitted to present his or her own case and be represented in accordance with the provisions of N.J.A.C. 10:49-9.9(a)3; and

7. The Department shall not deny or dismiss a request for a hearing except where it has been withdrawn by claimant in writing or abandoned.

(c) For purposes of these rules, the right to a hearing is considered abandoned if claimants or their representative fail to appear at a scheduled hearing and, within five days after receipt of an inquiry as to whether they desire any further action on their request, no reply is received. Refusal of acceptance of a registered letter inquiring into contemplated further action by claimants shall constitute abandonment effective the date of refusal.

10:49-10.4 Advance notice of intent to terminate, reduce, or suspend assistance

(a) In cases of any proposed action to terminate, reduce or suspend assistance, the Department shall give the claimant timely and adequate notice detailing the reasons for the proposed action. Under these requirements:

1. "Timely" means that the notice is dated at least 10 days before the action is to be taken; and

2. "Adequate*[ly]* advance notice" means a written notice that includes a statement of the action the Department intends to take, reasons for the proposed departmental action, the specific regulations that support, or the change in Federal or State law that requires, the action, the claimant's right to request a fair hearing, or in cases of a departmental action based on a change in law, the circumstances under which a hearing shall be granted, and the circumstances under which assistance shall be continued if a fair hearing is requested.

(b) In cases in which there is a request for a fair hearing within the advance notice period:

1. Assistance shall be continued until a decision is rendered unless:

i. It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

ii. The Department promptly informs the claimant in writing that services shall be terminated or reduced pending the hearing decision.

2. If the Department's action is sustained by the hearing decision, the Department may institute recovery procedures against claimants to recoup the cost of any services furnished claimants to the extent the services were furnished solely by reason of this section.

(c) The Department may reinstate services if a claimant requests a hearing not more than 10 days after the effective date of the termination, suspension or reduction of eligibility or covered services.

1. If services are reinstated, they shall continue until a hearing decision is made unless it shall be determined at the hearing that the sole issue is one of Federal or State law or policy.

(d) The Department shall reinstate and continue services until a decision is rendered after a hearing if:

1. An action is taken to terminate, suspend or reduce eligibility or covered services without affording claimants adequate advance notice as defined herein;

2. Claimants request a hearing within 10 days of the date of the notice of action; and

3. The Department determines that the action to terminate, reduce or suspend assistance resulted from reasons other than the application of federal or State law or policy.

(e) If a claimant's whereabouts are unknown, as indicated by the return of unforwardable departmental mail directed to them, any *[discounted]* ***discontinued*** services shall be reinstated if their whereabouts become known during the time they are eligible for services.

10:49-10.5 Location of hearing

The hearing shall be conducted at a reasonable time, date and place after adequate written notice of the hearing is given.

10:49-10.6 Inpartiality of official conducting the hearing

The hearing shall be conducted by an Administrative Law Judge from the Office of Administrative Law or by other persons eligible to conduct hearings pursuant to the New Jersey Administrative Procedure Act, set forth in N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq.

10:49-10.7 Recipient's right to different medical assessment

When the hearing involves medical issues, such as those concerning a diagnosis or an examining physician's report or the medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the person or persons involved in making the original decision, such medical assessment shall be obtained at Departmental expense from a source satisfactory to the claimant and shall be made part of the record.

10:49-10.8 Hearing procedures

The hearing shall be conducted pursuant to the procedures set forth in the Administrative Procedures Act, ***and*** the Uniform Administrative Procedure Rules (N.J.A.C. 1:1) *[and the]** ***The*** Special Hearing Rules set forth at N.J.A.C. 1:10B ***apply to claimant (recipient) hearings***. (See 42 C.F.R. 431.200, Subpart E).

10:49-10.9 Prompt, definitive and final action

Prompt, definitive and final administrative action shall be taken within 90 days from the date of the request for a fair hearing, except where claimant requests an adjournment.

10:49-10.10 Notification to claimants

Claimants shall receive a written final decision, in the name of the Department and shall be notified of their right to judicial review.

10:49-10.11 Action upon favorable decision to claimants

When the final hearing decision is favorable to claimants or when the Department decides in favor of claimants prior to the hearing, the Department shall make corrective payments retroactively to the date the incorrect action was taken or such earlier date as may be provided under State policy.

10:49-10.12 Hearing decision

(a) A final decision by the agency head shall specify the reasons for the decision and identify the supporting evidence or may incorporate by reference the findings, conclusions, and recommendations, contained in the initial decision.

(b) Final decisions shall be binding on the Department.

(c) Under this rule, no person who participated in the local decision being appealed shall participate in a final administrative decision on such a case; the Department shall be responsible for seeing that the decision is carried out promptly.

(d) The final decision shall be promptly implemented.

10:49-10.13 Accessability of hearing decisions to local agencies and the public

The Department shall establish and maintain a method for informing, at least in summary form, all local agencies of all fair hearing decisions by the hearing authority and the decisions shall be accessible to the public (subject to the provisions of safeguarding public assistance information).

SUBCHAPTER 11. EXCLUSION FROM PARTICIPATION IN THE NEW JERSEY MEDICAID PROGRAM (SUSPENSION, DEBARMENT, AND DISQUALIFICATION)

10:49-11.1 Program participation

(a) The provisions of this section were adopted and issued pursuant to Executive Order No. 34, dated March 29, 1976, and the authority vested in the Division of Medical Assistance and Health Services to implement the New Jersey Medicaid Program by rules and regulations set forth in N.J.S.A. 30:4D-5, and by N.J.S.A. 30:4D-17.1 a and c.

(b) Suspension, debarment, and disqualification are measures which shall be invoked by the Division of Medical Assistance and Health Services to exclude or render ineligible certain persons from participation in contracts and subcontracts with the Division, or in projects or contracts performed with the assistance of and subject to the approval of the Division, on the basis of a lack of responsibility. These measures shall be used for the purpose of protecting the interests of the Division and not for punishment. To assure the Division the benefits to be derived from the full and free competition between and among such persons and to maximize the opportunity for honest competition and performance, these measures shall not be invoked for any time longer than deemed necessary to protect the interests of the Division.

1. Any individuals, including, but not limited to, owners, officers, administrators, assistant administrators, employees, accountants, attorneys, and management services, who have been suspended, debarred or disqualified from participation in the Medicaid Program for any reason shall not be involved in any activity relating to the New Jersey Medicaid Program.

2. Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited to such individuals, and such amounts shall not be reimbursed by the New Jersey Medicaid Program.

3. Providers reimbursed on a fee-for-service basis may not submit claims and shall not be reimbursed for any goods supplied or services rendered by such individuals.

4. The above policy shall apply only for the period during which such individuals are suspended, debarred or disqualified from Medicaid participation.

(c) Definitions, as used in this section, shall include the following:

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Debarment" means an exclusion from State contracting, on the basis of a lack of responsibility evidenced by an offense, failure or inadequacy of performance, for a reasonable period of time commensurate with the seriousness of the offense, failure or inadequacy of performance.

"Disqualification" means a debarment or a suspension which denies or revokes a qualification to bid or otherwise engage in State contracting which has been granted or applied for pursuant to statute, or rules and regulations.

"Division" means the Division of Medical Assistance and Health Services, which administers Medicaid, Federally waivered programs (see N.J.A.C. 10:49-1.6) and state funded programs (see N.J.A.C. 10:49-1.7).

"Fiscal Agent" means an entity which processes and pays claims on behalf of the State of New Jersey.

"Person" means any natural person, company, firm, association, corporation or other entity.

"Provider" means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under the New Jersey Medicaid Program P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.), as amended, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

"State" means the State of New Jersey or any of the departments or agencies in the executive branch of government with the lawful authority to engage in contracting.

"State contracting" means any arrangement giving rise to an obligation to supply anything to or perform any service for the State, other than by virtue of State employment, or to supply anything to or perform any service for a private person where the State provides substantial financial assistance and retains the right to approve or disapprove the nature or quality of the goods or service or the persons who may supply or perform the same.

"Suspension" means an exclusion from State contracting for a temporary period of time, pending the completion of an investigation or legal proceedings.

(d) Any of the following, among other things, shall constitute a good cause for suspension, debarment, or disqualification of a person engaged in State contracting, as defined herein, by the Division of Medical Assistance and Health Services:

1. Commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract, or subcontract thereunder, or in the performance of such contract or subcontract;

2. Violation of the Federal Organized Crime Control Act of 1970, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, perjury, false swearing, receiving stolen property, obstruction of justice or any other offense indicating a lack of business integrity or honesty;

3. Violation of the Federal or State antitrust statutes, or of the anti-kickback provisions of the Social Security Act at 42 U.S.C. 1320 a-7b (b), subject to the exceptions set forth in 42 CFR 1001.952;

4. Violations of any of the laws governing the conduct or elections of the State of New Jersey or of its political subdivisions;

5. Violation of the "Law Against Discrimination" (P.L. 1945, c.169, N.J.S.A. 10:5-1 et seq. as supplemented by P.L. 1975, c.127), or of the "Act Banning Discrimination in Public Works Employment" (N.J.S.A. 10:2-1 et seq.) or of the "Act Prohibiting Discrimination by Industries Engaged in Defense Work in the Employment of Persons Therein" (P.L. 1942, c.114, N.J.S.A. 10:1-10 et seq.);

6. Violations of any laws governing hours of labor, minimum wage standards, prevailing wage standards, discrimination in wages, or child labor;

7. Violations of any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries;

8. Willful failure to perform in accordance with contract specifications or within contractual time limits;

9. A record of failure to perform or of unsatisfactory performance in accordance with the terms of one or more contracts, provided that such failure or unsatisfactory performance has occurred within a reasonable time preceding the determination to debar and was caused by acts within the control of the person debarred;

10. Violations of contractual or statutory provisions regulating contingent fees;

11. Presentment for allowance or payment of any false or fraudulent claim for services or merchandise;

12. Submitting false information for the purpose of obtaining greater compensation than that to which the person is legally entitled;

13. Submitting false information for the purpose of obtaining authorization requirements;

14. Failure to disclose or make available to the Division of Medical Assistance and Health Services or its authorized agent, records of services provided to or payments made on behalf of Medicaid recipients;

15. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of peers;

16. Engaging in a course of conduct or performing an act deemed improper or abusive of the New Jersey Medicaid Program following notification that said conduct should cease;

17. Breach of the terms of the Medicaid provider agreement entered into with the Division or failure to comply with the terms of the provider certification on the Medicaid claim form;

18. Overutilizing the New Jersey Medicaid Program by inducing, furnishing or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the recipient;

19. Rebating or accepting a fee or portion of a fee or charge for a Medicaid recipient referral;

20. Violating any provision of N.J.S.A. 30:4D-1 et seq. (New Jersey Medical Assistance and Health Services Act) as amended, or any rule or regulation promulgated by the Commissioner of Human Services pursuant thereto;

21. Conviction of any crime involving moral turpitude;

22. Submission of a false or fradulent application for provider status to the Division or to its fiscal Agent;

23. Any other cause affecting responsibility as a State contractor of such serious and compelling nature as may be determined by the Division to warrant debarment, including such conduct as may be proscribed by the laws or contracts enumerated in this subsection, even if such conduct has not been or may not be prosecuted as violations of such laws or contracts;

24. Debarment by some other department or agency in the executive branch;

25. Suspension, debarment, disqualification or exclusion from participation in the Medicaid Program of another state; or

26. Suspension or exclusion from participation in the delivery of medical care or services under Title XVIII, XIX or XX of the Federal Social Security Act by the Secretary of the United States Department of Health and Human Services.

(e) Conditions for debarment shall be as follows:

1. Debarment shall be made only upon approval of the Director of the Division, except as otherwise provided by law.

2. The existence of any of the causes set forth in (d) above shall not necessarily require that a person be debarred. In each instance, the decision to debar shall be made within the discretion of the Director of the Division unless otherwise required by law, and shall be rendered in the best interests of the Division.

3. All mitigating factors shall be considered in determining the seriousness of the offense, failure or inadequacy of performance and in deciding whether debarment is warranted.

4. The existence of a cause set forth in (d)1 through 7 above shall be established upon the rendering of a final judgment or conviction by a court of competent jurisdiction or by an administrative agency empowered to render such judgment. In the event an appeal taken from such judgment or conviction results in reversal thereof, the debarment shall be removed upon the request of the debarred person unless other cause for debarment exists.

5. The existence of a cause set forth in (d)8, 9, 10 and 23 above shall be established by evidence which the Division or agency determines to be clear and convincing in nature.

6. The existence of a cause set forth in (d)1 through 7, 11 through 22, and 24 above shall be established by a preponderance of the believable evidence.

7. Debarment for the cause set forth in (d)24 above shall be proper, provided that one of the causes set forth in (d)1 through 23 above was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.

(f) If the Division seeks to debar a person or his or her affiliates, the Division shall furnish such party with a written notice stating

that debarment is being considered, setting forth the reasons for the proposed debarment and indicating that such party will be afforded an opportunity for a hearing if he or she so requests within a stated period of time. All such hearings shall be conducted in accordance with the provisions of the Administrative Procedure Act. However, where one department or agency has imposed debarment upon a party, a second department or agency may also impose a similar debarment without affording an opportunity for a hearing, provided that the second agency furnishes notice of the proposed similar debarment to that party and affords that party an opportunity to present information in his or her behalf to explain why the proposed similar debarment should not be imposed in whole or in part.

(g) Debarment shall be a reasonable, definitely stated period of time which as a general rule shall not exceed five years. Debarment for an additional period shall be permitted provided that notice thereof is furnished and the party is accorded an opportunity to present information in his or her behalf to explain why the additional period of debarment should not be imposed.

(h) Scope of debarment rules shall be as follows:

1. Except as otherwise provided by law, a debarment may be removed or the period thereof may be reduced at the discretion of the debarring agency upon the submission of a good faith application under oath, supported by documentary evidence, setting forth substantial and appropriate grounds for the granting of relief, such as newly discovered material evidence, reversal of a conviction or judgment, actual change of ownership, management or control, or the elimination of the causes for which the debarment was imposed.

2. A debarment may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his or her official duty or was effected by him or her with the knowledge or approval of such person.

3. Debarment by the Director of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agent for any services or supplies he or she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the debarment. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agent for any services or supplies provided by a person within such organization who has been debarred by the Director, except for services or supplies provided prior to the debarment.

4. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the Director may debar such organization and/or any individual person within said organization who is responsible for such violation.

(i) The Division may suspend a person in the public interest for any cause specified in (d) above, or upon a reasonable suspicion that such cause exists, or when, in the opinion of the Director, such action is necessary to protect the public welfare and the interests of the medical assistance Program.

(j) Conditions for suspension shall be as follows:

1. Suspension shall be imposed only upon approval of the Director of the Division and upon approval of the Attorney General, except as otherwise provided by law.

2. The existence of any cause for suspension shall not require that a suspension be imposed, and a decision to suspend shall be made at the discretion of the Director of the Division and of the Attorney General, and shall be rendered in the best interests of the Division.

3. Suspension shall not be based upon unsupported accusation, but upon adequate evidence that cause exists or upon evidence adequate to create a reasonable suspicion that cause exists.

4. In assessing whether adequate evidence exists, consideration shall be given to the amount of credible evidence which is available, to the existence or absence of corroboration as to important allegations, and to inferences which may properly be drawn from the existence or absence of affirmative facts.

5. Reasonable suspicion of the existence of a cause described in (d) above may be established by a judgment or order of an administrative agency, or court of competent jurisdiction, or by a judgment of conviction, grand jury indictment, accusation, arrest, or by evidence that such violations of civil or criminal law did in fact occur.

6. A suspension invoked by the Division for any of the causes described in (d) above may be the basis for the imposition of a concurrent suspension by another agency, which may impose such suspension without the approval of the Attorney General.

(k) The Division may suspend a person or his affiliates provided that within 10 days after the effective date of the suspension, the Division provides such party with a written notice stating that a suspension has been imposed and its effective date, setting forth the reasons for the suspension to the extent that the Attorney General determines that such reasons may be properly disclosed, stating that the suspension is for a temporary period pending the completion of an investigation and such legal proceedings as may ensue, and indicating that, if such legal proceedings are not commenced or the suspension removed within 60 days of the date of such notice, the party shall be given either a statement of the reasons for the suspension and an opportunity for a hearing, if he so requests, or a statement declining to give such reasons and setting forth the agency's position regarding the continuation of the suspension. Where a suspension by the Division has been the basis for suspension by another agency, the latter shall note that fact as a reason for its suspension.

(l) A suspension shall not continue beyond 18 months from its effective date unless civil or criminal action regarding the alleged violation shall have been initiated within that period, or unless debarment action has been commenced. Whenever prosecution or debarment action has been initiated, the suspension may continue until the legal proceedings are completed.

(m) Scope of suspension rules are as follows:

1. A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his official duty or was effectuated by him or her with the knowledge or approval of such person.

2. Suspension, by the Director, of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agent for any services or supplies he or she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the suspension. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agent for any services or supplies provided by a person within such organization who has been suspended by the Director, except for services or supplies provided prior to the suspension.

3. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the Director may suspend such organization and/or any individual person within said organization who is responsible for such violation.

(n) Exclusion from State contracting by virtue of debarment, suspension or disqualification shall extend to all State contracting and subcontracting within the control or jurisdiction of the Division. However, when it is determined essential to the public interest by the Director of the Division, and upon filing of a finding thereof with the Attorney General, an exception from total exclusion may be made with respect to a particular State contract.

(o) Insofar as practicable, prior notice shall be given to the Attorney General and the Treasurer of any proposed debarment or suspension.

(p) The Division shall provide the State Treasurer with the names of all persons suspended or debarred and the effective date and term thereof, if any.

(q) This section shall be applicable to all persons, providers, contractors, Fiscal Agent, and their affiliates who engage in State contracting with the Division as defined in this section.

SUBCHAPTER 12. PROVIDER REINSTATEMENT

10:49-12.1 Definitions

As used in this subchapter, the following words shall have the following meanings, unless the context clearly indicates otherwise:

"Committee" means the Provider Reinstatement Committee.

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

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

"Person" means any natural person, company, firm, corporation, professional association, partnership, or other entity, who has been excluded from participation in the New Jersey Medicaid Program.

10:49-12.2 Requests for reinstatement

Persons who have been debarred, disqualified or suspended from participating in the New Jersey Medicaid Program or programs administered by the Division shall petition the Director for reinstatement in writing.

10:49-12.3 Petition by debarred, disqualified or suspended person

(a) Persons debarred or disqualified for a definitely stated period of time may petition the Director for reinstatement 90 days prior to the expiration of the period of debarment or disqualification.

(b) Persons disqualified for an indefinitely stated period of time may petition the Director for reinstatement after a disqualification period of eight years.

(c) Persons who have been suspended, debarred or disqualified as the result of an indictment, conviction or license revocation may immediately petition the Director for reinstatement upon acquittal, reversal of the conviction upon appeal or restoration of the license, whichever is applicable.

10:49-12.4 Director's powers

The Director may on his or her own motion order the reinstatement of debarred, disqualified or suspended persons or may refer the matter to the Provider Reinstatement Committee.

10:49-12.5 Provider Reinstatement Committee

(a) The Provider Reinstatement Committee shall be a non-standing committee that is convened for the purpose of evaluating requests for reinstatement.

1. The Committee shall be composed of three impartial officials of the Division appointed by the Director.

i. Under this requirement, the Committee members shall not have been directly involved in the debarment, disqualification or suspension of persons requesting reinstatement.

ii. The Chairperson of the Committee shall be an attorney from the Office of Legal and Regulatory Liaison/Division of Medical Assistance and Health Services.

iii. Whenever possible, the associate members of the Committee shall be one member of the Division staff from the same discipline as the debarred, disqualified or suspended persons and one member from the general administrative staff of the Division.

10:49-12.6 Criteria for reinstatement

(a) Reinstatement will not be granted unless it is reasonably certain that the causes which led to the debarment, disqualification or suspension shall not be repeated. In determining a person's fitness for reinstatement, the Committee and the Director may consider, among other factors:

1. Statements from debarred, disqualified or suspended persons setting forth the reasons why they should be reinstated;

2. Statements from private health insurers, indicating whether there have been any questionable claims submitted during the period of exclusion from Program participation;

3. Statements from peer review bodies, probation or parole officers or professional associates, attesting to their belief, supported by facts, that the causes which led to the debarment, disqualification or suspension shall not be repeated;

4. The absence of any pending criminal, licensing, or professional disciplinary proceedings;

5. Full restitution and the payment of any criminal fines imposed;

6. Full satisfaction of any civil penalties imposed;

7. Full satisfaction of interest payments;

8. Compliance with the terms and conditions of Consent Orders or Court Orders; and

9. Satisfaction of any conditions or requirements previously imposed by the Division.

10:49-12.7 Committee procedures

(a) The Committee shall meet at the Division's central offices.

(b) Persons requesting reinstatement and/or their representative shall be notified, in writing, as to the time, date and place of the meeting.

(c) All correspondence concerning the meeting shall be directed to the Chairperson of the Committee.

(d) Persons requesting reinstatement may appear on their own behalf or be represented by counsel.

(e) The Committee shall be governed by the New Jersey Administrative Procedure Act concerning admissibility of evidence at the meeting.

(f) The Chairperson of the Committee shall rule on all procedural questions and objections that may be raised at the meeting.

(g) Persons requesting reinstatement shall have the burden of providing their fitness for reinstatement by a preponderence of the evidence.

(h) Persons may present evidence of their fitness for reinstatement by the testimony of witnesses under oath or by documentary evidence, or both.

(i) After reviewing the testimony and documentation presented, the Committee shall prepare a written report which discusses the testimony, contains findings of facts and recommended disposition.

(j) At least two members of the Committee shall concur in the recommended dispostion.

(k) Copies of the Committee's report shall be sent to all parties at the meeting. Upon receipt of the Committee's report, the parties shall have the opportunity to submit written objections or exceptions to said report within the time period specified by the committee.

(l) After the expiration of the time period prescribed for the filing of the exceptions, the Committee's report, exceptions or objections thereto, evidence and any transcripts shall be forwarded to the Director.

(m) The Director shall have final decisional authority and may adopt, reverse or modify the Committee's recommended determination. The Director may also, for cause, remand the matter back to the Committee for further testimony.

SUBCHAPTER 13. PROGRAM CONTROLS

10:49-13.1 Medical review and evaluation

Under the provisions of Federal and State law, the Division of Medical Assistance and Health Services shall provide continuing review and evaluation of the care and services provided under the Program. This includes review of utilization of services of practitioners and other providers.

10:49-13.2 Audits

(a) A field audit shall be subject to the following:

1. "Completion of the field audit" for nursing facility providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:

i. For all such audits and audit recovery cases pending on March 1, 1983, it shall mean the date that field work is completed, or the date information requested from the provider during the course of that field work is received, whichever is later.

ii. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other

agency for criminal investigation, it means the date the Office of Program Integrity Administration (OPIA) receives authorization to take administrative action.

iii. For all such audits initiated on or after March 1, 1983, it means the date the exit conference is completed or the date information requested from the provider during the course of the exit conference is received, whichever is later.

2. "Completion of the field audit" for all other providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:

i. For all such audits and audit recovery cases pending on March 1, 1983, it means the date of final screening of the case file by the Assistant Director, Office of Program Integrity Administration (OPIA) or, if the case is referred to the Legal Action Committee or the Division of Criminal Justice, the date OPIA receives authorization to take administrative action;

ii. For all such audits initiated on or after March 1, 1983, it means the date of final screening of the case file by the Assistant Director, OPIA.

3. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after March 1, 1983, the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires additional field work, the field audit shall be considered completed when the additional field work is completed.

4. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after March 1, 1983, the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall be considered reopened and interest shall again accrue for the period beginning 20 days from the date the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.

5. Notwithstanding any of the previous paragraphs, if all or part of any provider audit initiated on or after March 1, 1983, is referred to the Division of Criminal Justice or other agency for criminal investigation:

i. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation; and

ii. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OPIA receives authorization to take administrative action.

(b) "Final audit," for purposes of N.J.S.A. 30:4D-7m only, means that point in the audit process when the Division issues to the provider an audit report specifically designated as the "final audit" for a specified period audited.

SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

10:49-14.1 Recovery of payments correctly made

(a) Correctly paid benefits shall only be recoverable from the estate of an individual who was 65 years of age or older when he or she received medical assistance if:

1. The individual leaves no surviving spouse;
2. The individual leaves no surviving child;
3. The amount to be recovered is in excess of $500.00; and
4. The gross estate is in excess of $3,000.

(b) Paragraphs (a)3 and 4 above shall apply to recoveries from the estates of individuals who died on or after July 20, 1981, the effective date of P.L. 1981, c.217 (N.J.S.A. 30:4D-7.2a).

10:49-14.2 Sanctions—Special Status Program

(a) The "Special Status Program" either restricts the Medicaid recipient(s) listed on the Medicaid Eligibility Identification (MEI) Card to a single provider, except in a medical emergency, or warns providers that the recipient's card has been used by an unauthorized person or persons, or for an unauthorized purpose. If a warning card is issued, a message will be printed on the card alerting the provider to ask the Medicaid recipient for additional identification or to take other appropriate action.

1. The restrictive card is issued to Medicaid recipients determined to have misused, abused or overutilized their Medicaid benefits. Overutilization occurs when a recipient has utilized Medicaid services or items at a frequency or amount that is not medically necessary. Examples of misuse or abuse include, but are not limited to, medically harmful or inappropriate use of different drugs or provider services and forgery or alteration of prescriptions. A determination that there has been misuse, abuse or overutilization of benefits obtained by use of an MEI Card shall create a presumption that the recipients listed on the MEI Card were responsible for such actions. If this presumption is successfully rebutted by the Medicaid recipient, he or she shall not be enrolled in the Special Status Program.

i. A recipient shall be permitted to change the designated provider upon demonstration of good cause and the Division may grant the request.

ii. The Division may change the provider to which the recipient is restricted if a pattern of continued misuse, abuse or overutilization is evident.

iii. The recipient may request a contested case hearing in the following situations:

(1) If the recipient objects to being included in the special status program;

(2) If the recipient requests a change and the request is denied;

(3) If the agency causes undue delay in responding to the recipient's request for change.

2. The warning card is issued to Medicaid recipients determined to have had their MEI Card used by an unauthorized person or persons, or for an unauthorized purpose. The purpose of the warning card is to notify providers that the recipient's MEI Card has been used by an unauthorized person or persons, or for an unauthorized purpose. A message will be printed on the card alerting the provider to ask the Medicaid recipient for additional identification or to take other appropriate action. A determination that an MEI Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the recipients listed on the MEI Card were responsible for such actions. If this presumption is successfully rebutted by the recipient, the recipient shall not be issued a warning card.

10:49-14.3 Authority to adjust, compromise, settle or waive claims, liens, and certificates of debt

(a) The Commissioner, Department of Human Services; Director, Division of Medical Assistance and Health Services; Assistant Director, Office of Program Integrity Administration; or anyone serving in an acting capacity in any of those positions shall have the authority to adjust, compromise, settle or waive any claim, lien or certificate of debt arising under this act (N.J.S.A. 30:4D-1 et seq.), and to execute an appropriate release or document of discharge with respect to that claim, lien or certificate of debt.

(b) Such authority may be exercised by other officials only in the following limited circumstances:

1. The Chief of the Bureau of Administrative Control may compromise, settle or waive any claim or lien not arising under N.J.S.A. 30:4D-7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services; and

2. The Fiscal Agent may compromise, settle or waive claims arising under N.J.S.A. 30:4D-7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services.

10:49-14.4 Recoveries involving county welfare agencies

(a) The purpose of this section is to define areas of responsibility and establish basic principles and procedures in those collection activities in which the Division of Medical Assistance and Health Services (DMAHS), the Division of Economic Assistance (DEA) and/or a county welfare agency (CWA) may be involved. It is intended that maximum conservation of public funds be effected without duplication of effort. It is recognized that certain situations

may fall into more than one of the following categories. Any such matter will be processed in accordance with the provisions of the first occuring applicable category.

(b) The following pertain to incorrectly granted assistance (cash and/or medical assistance):

1. In instances involving incorrect eligibility for medical assistance, whether or not in combination with cash assistance, the CWA shall determine the period(s) of ineligibility and ascertain from DMAHS the amount of medical assistance incorrectly granted. The CWA shall then attempt recovery of medical assistance incorrectly granted either by administrative collection, or by way of restitution in a criminal or disorderly persons proceeding.

i. Recoveries or attempts at recoveries can be made from those persons specified in N.J.S.A. 30:4D-7i.

2. When recovery cannot be obtained by these methods in a case generated by the Internal Revenue Service (IRS) unearned income component of the Income and Eligibility Verification System (IEVS), the case shall be referred by the CWA to DMAHS for possible initiation of recovery proceedings.

3. When in any other case not generated by IEVS, recovery cannot be obtained by these methods, the CWA is authorized after securing DMAHS approval to initiate recovery proceedings as DMAHS' agent. If the CWA does not initiate such recovery proceedings, it shall refer the case to DMAHS for possible initiation of recovery proceedings.

4. When collection occurs in a case involving both cash assistance and medical assistance, the CWA shall, in the absence of court instruction to the contrary, apply the net proceeds, after deducting identifiable costs of collection such as filing fees and advertising costs but not including such costs as CWA staff time, supplies, counsel fees or overhead, to the repayment of cash assistance and the reimbursement of DMAHS.

5. When in any other case a CWA recovers only medical assistance improperly granted, the CWA shall reimburse itself for those cash expenses directly related to the recovery such as filing fees and advertising costs but not including costs such as CWA staff time, supplies, counsel fees or overhead. In addition, the CWA shall retain 10 percent of the gross amount of the recovery up to $250.00. The CWA shall remit the remaining proceeds to DMAHS. The reimbursement shall be payable to the Treasurer, State of New Jersey.

6. When any CWA action, whether alone or in combination with DMAHS, results in a recovery of improperly granted medical assistance from a case generated by the Internal Revenue Service (IRS) unearned income component of the IEVS match, all funds recovered shall be remitted to DMAHS, payable to the Treasurer, State of New Jersey, which shall then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

(c) The following pertain to third party liability claims in tort actions:

1. Whenever either a CWA or DMAHS learns of a situation in any case in which the other may have a claim it will notify the other.

2. Unless the individual case circumstances intervene, the first claim after settlement or judgment is for any payments by DMAHS arising from the occurrence notwithstanding any CWA claim for recovery of cash assistance. The next claim is that which the CWA may assert in accordance with an agreement to repay or similar document. The DMAHS and the CWA will, insofar as their controls allow, maintain priority of payment in the above order.

(d) The following pertain to liquidation of potential resources:

1. The CWA will participate in the liquidation of potential resources according to the Program requirements under which eligibility has been established, regardless of whether cash assistance is being granted. Notification of the potential resource to be liquidated shall be forwarded to DMAHS, enabling it to seek a voluntary contribution. Sale of real property to which title is held by a CWA is subject to DEA approval in all instances regardless of the proposed distribution of the proceeds.

2. All funds arising from the liquidation of resources and which, by action of law, regulation, or agreement with the owner, fall under the jurisdiction of either a CWA or DMAHS for distribution will, insofar as possible, be allocated as follows:

i. Proceeds will be first applied to the cash costs of liquidation, such as advertising costs and filing fees but not including costs such as CWA staff time, supplies, counsel fees or overhead.

ii. Proceeds will be next applied to any claims superior to that of the CWA (for example, taxes).

iii. Proceeds will be next applied to any funds owing to and collectible by the CWA.

iv. Any residue remaining after the above payments are allocated would, in the absence of circumstances to the contrary, be the property of the client and thereby subject to (d)3 below.

3. All funds properly belonging to a client free of any agency claim are to be remitted to the client as promptly as possible or otherwise disbursed at the client's instruction. The CWA will promptly re-evaluate eligibility following such distribution, taking into consideration any voluntary repayment to DMAHS.

(e) The following pertains to recovery from estates of deceased clients:

1. The CWA shall normally undertake recovery activity as agent for DMAHS in any case in which the CWA is or will be undertaking activities on its own account. However, in those cases where the recovery of medical assistance is possible and where the entire CWA claim is for burial expenses only, DMAHS shall initiate recovery activity inclusive of CWA burial costs. DMAHS may, in certain cases, assume direct jurisdiction in recovery of its claim concurrent with CWA activity. DMAHS shall make the CWA aware of its activity in such cases.

2. CWA recoveries and distribution shall be in accord with the following procedures:

i. From the proceeds of liquidation, the CWA shall first recover the amount necessary to satisfy its own claim, including costs of liquidation and the claims of other New Jersey CWAs. The CWA shall recover funds from the clearing account in the order in which the funds were received in the clearing account. If any part of any remaining surplus has been received from the proceeds of assigned life insurance for which there was a named beneficiary other than the client's estate, that surplus or the policy benefit, whichever is less, is the property of the beneficiary and should be so directed.

ii. All other surplus funds are part of (or the entire) the client's estate and are payable to the legally designated representative of the estate. If the representative of the estate is unknown or if no representative has been appointed and there are no known next of kin, the CWA shall forward to the DMAHS an amount not to exceed the amount of the proper medical assistance claim as determined by communication with the Chief, Bureau of Administrative Control, DMAHS. Any remaining funds will escheat to the State of New Jersey.

iii. When there are known next of kin, the CWA shall request the next of kin to take appropriate legal action to be appointed administrator if the amount to be disbursed is greater than the claim of DMAHS. If the claim of DMAHS will equal or exceed the estate, the CWA shall request the next of kin to sign a consent to transfer his or her rights to DMAHS and, upon receipt of such signed consent, the CWA shall forward the funds to DMAHS.

iv. When the next of kin will not sign a consent to transfer his or her right to DMAHS and will not file to become the administrator, the CWA may, at its option, arrange for someone to file to become administrator or the CWA may refer the information to DMAHS for action.

v. In any questions or dispute among two or more claimants on surplus funds, the CWA shall withhold payment pending resolution by mutual consent of all claimants or by court order.

3. DMAHS recoveries and distribution shall be in accordance with the following procedures:

i. DMAHS shall undertake recovery activity in medical assistance payment cases in which no CWA shall be submitting a claim. However, should information from the CWA be necessary to such DMAHS activity, the CWA shall communicate with DMAHS, supplying such material as may be required.

ii. In cases in which DMAHS is acting for a CWA in collection of burial expenses, DMAHS shall accord payment of the burial claim priority over its own recovery.

(f) The CWA may at any time accept an offer of voluntary repayment, either on its own behalf or on behalf of DMAHS, up to but not in excess of the amount of assistance granted. To any inquiry as to amount granted, the CWA shall supply the appropriate information, identifying the respective amounts granted by the CWA and DMAHS. In the absence of instruction from the payer, the CWA will reimburse cash assistance first and then remit any balance to DMAHS.

(g) Regarding compromise settlements:

1. Compromise settlements of cash assistance are subject to DEA approval.

2. Compromise settlements of medical assistance are subject to DMAHS approval.

(h) This section shall apply to all pending and future recovery cases, except that (b)6 above shall apply to all IEVS-related recoveries received on or after July 1, 1989 by either DMAHS or the CWA, whichever agency is handling the recovery.

10:49-14.5 Administrative charges/service fees

(a) A provider shall not pay nor require payment of an administrative charge or service fee for the privilege of doing business with another provider or for services for which reimbursement is included as part of the Medicaid fee.

1. An example of a prohibited practice is that a nursing facility may not require a pharmacy to pay an administrative charge or service fee to the facility for handling of the nursing facility resident's medications, drugs and/or related pharmaceutical records.

2. An administrative charge may be made for the collection of a copayment on behalf of pharmacies from beneficiaries of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program who are residents in nursing facilities. Such administrative charges may not exceed 10 percent of the billed amount, or $2.00, whichever is less.

10:49-14.6 Contracts with county welfare agencies

Payment shall be made by the Department of Human Services/ Division of Medical Assistance and Health Services to county welfare agencies for conducting investigations and for determining whether applicants qualify for benefits under the New Jersey Medicaid Program.

SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

10:49-15.1 Maintenance of public policy issuances

Program manuals and other policy issuances which affect the public, including the Divisions' rules and regulations governing eligibility, need and amount of assistance, recipient's rights and responsibilities, and services offered by the agency, shall be maintained in the State office and in each Medicaid District Office for examination during regular workdays and regular office hours by individuals, and upon request, for study or reproduction by such individuals. These manuals and other policy issuances are also distributed to entities which serve as custodians such as the State Library, County Welfare Agencies, and regional legal services offices.

10:49-15.2 Availability of material

(a) In order to facilitate public access, a current copy of material described in N.J.A.C. 10:49-15.1 shall be made available without charge to custodians who request the material for this purpose.

(b) Custodians shall meet the following requirements:

1. They shall be centrally located and publicly accessible to a substantial number of the recipient population they serve; and

2. They shall agree to accept responsibility for filing all amendments forwarded by the agency.

10:49-15.3 Reproduction of policy material

(a) The specific policy materials necessary for an applicant or recipient (or his or her representative) to determine whether a fair hearing should be requested, or to prepare for a fair hearing, shall be reproduced without charge upon request.

(b) The Division may impose a charge for copying or reproducing materials. If a charge is imposed, it shall be computed pursuant to N.J.S.A. 47:1A-1.

SUBCHAPTER 16. DEMONSTRATION PROJECTS

10:49-16.1 Purpose

This subchapter sets forth the basic parameters for demonstration projects established pursuant to N.J.S.A. 30:4D-1 et seq., as amended, and Section 1115 of the Social Security Act. Any time a demonstration project is implemented, New Jersey Medicaid providers will receive information and instructions if the project is relevant to the services they provide.

10:49-16.2 Definitions

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

"Beneficiary" means any person certified eligible for receipt of services in accordance with Title XIX of the Social Security Act and Chapter 413 of the Public Laws of New Jersey, including those persons who are covered by virtue of the waiver granted under Section 1115 of the Social Security Act.

"Commissioner" means the Commissioner of the Department of Human Services.

"Department" means the Department of Human Services.

"Eligible beneficiaries" means those beneficiaries who meet the requirements to become a recipient.

"Principal" means all management personnel.

"Project" means any demonstration project authorized through a waiver of certain requirements under Title XIX of the Social Security Act as provided under Section 1115 of the Social Security Act.

"Provider" means providers of medical and health services under a project.

"Recipient" means any beneficiary who receives services from the project.

"Services" means medical or health services rendered as an integral part of the project.

10:49-16.3 Implementation of projects

The Department may implement projects directly or through contractual arrangements with any legal entity, including, but not limited to, corporations organized pursuant to Title 14A, New Jersey statutes (N.J.S.A. 14A:1-1 et seq.) and Title 15 revised statutes (R.S. 15:1-1 et seq.), as well as boards, groups, agencies, persons and other public or private entities.

10:49-16.4 Necessary criteria for a project

(a) The following shall apply to all projects implemented under this subchapter:

1. All projects shall have approval from the United States Department of Health and Human Services;

2. All projects entered into under this subchapter shall be subject to all relevant State and Federal statutes and regulations, except to the extent that appropriate waivers shall have been granted;

3. The Commissioner shall have the authority to review and approve in writing arrangements and agreements, whether formal or otherwise, between all projects and third parties prior to the execution thereof;

4. All projects in their hiring policies shall not discriminate against any individual on the basis of race, sex, religion, ethnicity or age, and shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, and other applicable Federal and State laws or regulations pertaining to the civil rights of individuals;

5. No project shall deny services to any eligible person on the basis of race, sex, religion, ethnicity or age, and shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, pertaining to the civil rights of individuals;

6. All projects shall institute procedures for safeguarding of information in compliance with applicable Federal and State regulations and shall strictly adhere to same;

7. All projects shall collect and report data relevant to the project on a periodic basis, in a manner and fashion prescribed by the Department, including, but not limited to, the following:

i. Financial data, such as line item expenditure statements and audit reports;

ii. Data necessary to the project regarding the characteristics of the population involved in the project and the control population, if any; and

iii. Program data, such as number and type of service rendered;

8. All projects shall furnish to the Department, in a manner and fashion prescribed by the Department, periodic progress reports;

9. The Department, at its option, may require receipt of copies of all project reports;

10. Any project entered into under this subchapter may include components fundable from sources other than that authorized by Section 1115 of the Social Security Act. These funds cannot be matched under the provisions of Section 1115 if they are Federal funds or if these funds are not otherwise matchable;

11. Nothing herein shall abridge the Commissioner's statutory authority to implement and administer demonstration programs under Section 1115 of Title XIX of the Social Security Act and N.J.S.A. 30:4D-7, as amended;

12. Each project shall have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This shall include as a minimum the following:

i. A full-time administrator to manage the day-to-day business activities of the project;

ii. Data reporting capabilities sufficient to provide necessary and timely reports to the Department;

iii. Financial reports and books of accounts maintained in accordance with general accepted accounting principles, which are sufficient to fully disclose the disposition of all program funds received; and

iv. An annual independent audit arranged for by the project;

13. Each project director shall advise the Department of the project's administrative organization and changes thereto. This includes the functions and responsibilities of each principal. An organization chart, and a list of all personnel, and providers used either directly by the project or through contractual arrangements. For each principal and each provider, not previously reported, the following information shall be included:

i. Full name;

ii. Business address;

iii. Date and place of birth;

iv. Social Security Account Number;

v. IRS employer number;

vi. Professional license number (when applicable); and

vii. Medical specialty (when applicable);

14. Each project director shall submit to the Commissioner for written approval a manual of administrative procedures which shall include personnel, purchasing and internal fiscal procedures. This manual shall be in conformance with approved management procedure; and

15. In those instances where a project involves the delivery of services, the following shall apply where appropriate and necessary:

i. The project shall demonstrate, to the satisfaction of the Commissioner, the capability to provide for and/or arrange for the provision of those services which are required as components of the project;

ii. All individuals receiving services funded under Title XIX of the Social Security Act shall be informed in a simple, brief statement of their rights to a fair hearing;

iii. The project shall develop and establish grievance procedures for recipients in addition to fair hearing procedures established pursuant to this paragraph;

iv. The project shall take steps to insure that it is rendering services that are consistent with and utilizes existing related Federal and State programs such as the EPSDT;

v. The project shall insure that there will be periodic peer review and quality of care audits;

vi. The project shall utilize eligibility criteria for eligibles to receive services as defined by the Department, and the Department shall insure, by a review process, that the project is in conformance with these criteria;

vii. The project shall take appropriate action to insure that the eligibility criteria provided per (a)15vi above is faithfully executed;

viii. The project shall obtain written approval from the Commissioner prior to implementing the following:

(1) The methods of enrollment and enrollment forms to be used to enroll beneficiaries;

(2) The form and content of informational and instructional materials to be distributed to beneficiaries outlining the nature and scope of covered services provided by the project;

(3) The form and content of informational and instructional materials to be distributed to inform enrollees of changes in program scope or administration; and

(4) Provider claim forms and instructions for their use where such claim forms are unique to this contract;

ix. The project shall provide to the Department, for written approval prior to use, the form and content of all public information releases pertaining to the project; and

x. The project shall insure that all marketing representatives have received instruction, as appropriate, from the Department, on acceptable enrollment practices.

10:49-16.5 Sanctions

The Commissioner, in addition to any and all other authority, shall have the authority to totally suspend or partially reduce payment in order to enforce compliance with this subchapter.

SUBCHAPTER 17. HOME AND COMMUNITY-BASED SERVICES WAIVERS

10:49-17.1 Introduction

(a) Home and Community-Based Services Waivers are five-year, renewable Federal waiver programs, prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981 (Section 2176, Public Law 97-35 and amendments under P.L. 99-509). These Home and Community-Based Services Waivers were submitted to the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. The purpose of these programs is to help eligible individuals remain in the community, or return to the community, rather than be cared for in a nursing facility or hospital setting.

(b) Retroactive eligibility is not available to waiver program recipients; no waiver service received prior to the date of enrollment shall be considered for reimbursement.

(c) Total program costs are restricted by limits on the number of community care slots and on per-person costs. The case manager is responsible for the development of the service plan with the client/family, with input from provider agencies, and for monitoring the cost of the service package.

(d) Any questions regarding Home and Community-Based Services Waivers may be directed to the Office of Home Care Programs, located in the Division of Medical Assistance and Health Services' Central Office, telephone number (609) 588-2620.

(e) The Division administers the following five Statewide waivers that are described in N.J.A.C. 10:49-17.2, 17.3 and 17.4 respectively:

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

2. Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Medicaid's Model Waivers I, II, and III); and

3. AIDS Community Care Alternatives Program (ACCAP).

10:49-17.2 Community Care Program for the Elderly and Disabled (CCPED)

(a) CCPED became effective October 1, 1983. The program allows for community care slots, allocated on a county basis in accordance with the needs of the county.

(b) The seven services listed below are available under CCPED. Other Medicaid (Title XIX) services are not available to the waiv-

ered population. There is a cost cap on each individual service package.

1. Case management;
2. Home Health;
3. Homemaker;
4. Medical day care;
5. Medical transportation (non-emergency);
6. Respite care; and
7. Social day care.

(c) Eligibility requirements for CCPED are as follows:

1. All individuals must be assessed to be in need of nursing facility care.

2. Individuals age 65 or over must be eligible for Medicare or have other health insurance coverage which includes hospital and physician coverage.

3. Individuals under 65 must be determined disabled by the Federal Social Security Administration and be eligible for Medicare or be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section and have other health insurance, including hospital and physician coverage.

4. An individual's own income must exceed the SSI community standard up to the institutional cap or be ineligible in the community because of SSI Deeming Rules. An individual's resources may not exceed those required in the institutional program. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. In order to be enrolled in the program, a waiver slot must be available.

10:49-17.3 Medicaid's Model Waivers—I, II and III

(a) The Model Waivers are Home and Community-Based Services Waivers for Blind or Disabled Children and Adults. Included are Model Waiver I (effective September 1, 1983), Model Waiver II (effective April 1, 1985) and Model Waiver III (effective April 1, 1986).

1. Model Waivers I and II serve a maximum of 50 individuals each. Model Waiver III serves 150. There are no geographic limitations nor limitations on the number of individuals who can be served within any one county.

(b) The Model Waiver programs offer, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus case management. Model Waiver III also offers private-duty nursing. "Private duty nursing" means individual and continuous care, in contrast to part-time or intermittent care, provided by licensed nurses. Private duty nursing is limited to a maximum of sixteen hours per day per person and will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the recipient.

1. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

(c) Eligibility requirements for the Model Waivers are as follows:

1. Individuals must be in need of institutional care and meet the minimum nursing facility (NF) level of care criteria. Model Waiver III also requires that individuals need private-duty nursing service.

2. For Model Waivers I and II, individuals must meet optional categorically needy standards. Total income must exceed the SSI community standard up to the institutional CAP, or the individual must be ineligible in the community because of SSI Deeming Rules. Parental income or resources are not considered in determining eligibility. While a spouse's income is not considered towards eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

3. Model Waiver III applicants can either be optional categorically eligible or categorical eligible. In other words, MW III also serves individuals who are eligible under SSI, DYFS or AFDC programs.

4. Individuals must be blind or disabled children and adults. Individuals who have not been determined disabled under the Social Security Act must be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section.

5. In order to be enrolled in the program, a waiver slot must be available.

10:49-17.4 AIDS Community Care Alternatives Program (ACCAP)

(a) ACCAP became effective March 1, 1987. The program allows for an allocation of a specific number of slots in accordance with the needs of each county in the State.

(b) ACCAP offers, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus those listed in (a)1 through 7 below. Total program costs are restricted by the number of community care slots each year and on per-person costs. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

1. Case management;
2. For children:

i. Intensive supervision to children who reside in Division of Youth and Family Services' foster homes; and

ii. Specialized group foster home;

3. Hospice care services at home;
4. Medical day care (specialized);
5. (Certain) Narcotic and drug abuse treatments at home;
6. Personal care assistant services (no limitation on the number of hours); and
7. Private-duty nursing.

(c) Eligibility requirements for ACCAP are as follows:

1. Individuals must be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria.

2. Individuals must be diagnosed as having AIDS or ARC. Children under the age of five may also be diagnosed HIV positive.

3. Individuals who are categorically needy or optional categorically needy are served under the program.

4. There is no deeming or parental income or resources in the determination of eligibility. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. Optionally categorically eligibles under age 65 must be determined disabled by the Social Security Administration (SSA) or by the Disability Review Section, Division of Medical Assistance and Health Services.

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

SUBCHAPTER 18. HOME CARE EXPANSION PROGRAM

10:49-18.1 Introduction

(a) The Home Care Expansion Program (HCEP) (P.L. 1988, c.92), as set forth in N.J.S.A. 30:4E-6, is a Casino Revenue funded program. The intent of the legislation is to offer home care services to elderly and disabled persons in New Jersey who are at risk of institutionalization and whose income and resources exceed the financial requirements for Medicaid or the Community Care Program for the Elderly and Disabled (CCPED). It is anticipated that the provision of home care service will delay or prevent institutionalization. HCEP is available Statewide. Program slots are allocated to each county.

(b) The Division of Medical Assistance and Health Services has the responsibility for overall administration of the program and for monitoring the case management sites. The determination of eligibility and cost-share billing and collection is the responsibility of the Division's Bureau of Pharmaceutical Assistance to the Aged and Disabled (PAAD).

10:49-18.2 Services

(a) HCEP can provide payment for a limited package of services including:

1. Case management services;

i. Case management is provided by a nurse or social worker. Case managers are responsible for assessing need for care, planning, locating, coordinating and monitoring the services designed to meet

individual needs of persons being served. Case management services, provided by a variety of agencies, also include responsibility for the development of a service plan with input from the client/family, attending physician and provider agencies, and for monitoring the cost of the service package, and calculating cost-share liability;

2. Home health care over and above what Medicare allows;
3. Homemaker services;
4. Medical day care;
5. Non-emergency medical transportation;
6. Respite care to relieve caregiver for short periods of time; and
7. Social day care.

(b) Cost limitations/requirements for HCEP are as follows:

1. Total costs for HCEP are restricted by the amount of money appropriated to the Division of Medical Assistance and Health Services from the Casino Revenue Fund. The number of HCEP slots and the per person costs are limited in order to stay within these appropriated monies. The cost for care for each individual is limited to a percentage of the cost of nursing home care which will be determined periodically. There is no payment for services provided before enrollment in the program.

2. Clients may be required to share in the cost of their care. The amount of this cost-share is determined by the individual's income, the cost of the services, and the additional medical or remedial care received. Non-payment of this cost-share will result in termination from the program.

10:49-18.3 Eligibility requirements

(a) To qualify for HCEP services, an individual 65 or over must:

1. Need long-term home care services which are medically necessary to avoid or delay institutionalization;

2. Be eligible for Medicare or have other health care insurance which includes hospital and physician coverage; and

3. Have an annual income of less than $18,000 if single, or if married, less than $21,000 in combination with that of his/her spouse. Liquid resources must be less than $15,000 for single or married persons.

(b) To qualify for HCEP services, an individual under 65 must also:

1. Be receiving Social Security disability benefits; or

2. Be determined disabled by the Social Security Administration, or the New Jersey Division of Medical Assistance and Health Services, Disability Review Section; and also

3. Be eligible for Medicare or have other health care insurance which includes hospital and physician coverage.

10:49-18.4 Application

Application for HCEP can be made to PAAD, by calling the toll-free number, 1-800-792-9745. Inquiries about the program should be directed to the Division's Office of Home Care Programs at (609) 588-2620.

SUBCHAPTER 19. PREPAID HEALTH CARE SERVICES: MEDICAID ELIGIBLES

10:49-19.1 Definitions

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

"Benefits" means medical, psychiatric and related health services which the contractor has agreed to provide, arrange for and be held fiscally responsible for under the negotiated contract. The benefit package that shall be provided by the contractor under the terms of the contract is specified in N.J.A.C. 10:49-19.3.

"Capitation rate" means a stated sum due the contractor for a stated group of services for each enrollee for a period of time specified in the contract.

"Commissioner" means the Commissioner of the Department of Human Services or a duly authorized representative.

"Contractor" means a health maintenance organization or prepaid health plan as defined herein which contracts with the Department for the provision of comprehensive health care services to Medicaid enrollees on a prepayment basis.

"CWA" means county welfare agency, that agency of county government which is charged with the responsibility for determining eligibility for certain public assistance programs.

"Department" means the Department of Human Services.

"Director" means the Director of the Division of Medical Assistance and Health Services or a duly authorized representative.

"Disenrollment" means the process of removal of an enrollee from the contractor's plan, not from the Medicaid Program.

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

"Emergency services" means those services required to treat a life-threatening or organ-threatening condition or potentially life or organ-threatening condition of such immediate nature that any unusual delay in treatment would be dangerous to the health or well-being of the enrollee.

"Enrollee" or "enrolled recipient" means an individual who is eligible for Medicaid residing within the defined market area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the contractor's plan and meets specific Medicaid eligibility requirements for Plan enrollment agreed by the Department and the contractor.

"Enrollment" means the process by which individuals eligible for Medicaid voluntarily contract to utilize prepaid health care services in lieu of standard Medicaid benefits.

"Enrollment area" means the boundaries established by Zip Code, within which the HMO shall limit their enrollment.

"EPSDT" means Early, Periodic, Screening, Diagnosis, and Treatment mandated by Title XIX of the Social Security Act.

"Federally qualified HMO" means an HMO that has been determined by the Public Health Service (PHS) to be a qualified HMO under section 1310(d) of the PHS Act.

"Health maintenance organization" or "HMO" means a public or private organization, organized under State law which:

1. Is a Federally qualified HMO (defined above); or

2. Meets the State Plan's definition of an HMO which includes at a minimum the following requirements:

i. Is organized primarily for the purpose of providing health care services;

ii. Makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid eligible individuals within the area served by the HMO; and

iii. Makes provision, satisfactory to the Division, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

"HHS" or "DHHS" means the Department of Health and Human Services of the Federal government.

"IPN" means Independent Practitioner Network which is one of the types of HMO operation. Services are provided for enrollees in the individual offices of the contracting physician case managers (PCMs).

"Market area" means the defined geographic area within which all potential enrollees shall reside.

"Marketing" means any presentation by or on behalf of an HMO for enrollment purposes.

"Medicaid" refers to the program funded under Title XIX of the Social Security Act administered by the Department.

"Medicaid recipient" means an individual eligible to receive services under the New Jersey Medicaid Program as authorized by State and Federal law and amendments thereto.

"Non-covered HMO services" means services not covered in the contractor's benefits package included under the terms of the Medicaid contract.

"Non-covered Medicaid services" means all services not covered under the New Jersey State Plan for the Medicaid Program.

"Nonrisk" means that the contractor is not at financial risk for changes in the cost or utilization of services provided for in the payment rate agreed upon at the beginning of the contract period. Under a nonrisk contract, the State agency may make retroactive adjustments during and at the end of the contract period so that the contractor is reimbursed for costs actually incurred, subject to

the upper limit of payment established in 42 CFR *[447.382]* ***447.362*** or any lower limit specified in the contract.

"PCM" means physician case manager which is the primary care physician.

"Plan" means all services and responsibilities undertaken by the contractor pursuant to this contract.

"Prepaid health plan (php)" means an entity that provides medical services to enrollees, under a contract with the Medicaid agency and on the basis of prepaid capitation fees, but does not necessarily qualify as an HMO.

"Primary care physician" means a physician who has the responsibility for general care and treatment and for initiating referrals for specialist care and for maintaining continuity of patient care. In general, the primary care physician is a general or family practitioner, internist, pediatrician or obstetrician/gynecologist.

"Referral services" means those health care services rendered outside of the contractor's facilities or IPN when ordered and approved by the contractor.

"Risk" or "underwriting risk" means the possibility that a contractor may incur a loss because the cost of providing services may exceed the payments made by the agency to the contractor for services covered under the contract.

"Service area" means the geographic area in which the contractor is obligated to provide covered services for its Medicaid enrollees under its contract.

"Subcontract" means any written agreement between the contractor and a third party to perform a specified part of the contractor's obligations under the contract.

"Subcontractor" means any third party who has a written agreement with the contractor to perform a specified part of the contractor's obligations, and is subject to the same terms, rights, and duties as the contractor.

"Target population" means the population from which the initial number of enrollees, not to exceed any limit specified in the contract, will be drawn; that is, individuals eligible for Medicaid residing within the stated market area and belonging to one of the categories of eligibility for Medicaid to be covered under the contract.

"Termination" means the loss of Medicaid eligibility and therefore automatic disenrollment from the HMO if beyond the guaranteed eligibility period.

10:49-19.2 Criteria for contracting with the Department

(a) The contractor shall:

1. Comply with the requirements of the New Jersey Certificate of Authority (P.L. 1973, c.337, N.J.S.A. 26:2J-1 et seq.) statutes and regulations;

2. Provide to the Division of Medical Assistance and Health Services, Department of Human Services, a copy of the Department of Health approved Certificate of Authority and application document on request;

3. Furnish the Department with such information and reports that the Department finds necessary and maintain records as required by the Department, State and Federal governments;

4. Enroll individuals and provide services without reference to race, sex, age, religion, creed, color, national origin, ancestry or on the basis of health status or need for health services other than those services specifically excluded from coverage by the contract;

5. Comply with the requirements of having any contract resulting from a proposal be approved by the Health Care Financing Administration (HCFA) and the appropriate State control agencies before it shall become effective;

6. Have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This shall include at a minimum, the following:

i. A full time administrator to manage day-to-day business activities of the contractor and who is the responsible contract officer. (This does not require a full time administrator to be dedicated solely to the Medicaid contract.);

ii. Data reporting capabilities sufficient to provide necessary reports and to assure orderly and timely flow of reports to the Department;

iii. Financial records and books of accounts maintained in accordance with generally accepted accounting principles which are sufficient to disclose fully the disposition of all program funds received; and

iv. An annual independent audit arranged for by the contractor and which shall be performed by a certified public accountant;

7. Advise the Department of its administrative organization and changes thereto. This includes the functions and responsibilities of each principal, an organizational chart and list of all personnel and providers used either directly by the contractor or through subcontractual arrangements. For each principal and each provider not previously reported, include the following information:

i. Full name;

ii. Business address;

iii. Date of birth;

iv. Social Security Number;

v. IRS employer number;

vi. Professional license number (when applicable); and

vii. Medical specialty (when applicable);

8. Comply with eligibility requirements of the program which, for example, include but are not limited to: contractor shall only enroll individuals who are covered under specified Medicaid categories of assistance and who reside in the agreed upon market area;

9. Identify and provide financial disclosure of subcontractors with whom it has had business transactions in excess of $25,000 per year, and any significant business transactions with such subcontractors. Transactions that shall be reported include:

i. Any sale, exchange or leasing of property;

ii. Any furnishing for consideration of goods, services, or facilities (but not employee salaries); and

iii. Any loans or extensions of credit;

10. Make available any information reported to the State, and upon request, to the Secretary of the U.S. Department of Health and Human Services, the Office of the Inspector General, the Comptroller General and to its enrollees. The State or Secretary may request that the information be in the form of a consolidated financial statement;

11. Disclose to the Division the identity of each person with a controlling interest or ownership of five percent or more; and

12. The contractor may not employ or contract with:

i. Any individual or entity excluded from Medicaid participation under Sections 1128 or 1128A of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; or

ii. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity.

(b) The contractor shall also comply with the Federal regulations governing HMOs or PHPs, as currently exist or hereinafter may be amended. The federal regulations governing prepaid health care services may be found in the Code of Federal Regulations at 42 CFR 434 and 42 CFR 110.

10:49-*[19.4]***19.3*** Benefits

(a) Rules on the scope of benefits require that:

1. The Division shall be responsible for providing all non-HMO covered services that are Medicaid benefits to Medicaid enrollees. This means that any service or item normally provided under the New Jersey Medicaid Program shall be provided to members if it is not covered under the terms of the contract with the HMO or PHP. The same limitations, such as prior authorization and medical necessity, shall still be applicable for Medicaid services provided outside the contract.

2. The benefits available under a nonrisk contract shall be those services and/or items that are specified in the contract.

3. The benefits available under a risk contract shall be those services and/or items that are specified in the contract.

4. Pursuant to Federal regulations (42 CFR 434.21), risk comprehensive contracts are risk contracts for furnishing comprehensive services, which shall include inpatient hospital services and any of the following services, or any three or more of the following services or groups of services:

i. Outpatient hospital services;

ii. Other laboratory and x-ray services;

iii. Covered long-term care services provided in nursing facilities, early and periodic screening, diagnosis and treatment (EPSDT), and family planning;

iv. Physicians' services;

v. Home Health services.

(b) Responsibilities of the contractor are as follows:

1. The contractor shall make available emergency services, as defined in N.J.A.C. 10:49-19.1, on a 24-hour-a-day, seven-day-a-week basis.

2. The contractor shall offer health education services as an integral part of its health care delivery system to its enrollees in order to assure appropriate use of health care services and to promote the maintenance of health.

3. The contractor shall provide EPSDT equivalent services for all Medicaid enrollees under 21 years of age in accordance with the protocols approved by the Division.

i. Initial physical examinations shall be provided. All further treatments indicated shall be provided in an appropriate and timely manner and shall be appropriately documented as specified by EPSDT requirements. The above shall be in accordance with EPSDT regulations.

(1) The Division shall monitor the EPSDT equivalent through periodic audits.

4. The contractor shall provide or arrange to have provided all covered necessary health care services in a manner that is prompt, appropriate, and of a quality that comforms to generally acceptable professional standards as set forth in the Federal Social Security Act, 42 U.S.C. 1302 et seq., and all other applicable Federal and State laws.

(c) Limitations on services in an HMO setting are as follows:

1. The following service limitations are consistent with those of the fee-for-service Medicaid Program and are not included in the contractual service package or capitation payments even if provided by the HMO:

i. Services of podiatrists shall be provided with the exceptions of routine foot care and treatment of flat foot conditions, unless medical necessity determines otherwise.

ii. Physical therapy, occupational therapy, and treatment for speech, language or hearing disorders are provided but limited to such services when provided to an enrollee by a nursing facility, by an approved home health agency, hospital outpatient department, independent outpatient clinic, or at Contractor's facilities. Services provided by privately practicing therapists shall not be eligible for payment under the capitation rate unless:

(1) The Physical therapist holds a current license to practice in New Jersey;

(2) The physical therapist is under contract with the contractor and will abide by the provisions of the contract; and

(3) The costs of these services are specifically identified in the contractor's proposed capitation rate.

iii. Abortions are not covered under an HMO program but will continue to be paid on a fee-for-service basis by the Medicaid Program.

(d) Exclusions: The following are not covered services:

1. All claims arising directly or indirectly from services provided by or in institutions owned or operated by the Federal government;

2. Elective cosmetic surgery;

3. Rest cures and custodial or domiciliary care;

4. Personal comfort and convenience items; services and supplies not directly related to the care of the patient, including but not limited to guest meals and accommodations, telephone charges, travel expenses other than those services which may be specifically covered under the contract (such as ambulance services), take-home supplies and similar costs;

5. Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey and regulations issued pursuant thereto;

6. All services not provided, approved, or arranged by the HMO physician except in emergency services as defined in N.J.A.C. 10:49-19.1;

7. Services provided in an inpatient psychiatric institution that is not an *[active]* ***acute*** care hospital to individuals under 65 years of age and over 21 years of age; and

8. Private duty nursing.

(e) Availability of services rules require that:

1. Each contractor shall demonstrate the availability and accessibility of sufficient numbers of institutional facilities and professional, allied and supporting paramedical personnel to perform adequately the agreed-upon services;

2. Each contractor shall insure that no distinctions will be made with regard to quality of service or availability of benefits between Medicaid enrollees under this subchapter and any other parties served by the contractor;

3. To the extent feasible and appropriate, each Medicaid enrollee shall be given the choice of a primary care physician who will supervise and coordinate his or her care; and

4. Generally, the contractor shall have only one market area for all Medicaid parties served, including those served under these regulations. Modifications of such market area for purposes of contracting under this subchapter shall be subject to approval by the Division.

10:49-19.4 Marketing and enrollment

(a) The following pertain to marketing:

1. The contractor shall obtain written approval from the Division prior to implementing the following:

i. The form and content of informational and instructional materials to be distributed to Medicaid enrollees, outlining the scope and nature of benefits provided by the contractor;

ii. The form and content of informational and instructional materials to be distributed to inform Medicaid enrollees of changes in program scope or administration; and

iii. The form and content of all public information releases pertaining to the enrollment of Medicaid individuals in the contractor's plan.

2. The contractor shall insure that:

i. All marketing presentations accurately and clearly represent the benefits and limitations of the contractor's plan;

ii. The marketing representatives have received sufficient instructions and training to be capable of performing such marketing activities;

iii. The marketing representatives shall only represent themselves as agents of the contractor involved in marketing;

iv. That all marketing presentations make clear that HMO enrollment is voluntary; and

v. The marketing representatives shall be prohibited from offering or giving any form of compensation or reward as an inducement to a Medicaid recipient to enroll in the contractor's plan.

(b) The following pertain to information provided to enrollees:

1. At such time as a Medicaid recipient signs an enrollment application of an HMO or prepaid health plan, the contractor shall inform the eligible that:

i. There is normally a minimum 30 to 45-day processing period between the date of application and the effective date of enrollment;

ii. During this interim period, the Medicaid enrollee may continue to receive health care services under his or her current arrangement as long as he or she retains Medicaid eligibility; and

iii. Subject to the disenrollment rules in (d) below and the termination provisions in the contract between the contractor and the Department, enrollment shall be for a period of six months at a time;

2. Within 10 days after the effective date of coverage, or as specified in the contract, the contractor shall provide in writing to a new enrollee:

i. Notification of his or her effective date of enrollment;

ii. An identification card clearly indicating that the bearer is an enrollee in the HMO or prepaid health plan;

iii. Specific written details on benefits, limitations, exclusions, and availability and location of services and facilities. Thereafter, such notification shall be provided at least annually;

iv. An explanation of the procedure for obtaining benefits including the address and telephone number of primary care physicians, the hours and days facilities are open, and accepted appointment procedures;

v. Information regarding continued enrollment in the contractor's plan including patient's rights and patient's responsibilities, and the reasons a person may lose eligibility for the plan and what should be done if this occurs;

vi. Procedures for resolving complaints;

vii. Information giving reasons and procedures for disenrollment;

viii. Any other information essential to the proper use of the plan as may be required by the Division;

ix. An explanation of where and how 24 hour a day emergency medical care and out-of-area coverage is available; and

x. An explanation of how to obtain non-covered HMO services that are Medicaid benefits.

3. Information as required by (b)2 above shall be supplied whenever there are significant changes in the services provided or the locations where they can be obtained, or other changes in program nature and administration. Such information shall be provided to each enrolled family household at least 10 days prior to such change.

(c) The following pertain to enrollment:

1. The contractor shall enroll Medicaid recipients in the order in which they apply, without restrictions, up to contract limits.

2. Enrollment shall be accomplished by the Medicaid eligible individual's voluntary signing of an enrollment application agreeing to utilize only the health care services provided or arranged by the contractor, and completion of the enrollment procedures specified by the Division.

3. Enrollment shall be for the entire Medicaid case (family household). The contractor may not enroll a partial case except at the Director's discretion.

4. Enrollment shall be for periods of six months and in accordance with Federal statute, Section 1903(m)(2)(F) of the Social Security Act with the exceptions indicated in (d) below. This fact shall be clearly stated on the enrollment application.

5. At any time during the first 30 days of each six month enrollment period, the enrollee may elect to disenroll from the contractor's plan, upon written notification to the contractor, without stating a cause and with cause thereafter. The contractor may terminate an enrollee's enrollment for reasonable cause, through a grievance process which is consistent with applicable State and Federal regulations and is approved by the Division.

6. The contractor shall obtain written approval from the Director prior to implementing a method of enrollment and enrollment forms to be used to enroll Medicaid recipients.

7. For any person who applies for participation in the Plan and who is hospitalized at the time this coverage becomes effective, such coverage shall not commence until the date such person is discharged from the hospital.

(d) The following pertain to disenrollment:

1. Disenrollment of an enrollee from the plan will occur:

i. Whenever the enrollee is no longer qualified to receive Medicaid services, unless otherwise specified in the contract;

ii. Whenever the enrollee moves outside of the market area boundaries;

iii. Whenever the contract between the Department and the contractor is terminated; or

iv. Through formal grievance.

2. Provision shall also be made for an enrollee's voluntary disenrollment from the contractor's plan in accordance with Section 1903(m)(2)(F) of the Federal Social Security Act.

3. Until such time as the enrollee's termination of coverage becomes effective, the contractor shall remain liable for all contracted services. If an enrollee is hospitalized at the time of disenrollment or termination, the contractor shall be liable for all inpatient hospital charges (if a contracted service).

10:49-19.5 Medical records; peer review; quality assurance

(a) The following pertain to medical records:

1. Each contractor shall maintain a medical record on each member who has received medical services while enrolled in the contractor's plan.

2. Each enrollee's medical records shall be kept in detail consistent with Federal and State requirements and good medical and professional practice based on the service provided. Furthermore, each contractor shall conform to the standards of confidentiality of information mandated for Federal and State officials (Section 1902(a)(7) of the Federal Social Security Act, 42 CFR 431.300, N.J.S.A. 30:4D-7(g), and N.J.A.C. 10:49-9.4 and 9.5.).

3. Medical records of enrollees shall be sufficiently complete to permit subsequent peer review or medical audit. All required records, either originals or reproductions thereof, shall be maintained in legible form and readily available to appropriate Division professional staff upon request for review and evaluation by professional medical and nursing staff.

4. The contractor shall release medical records of enrollees, as may be directed by authorized personnel of the Division, appropriate agencies of the State of New Jersey or the U.S. Government and shall be consistent with the provisions of confidentiality. (Section 1902(a)(7) of the Federal Social Security Act, 42 CFR 431.300, N.J.S.A. 30:4D-7(g), and N.J.A.C. 10:49-9.6).

5. All records shall be retained in accordance with the record retention requirements of 45 CFR Part 74 and appropriate State law.

6. The Division has the right to conduct audits according to appropriate Federal and State statutes and regulations.

(b) The following pertain to peer review:

1. Each contractor shall submit a description of its system of internal peer review to the Division for approval to assure that acceptable professional practice shall be followed by the contractor as well as its subcontractors.

2. There shall also be an explanation of how such peer review procedures will relate to the applicable peer review organization (PRO) should such exist.

3. The number of cases reviewed and summaries of the actions taken by the peer review system shall be reported annually to the Division.

(c) The following pertain to quality assurance:

1. The Division and the U.S. Department of Health and Human Services shall have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under this contract in accordance with State and Federal requirements.

2. The contractor shall offer assurances that all health care services required by its enrollees shall meet quality standards within the acceptable medical practice of care consistent with the medical community standards of care.

3. The contractor shall submit a detailed plan for establishing and maintaining an internal quality assurance system to the Division for approval to assure that acceptable professional practice shall be followed by the organization and its subcontractors. This shall include a proposed system for continuing performance review and health care evaluation, that is, explanation of the methods which the contractor proposes to follow in guaranteeing that the services provided each enrollee shall meet criteria required by appropriate Federal and State statutes and regulations (42 CFR 434.34).

4. The contractor shall agree to medical audits relating to its standard of medical practice and the quality, appropriateness and timeliness of health care services provided all members, as may be required by the Division. The medical audit shall include, at a minimum, the review of:

i. The delivery system for patient care;

ii. Utilization data and medical evaluation of care provided and patient outcomes for specific enrollees as well as for a statistical representative sample of enrollee records.

iii. The peer review system and reports; and

iv. The grievances relating to medical care including their disposition.

5. The results of the medical audits may be disclosed to the public on a need-to-know basis by the State, consistent with State and Federal law.

6. The contractor shall agree to release the comprehensive medical records of enrollees upon termination of their coverage, as may be directed by the member, authorized personnel of the Division, appropriate agencies of the State of New Jersey, or the United States Government.

10.49-19.6 Grievance procedure

(a) The contractor shall establish a grievance procedure for the receipt and adjudication of any and all complaints from enrollees relating to quality, scope, nature and delivery of services. Such grievance procedure shall be communicated to the enrollee in writing to provide for expeditious resolution of grievances by the contractor's personnel at a decision-making level with authority to require corrective action. The contractor shall also review the complaint procedure at reasonable intervals, but no less than annually, for the purpose of amending same, with the prior written approval of the Division in order to improve said system and procedure.

(b) The contractor shall insure that all enrollees receiving services funded under Title XIX of the Social Security Act shall be informed in a simple, brief statement of their rights to a fair hearing and of the contractor's grievance review procedures. This may be accomplished by an annual mailing as noted in N.J.A.C. 10:49-19.4, a member handbook, or any other method approved by the Division.

(c) The contractor shall report all completed girevances to the Division with a brief statement of the problem and resulting outcome on a quarterly basis.

10:49-19.7 Financial arrangements

(a) The contractor shall submit for Division approval information in sufficient detail to describe:

1. The exact capitation rate requested for each category of medical assistance covered under the contract;

2. The major cost components that constitute each capitation rate, including at a minimum the projected costs of hospital services, physician services, administration, and other components as approved by the Division; and

3. A detailed description of the underlying assumptions and procedures followed by the contractor in determining its rate.

(b) The annual capitation rate for any contractor may not exceed the expected per capita, fee-for-service cost for similar services provided to an actuarially equivalent non-enrolled population who reside in the contractor's market area.

(c) Capitation rates shall be subject to negotiation before the contract renewal, but shall not be revised more often than annually.

(d) Any capitation rates paid to the contractor shall not include payment for recoupment of losses incurred by the contractor from prior years.

(e) A stop loss provision may be made available for risk contracts as determined appropriate by the Division; the amount of the stop loss would be specified in the contract.

(f) The contractor is responsible for payment of all contracted covered services, including emergency services as defined in the contract, rendered to an enrollee whether or not such services are provided at the contractor's facilities.

(g) The contractor shall make available to the Division, for inspection and audit, any financial records of the contractor or its subcontractors in accordance with 42 C.F.R. 434.38 and as specified by the Division.

(h) If third party liability exists for an enrollee, for example, by health insurance contract, subrogation or tort, the Division shall require the contractor to recover, or attempt to recover, all appropriate payments from any and all liable third party sources for services provided to enrollees. Likewise, the Division shall require that the contractor use its best efforts to insure that its subcontractors utilize these same payment sources.

1. It is the contractor's responsibility to recover monies from liable third parties and any monies so recovered are the property of the contractor.

2. The contractor shall include in its periodic reporting to the Division a complete disclosure demonstrating its efforts to obtain payment from liable third parties and the amount and nature of third party payments recovered for Title XIX members including, but not limited to, services, and conditions which are:

i. Employment related injuries or illnesses;

ii. Related to motor vehicle accidents, whether injured as pedestrians, drivers, passengers or bicyclists; or

iii. Contained in Diagnosis Codes 800 through 999 (ICD-9-CM) with the exception of Code 994.6.

3. The Division shall thereafter pursue a policy of deducting an amount actuarially determined to be representative of the availability of third party coverage from the capitation rate, unless the capitation rate already includes an allowance for the recovery of third party payments.

10:49-19.8 Capitation payments to contractors

(a) For Medicaid enrollees enrolled in accordance with N.J.A.C. 10.49-19.4(c)2, the Division shall pay the capitation rate no later than the 15th day of the month in which that individual will be eligible to receive services.

(b) The Division shall make monthly payments to the contractor based upon the total number of certified enrollees and negotiated capitation rate(s).

10:49-19.9 General reporting requirements

(a) Each contractor shall furnish such timely information and reports as the Division may find necessary, and on such forms or in such format as the Division may prescribe. Such reports shall include information sufficient for Division management and evaluation purposes in at least the following areas:

1. Marketing and enrollment performance;

2. Enrollee identification data, such as age, sex, and residence;

3. Utilization data for covered services provided under the contract;

4. Financial data; and

5. Third party payment recoveries for enrollees.

(b) The contractor shall submit to the Division at least annually information specified by the Division on non-Medicaid enrollees for purposes of comparative analyses of services use and cost patterns.

(c) Each contractor shall maintain records in accordance with 45 C.F.R. 74, and applicable law, and make available to authorized personnel of the Division all records created pursuant to the contracts entered into under this subchapter.

(d) All significant changes that may affect the contractor's performance under the contract shall be immediately reported to the Division.

(e) The contractor, with the prior written approval of the Division as to form and content, shall arrange for the distribution of informational materials to all subcontractors providing services to enrollees, outlining the nature, scope and contract requirements.

10:49-19.10 Contract sanctions

(a) If the Division finds that a contractor fails to comply with any of the appropriate laws, regulations or terms of the contract, or for other good cause, the Division may impose one or all of the following:

1. A letter of admonishment to the contractor indicating that continued violations may lead to the imposition sanctions listed in (a)2, 3 or 4 below;

2. A suspension of further enrollments and one or more marketing activities;

3. A withholding of all or part of the capitation payments; and/or

4. Termination of the contract.

(b) The Division shall give reasonable written notice of its intention to impose sanctions to the contractor, and if necessary as determined by the Division, to enrollees and others who may be directly interested. Such written notice shall state the effective date of, and the reason for, the sanctions.

(c) The contractor or Division shall have the right to terminate the contract with at least 90 days written notice to the other party, or as otherwise stated in the contract.

(d) Pursuant to 42 U.S.C. 1396b(m)(5)(A), the Secretary of the U.S. Department of Health and Human Services may impose substantial civil money penalties on the contractor if:

1. It has failed to substantially provide required medically necessary items and services if that failure has adversely affected the enrollees or has substantial likelihood of adversely affecting the enrollees;

2. It imposes premiums on enrollees in excess of the premiums allowed by the law;

3. It discriminates among enrollees on the basis of their health status or requirements for health care services by expulsion or refusal to re-enroll an enrollee or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by eligible persons whose medical condition or history indicates a need for substantial future medical services; or

4. It misrepresents or falsifies information that is furnished to:

i. Secretary of the Department of Health and Human Services or the State; or

ii. To any person or to any other entity under this subsection.

(e) The Secretary may provide, in addition to any other remedies available under law, for any of the following remedies:

1. Civil money penalties of not more than $25,000 for each determination under (d) above, or, with respect to a determination under (d)3 or (d)4i *[if]* **of** not more than $100,000 for each such determination, plus, with respect to a determination under (d)2 above, double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under (d)3 above, $15,000 for each individual not enrolled as a result of a practice described in such paragraph.

SUBCHAPTER 20. THE GARDEN STATE HEALTH PLAN (GSHP)

10:49-20.1 Introduction

The Garden State Health Plan (GSHP) is a State-operated health maintenance organization (HMO) with a Certificate of Authority from the New Jersey State Department of Health to operate in selected counties. It was formerly a Federal demonstration project known as the Medicaid Personal Physician Plan.

10:49-20.2 Physician case manager (PCM)

(a) The primary component of the Garden State Health Plan is the medical case management system whereby the physician case manager (PCM) is responsible for the provision of all primary care services and for the management of referral, ancillary and inpatient services, Participating providers who are acting as PCMs can be in solo practice; group practice; professional corporation or association; health maintenance organization (HMO); independent, free-standing clinic; or in a hospital affiliated *[unity]* **entity** which allows for primary care services and is not subject to DRG reimbursement principles.

(b) The PCM must review and approve all medical services and expenditures on behalf of the patient (including referrals for ancillary services, specialty care, and inpatient hospital care) and provide or arrange for the provision of 24-hour, seven-day-a-week medical coverage.

(c) Participation by physicians in the Garden State Health Plan is voluntary and on a contractual basis. A physician can participate in both the Garden State Health Plan and the Medicaid fee-for-service program. A Physician, however, must be a Medicaid approved provider before he or she can participate in the Garden State Health Plan.

(d) The physician case manager must submit a claim form for each encounter with a patient who is included in his or her panel for GSHP members. The form is required for utilization data, quality assurance and reporting, not for billing purposes. Information on the claim is the same as that which is required on a regular fee-for-service claim. See the Fiscal Agent Billing Supplement for instructions to complete the claim form.

10:49-20.3 Capitation payment system

(a) Physician case managers (PCMs) participating in the Garden State Health Plan are reimbursed through a capitation payment system. The capitation payment system is divided into three funds:

1. The Monthly Prepayment Fund;
2. The Referral Services Fund; and
3. The Inpatient Services Fund.

10:49-20.4 Medicaid recipient

(a) The Garden State Health Plan is offered to the Medicaid recipient as an alternative to the existing Medicaid fee-for-service program. Participation by the Medicaid recipient is voluntary.

(b) A Medicaid recipient who joins the Plan is guaranteed up to 12 months of Medicaid eligibility. This guarantee is granted in six month segments and the individual must be Medicaid eligible the first day of each six month period.

(c) A Medicaid recipient who enrolls in the Plan selects a physician case manager from a list provided by the enrolling agent. Each Medicaid eligible has his or her own PCM. Each family member may have the same PCM or may choose a different physician. A Medicaid eligible family may enroll in the GSHP only if all the Medicaid eligible family (case) members join.

(d) When a Medicaid recipient enrolls in GSHP, the enrolling agent completes a GSHP Enrollment Application which the Medicaid recipient signs. The recipient is then given a copy of the application, a GSHP Conditions of Membership form and a GSHP Information Sheet at the time of application. (See Appendix, N.J.A.C. 10:49).

(e) Beginning on the effective date of enrollment in the GSHP, a message is printed on the Medicaid ID card (FD-152 Form, see N.J.A.C. 10:49-2.12 and Appendix, N.J.A.C. 10:49). The message states "HMO-CHECK GSHP ID CARD." This message alerts providers to ask the member for his or her GSHP identification card. The GSHP ID card lists each family member and his or her physician case manager's name and telephone number.

10:49-20.5 Action required by providers

(a) When providing services and requesting payment for services rendered GSHP members, providers are required to:

1. Check the Medicaid eligibility card for GSHP message;
2. Ask to see the GSHP Member Identification card for physician case manager's name and telephone number;
3. Contact the physician case manager to receive prior authorization to provide services; and
4. Follow billing instructions in the Fiscal Agent Billing Supplement.

10:49-20.6 GSHP services

(a) The following services are covered under the GSHP. Those services in (a)18 through 22 below do not require prior authorization from a physican case manager.

1. Chiropractic services;
2. Clinical laboratory services;
3. Clinic services at free-standing clinics;
4. Drugs (prescription);
5. EPSDT;
6. Hearing aids;
7. Home health services;
8. Hospital services, including

i. Emergency room service;

(1) True life- or organ-threatening conditions may be treated, with notification to the PCM as soon as possible;

ii. Inpatient hospitalization; and

iii. Outpatient clinic;

9. Medical equipment;
10. Medical supplies;
11. Mental health services including psychologist services; only one mental health service every six months (requires prior authorization by the physician case manager);
12. Optical appliances;
13. Optometric services;
14. Physician services, including inpatient physician services;

15. Podiatric services;
16. Radiological services;
17. Rehabilitative services (physical therapy, occupational therapy, audiology and speech-language pathology services);
18. Second surgical opinion consultations;
19. Physician fee for routine in-hospital newborn care;
20. Pediatrician attendance at at-risk vaginal deliveries or caesarian sections;
21. Practitioner fee for normal prenatal, delivery and post partum services; and
22. Certified nurse midwife services.

(b) The following services are non-covered services under the GSHP. Non-covered GSHP services are still available to the GSHP client, outside of the Plan, as long as the client retains his or her Medicaid eligibility. Such services must be provided in accordance with policies described in the appropriate manual.

1. Dental services;
2. Medical day care;
3. Nursing facility care;
4. Prosthetics and orthotics; and
5. Transportation services.

10:49-20.7 Emergency medical care situations for GSHP members

(a) Emergency medical care is available to all GSHP members on a 24-hour, seven-day-a-week basis. Listed below are the guidelines for assessing (for reimbursement and reconciliation purposes) the levels of care in an emergent, urgent or routine situation. These guidelines can be applied to any setting.

1. Level I—Emergency life-threatening or organ-threatening or potentially life-or-organ-threatening condition that requires immediate care. The treating provider must notify the physician case manager as soon as possible after stabilizing the patient.

2. Level II—Urgent condition that is potentially harmful to a patient's health and determined by the physician to be medically necessary for medical treatment within 12 hours to prevent deterioration. The PCM must be called by the treating provider for authorization of the services before providing treatment.

3. Level III—Routine medical care (non-emergent/urgent—that which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (for example, physician's office) or by the patient himself or herself. The physician case manager must be called by the treating provider for authorization of the services before providing treatment.

10:49-20.8 GSHP reimbursement policy for emergency services

(a) Level I emergency care will be reimbursed without the requirement of the PCM's prior authorization. However, the PCM must be notified as soon as the patient is stabilized. The GSHP office shall be contacted for exception for payment processing (telephone 1-800-525-0047).

(b) Services classified under Levels II and III will be reimbursed only when prior authorized by the PCM. If the PCM is contacted for authorization and he or she does grant his or her approval, the provider may then treat the patient and when billing for the service, include the PCM's authorization number in the appropriate portion of the claim form. The completed claim can then be submitted directly to the Fiscal Agent for payment.

1. In situations for services classified under Levels II and III where the provider and PCM do not agree and the provider renders service without authorization but feels reimbursement is warranted, the provider may request of the Plan Office payment consideration by stating and documenting his or her reasons for treatment on the GSHP 16 form, "Exception Payment Request Form" (obtained through the Plan Office). To receive consideration for reimbursement, it will be necessary for the provider to submit the completed GSHP-16 and a hard copy claim to the Garden State Health Plan Office.

i. The New Jersey Medicaid Program's policy on timeliness of claim submission and inquiry applies to the Garden State Health Plan; thus, the GSHP-16 must be submitted to and received by the Garden State Health Plan, in accordance with time frames stated in N.J.A.C. 10:49-7.2.

10:49-20.9 Exception Payment Request Form (GSHP-16)

(a) If due to unusual circumstances a provider failed to obtain authorization from the PCM before rendering a service, he or she may request a review by and retroactive approval from the PCM.

(b) After contacting the PCM, the provider will either be sent the authorization by the PCM, or will be refused. The PCM does have the right to refuse a request for a retroactive approval.

1. If retroactive authorization is refused by the PCM and the provider feels the care was appropriately rendered, he or she may request an Exception Payment Request Form (GSHP-16), for each occurrence, from the GSHP Office, DMAHS, CN-712, Trenton, N.J. 08625-0712. Detailed information about the nature of the service as well as the circumstances of the failure to obtain prior approval will be required. For more information, providers may contact the Plan office at 1-800-525-0047.

SUBCHAPTER 21. PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED (PAAD)

10:49-21.1 Introduction

(a) Pharmaceutical Assistance to the Aged and Disabled (PAAD) is a unique State-funded program to help certain New Jersey residents pay for prescription medicines and certain pharmacy items. A person who applies and is approved will receive a PAAD Eligibility Card (see Appendix, N.J.A.C. 10:49). A PAAD eligible person must pay a $2.00 copayment for each prescribed drug to the pharmacy. PAAD pays the rest.

1. Legend drugs, insulin, insulin syringes and needles and certain diabetic testing materials are covered. Drugs that the Food and Drug Administration determines to be proven not effective are not covered.

10:49-21.2 Eligibility requirements

(a) To qualify for PAAD, a person:

1. Must have been a New Jersey resident at a permanent address for at least 30 days before applying. Residence must not be seasonal or temporary but a legally established residence; and

2. Must meet the annual income criteria established by the New Jersey State Legislature for a single individual and/or married couples; and

3. Must be 65 years of age or older; or

4. Must be receiving Federal Social Security Disability benefits and be at least 18 years of age and under 65; *[or]* ***and***

5. Must not have any other health insurance or retirement benefits which provide prescription coverage, equal to, or better than, PAAD benefits, or may not be receiving Medicaid prescription benefits.

(b) A person under age 65 receiving Federal Social Security Disability benefits on behalf of someone else is not eligible for PAAD.

(c) A person in a nursing facility is eligible if he or she meets all the other standards. A person, whether married or single, who has been in a nursing facility for more than 30 days, can receive benefits if his or her own individual income is within the established income limit for single persons and if this income goes directly to the nursing facility. The single income limit similarly applies to the husband or wife of the patient who is not in a nursing facility but who would otherwise be eligible. For a stay of less than 30 days, the established limit for married couples applies.

10:49-21.3 Eligibility renewal

(a) The PAAD beneficiary must renew his or her eligibility every year unless his or her income is below the established biennial income eligibility limit. In that case, he or she would receive an updated eligibility card automatically for the second year, and would complete a renewal application every two years.

(b) Approximately four months prior to his or her expiration date, PAAD will notify the beneficiary if he or she is eligible for biennial eligibility or if he or she must complete a renewal form. Renewal applications must be returned to the PAAD Bureau by the beneficiary at least 45 days prior to the expiration date to ensure continuous coverage.

(c) Under the PAAD Quality Control Program, a person's name may be chosen at random for a review of eligibility. Selection of a person's name does not mean that a problem exists with that person's eligibility.

10:49-21.4 Loss of eligibility

(a) A person will be considered ineligible and PAAD will no longer pay for prescription drugs if:

1. Eligibility is not renewed;
2. The participant moves outside the State of New Jersey;
3. The participant's income increases above the established income limits;
4. A change occurs in a participant's marital status (for example, through divorce, death, remarriage) that increases his or her income above the allowable income limits; or if a spouse is discharged from a nursing home to the community altering a person's income eligibility;
5. The participant loses his or her Federal Social Security Disability benefits;
6. False information is submitted on or with the application; or
7. The participant obtains other health insurance or retirement benefits which provide prescription coverage equal to, or better than, PAAD benefits.

(b) By law, any changes that will affect a person's eligibility must be promptly reported to PAAD. If for any reason a person becomes ineligible, the PAAD card must be returned to PAAD immediately.

10:49-21.5 Applications

Applications for PAAD may be obtained from local pharmacies, senior citizens centers, Medicaid District Offices, County Offices on Aging or directly from PAAD. All documents of proof required must be submitted with the application. If married, and both husband and wife wish to apply, each must file separate applications, even though the joint income appears on both applications.

10:49-21.6 Inquiries

(a) Questions regarding PAAD may be directed to:
PAAD, CN 715, TRENTON, N.J. 08625

1. A toll-free number is also available: 1-800-792-9745.
2. A special teletypewriter telephone (TTY) is available for the hearing impaired by calling: (609) 588-7180. This is not a toll-free number.

SUBCHAPTER 22. LIFELINE PROGRAMS

10:49-22.1 Introduction

Lifeline Programs provide an annual benefit to eligible persons toward the cost of electricity and natural gas. The Lifeline Credit Program (LCP) provides the benefit as a credit on recipients' gas and/or electric bills. The Tenants Lifeline Assistance Program (TLAP) provides the benefit check to tenants whose utility costs are included in their rent. Supplemental Security Income (SSI) beneficiaries receive the benefit as a Special Utility Supplement (SUS) in their monthly SSI checks. For additional information, refer to N.J.A.C. 10:69B.

10:49-22.2 Eligibility requirements

(a) To qualify for Lifeline, a person must:

1. Be a New Jersey resident; and
2. Have annual income within the requirements established by the New Jersey Legislature; and
3. Be at least 65 years old; or receive Federal Social Security disability benefits from the month of July of one year through the month of January of the next year; and
4. Receive electric and/or gas bills in his or her name; or be a tenant who does not receive utility bills but has the cost of utilities included in the rent; or
5. Be eligible for or receiving benefits under the Federal Supplemental Security Income (SSI) program.

10:49-22.3 Lifeline Credit Program

(a) The credit is granted to utility customers as follows:

1. If the customer pays utility bills directly to a single utility company, a $225.00 credit will appear on the customer's utility bill. If the customer receives utility service from two different companies, (gas and electric), the credit will be divided and $112.50 applied to each company's bill. (A Special Utility Supplement (SUS) payment will be made to SSI beneficiaries instead of a Lifeline credit. See N.J.A.C. 10:49-22.5.)

(b) When a customer is billed directly:

1. The customer's application must apply to his or her primary place of residence, meaning the home where the customer lives most of the time during the year. Seasonal or temporary residence in New Jersey is not considered the primary residence.
2. When two or more related or unrelated persons live in a single household, Lifeline will accept only one application from that household. The application must be in the name of the person (or his or her spouse) whose name appears on the utility bills.
3. If the customer pays utility bills to two different companies and one bill is in the customer's name and the other in the spouse's name, the customer should report this at the time the application is made. In this instance, the credit would be divided with $112.50 applied to each of the two accounts.

10:49-22.4 Tenants Lifeline Assistance Program (TLAP)

(a) The benefit is granted to tenants as follows:

1. Tenants who do not pay utility bills directly receive a check for $225.00 toward the cost of utilities. Only one tenant in a household is entitled to the payment. (A Special Utility Supplement (SUS) payment is made to SSI beneficiaries instead of a TLAP payment. See N.J.A.C. 10:49-22.5.)

(b) When utilities are included in the rent:

1. The tenant's rental must be for his or her primary residence and not for seasonal or temporary rental.
2. A "residential tenant" means a person renting or leasing real property, including a mobile home park site as a personal residence, a net lease residential tenant, as well as a person who is a resident shareholder in a non-profit residential cooperative or mutual housing corporation, or an owner of a condominium, as defined by law.
3. Only one application may be filed per household. When two or more related or unrelated persons live in the same rented household, the person whose name is on the lease or who is the primary tenant or head of household should complete the form.

10:49-22.5 Lifeline for Supplemental Security Income (SSI) beneficiaries

(a) The benefit is granted to SSI beneficiaries as follows:

1. Recipients of Supplemental Security Income (SSI) receive the benefit as Special Utility Supplement (SUS) which is added to their monthly SSI checks. At the end of the fiscal year, those SUS recipients who did not receive the full benefit are sent a check for the difference.

(b) Eligibility for the Special Utility Supplement (SUS) is as follows:

1. Persons receiving SSI benefits who are not in a nursing facility or hospital may receive the SUS.
2. SSI beneficiaries will not receive an application and should not apply. The Lifeline benefit is automatically included in the SSI check. Persons who do not receive the full annual benefit in a year, receive a 13th payment for the balance not received through their SSI checks.

10:49-22.6 Review of eligibility for Lifeline

(a) Eligibility for participation in the Lifeline Programs will be reviewed.

1. If any person is found ineligible for Lifeline or became eligible by providing false or incorrect information, he or she will be required by law to repay the State of New Jersey the full amount of any payment made to, or credit made on his or her behalf.
2. A Lifeline representative may contact a person about his or her eligibility and application if additional information is required.
3. Under the Lifeline Quality Control Program, a person's name may be chosen at random for a review of eligibility. Selection of a person's name does not mean that a problem exists with that person's eligibility.
4. Refusal to be interviewed could result in recovery of a person's Lifeline benefit by the State of New Jersey.

10:49-22.7 Applications

(a) Applications for the Lifeline Programs are sent automatically to persons benefitting from the following programs:

1. Pharmaceutical Assistance to the Aged and Disabled (PAAD);
2. Medical Assistance to the Aged (MAA);
3. Medical Assistance Only (MAO); and
4. New Jersey Care ... Special Medicaid Programs

10:49-22.8 Inquiries

(a) Persons who have not received an application in the mail may call the Lifeline toll-free number: 1-800-792-9745.

1. A special teletypewriter telephone (TTY) is available for the hearing and/or speech impaired (609) 588-7180. This is not a toll-free number.

SUBCHAPTER 23. HEARING AID ASSISTANCE TO THE AGED AND DISABLED

10:49-23.1 Introduction

The Hearing Aid Assistance to the Aged and Disabled Program (HAAAD) is a New Jersey program which provides a $100.00 reimbursement to eligible residents who purchase a hearing aid during a calendar year. Purchases made in subsequent calendar years may be reimbursed upon reapplication. Medicaid recipients or persons who have other health insurance coverage or retirement benefits that provide full hearing aid coverage are not eligible. However, individuals who have only limited or partial coverage are eligible for a supplementary payment.

10:49-23.2 Eligibility requirements

(a) To meet the requirements for eligibility an individual must:

1. Have purchased a hearing aid;
2. Have been a New Jersey resident at a permanent address for at least 30 days;
3. Have gross income within the requirements established by the New Jersey Legislature; and
4. Be 65 years of age or older; or
5. Be receiving Social Security disability benefits.

10:49-23.3 Administration and application

(a) Applications may be obtained by calling the following toll-free number: 1-800-792-9745.

(b) Individuals not currently enrolled in the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program, should complete a PAAD Eligibility Application (AP-2). Those having a current PAAD card should complete a Hearing Aid Assistance to the Aged and Disabled (HA-1) Application (see Appendix, N.J.A.C. 10:49).

(c) A special teletypewriter telephone (TTY) is available for the hearing impaired by calling: 609-588-7180. This is not a toll-free number.

APPENDIX

Medicaid Eligibility Identification Card (FD-73/178)	Form #1
Medically Needy Claim Transmittal (FD-311)	Form #2
Public Assistance Inquiry (PA-1C)	Form #3
Certification of Presumptive Eligibility (FD-334)	Form #4
Application for Payment of Unpaid Medical Bills (FD-74)	Form #5
Department of Human Services Medicaid ID *[(FD-172)]* *(FD-152)*	Form #6
DYFS Validation for Health Services Program (DYFS-16-36)	Form #7
Validation of Eligibility (FD-34)	Form #8
Provider Application (FD-20)	Form #9
Provider Agreement (FD-62)	Form #10
Disclosure of Ownership and Control Statement (HCFA-1513)	Form #11
Patient Certification Form (FD-197)	Form #12
Garden State Health Plan Information Sheet	Form #13
Garden State Health Plan Conditions *[of]* *for* Membership (GSHP-4(a))	Form #14
Hearing Aid Assistance Application (HA-1)	Form #15
PAAD Eligibility Card	Form #16
Medicaid District Office Directory	Form #17

STATE OF NEW JERSEY
DEPARTMENT OF
HUMAN SERVICES
DIVISION OF
MEDICAL ASSISTANCE
AND
HEALTH SERVICES

MEDICAID ELIGIBILITY IDENTIFICATION CARD 1939902

ADDITIONAL HEALTH INSURANCE*

HSP (MEDICAID) CASE NO. PERSON NO.

VALID FROM TO

SOC. SEC. ACCT. NO. DATE OF BIRTH

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES

RECIPIENT'S SIGNATURE

FD-73/178 (REV. 3/91)

IMPORTANT NOTICE

You must sign the front of this card on the line above the Recipient's Signature. If you are unable to sign the card, the individual representing you must sign your name, initial the card and explain his/her relationship to you.

Immediately notify the Medicaid District Office or the Division of Youth and Family Services case manager or the County Welfare Agency (as appropriate):

1. If you have Medicare coverage or other health insurance not listed or incorrectly listed; or
2. If any changes are necessary to the front of this card; or
3. If you have any questions regarding the use of this card; or
4. If this card is lost or stolen. (Unless the report of the loss or theft can be documented at the appropriate agency, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use).

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the Medicaid Program. The Department of Human Services is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

THIS CARD IS NON-TRANSFERABLE UNDER PENALTY OF LAW.

NOTICE TO PROVIDERS

The printed name which appears directly above the line for Recipient's Signature on this card is the MEDICAID eligible person. This name identifies that person ONLY (except AFDC can include spouse/child(ren) listed with PERSON NUMBERS) as being eligible for MEDICAID benefits within the time period shown. If the name of a "REPRESENTATIVE PAYEE" appears on this card, that individual is not eligible for Medicaid benefits.

* Ask the cardholder if there is Medicare coverage or other health insurance not listed. Please indicate this information in the appropriate area on the claim form. Prior to billing Medicaid you are to bill other third party payers in accordance with N.J.A.C. 10:49.

Form #1

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICALLY NEEDY CLAIM TRANSMITTAL

RECIPIENT INFORMATION

HSP (Medicaid) CASE NO. _____

NAME _____

ADDRESS _____

PROVIDER INFORMATION

PROVIDER NO. _____

PROVIDER NAME _____

PROVIDER ADDRESS _____

TYPE OF SERVICE	DATE OF SERVICE	CHARGE	PAYMENT FROM OTHER SOURCE	CLIENT OBLIGATION	TOTAL FROM OTHER SOURCES
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Provider Instructions and Information:

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS _____

SIGNATURE _____
Authorized Representative

FD-311 (5/86)

Form #2

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PUBLIC ASSISTANCE INQUIRY

Referral for: ☐ SSI ☐ New Jersey Care ☐ Medicaid Only ☐ AFDC ☐ Newborn (complete items 1,2,4,11a,15 only)

TO: FROM:

(SSA / DO)
_____ (County Welfare Agency) _____
Hospital

_____

Date: _____

_____

☐ M
Sex ☐ F

1. Name: _____
(Last) (First) (Middle)
(For newborn referral, enter name and sex of parent.)

2. Social Security Account Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

3. Permanent Home Address: _____ Telephone: _____

4. Marital Status: *(Check one)* Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐

5. Date of Admission: _____ Date of Birth: _____

6. Address From Which Admitted: _____ Telephone: _____

7. Diagnosis: _____

8. Prognosis: _____
(For SSI disability/blindness and AFDC incapacity)

9. Referring Physician: _____ Telephone: _____

10. Spouse: Name: _____ Age: _____ Telephone: _____

Address: _____

11. Minor Children *(First Names and Ages)*: _____

☐ M
(a) Newborn Data: Name: _____ Date of Birth: _____ Sex ☐ F

Mother's HSP (Medicaid) Case No.: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___

12. Next of Kin *(If other than Spouse or Children)*: _____

Address: _____ Telephone: _____

13. Gross Monthly Income of Patient: _____ Source: _____

14. Gross Monthly Income of Family Members: _____

15. Hospital Insurance: Blue Cross ☐ I.D. No.: _____ Medicare ☐ H.I.C. No.: _____

(a) Applicable to Newborn? Yes ☐ No ☐

Other ☐ Carrier Name: _____ Policy No.: _____

16. Employer's Name: _____ Address: _____

17. Name of Spouse's Employer: _____ Address: _____

PA-1C (rev. 7/89)

Form #3

18. What inquiries have been made regarding financial responsibility for the hospital bill?

_____

What were the results? _____

_____

19. Does patient, patient's authorized agent, or relatives know that an inquiry is being made for the previously checked program?

Yes ☐ No ☐

20. Whereabouts:

Is client still in hospital? Yes ☐ No ☐

If YES, anticipated address upon discharge: _____

If NO, date of discharge: _____

Present address if known: _____

21. Other Comments: _____

_____

22. The above patient is being cared for in the hospital since _____ (Date) on a ward service or general service basis as to professional and other personal services and I believe that such a patient may be eligible for the previously checked program.

Signature: _____ Title: _____ Date: _____

23. Signature of Patient or Relative: _____ Date: _____

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that I must furnish certain information to the SSA/DO or the County Welfare Agency to establish eligibility and extent of need for Supplemental Security Income Benefits or public assistance, and that the appropriate agency will help to secure this information and verify it. I will supply complete and accurate information, within my knowledge, to representatives of the SSA/DO or the County Welfare Agency. I hereby authorize and direct my relatives, physician, hospital, employers, bankers, and any other person having information concerning the persons named above to furnish complete details to the appropriate agency investigating my application for such assistance. I understand that the information obtained will be used only in connection with the application for or receipt of assistance.

"I further authorize the Social Security Administration to release benefit information and entitlement dates to the hospital whose name appears on the reverse of this form. I understand the hospital will only use this information for purposes of establishing my eligibility to Medicaid."

Signature: _____ Relationship: _____ Date: _____

IF NOT SIGNED BY PATIENT, EXPLAIN WHY: _____

_____

NOTICE TO THE SSA/DO OR CWA INITIALLY RECEIVING THIS INQUIRY. WHEN IT IS NECESSARY TO REFER THE APPLICANT TO ANOTHER PUBLIC ASSISTANCE AGENCY, INCLUDE AT LEAST A COPY OF THIS PA-1C FORM.

DMAHS USE ONLY

PROVIDER USE ONLY

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

CERTIFICATION OF PRESUMPTIVE ELIGIBILITY

CLIENT INFORMATION:

Name: _____ County of Residence _____

Address: _____ Birth Date: — — - — — - — —

_____ Social Security No. — — —- — — - — — — —

Telephone No.: ( ) _____ Household Unit: ____ *(No. of persons in household)*

(Check appropriate boxes below.)

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Black ☐ American Indian ☐ Oriental ☐ Hispanic ☐ Other

Does client have a pending AFDC, SSI, Medicaid application? ☐ Yes ☐ No *(If yes, circle program.)*

Client is: ☐ U.S. Citizen ☐ Alien admitted for permanent residence
☐ Alien admitted for temporary residence ☐ Undocumented alien

Medicare Coverage: ☐ Yes ☐ No If Yes, HIC Number: _____

Other Insurance Company: _____ Other Insurance Policy No.: _____

INCOME INFORMATION:

Total Household Income:	Income	Frequency	Gross Monthly Amt.	Source
Gross Earnings				
Gross Earnings				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Child Support Amount				
Gross Alimony Amount				

Total Monthly Gross Income $ _____

Child Care Expense Amount: _____ Weekly _____ BiWeekly _____ Monthly

PREGNANCY INFORMATION:

Date of L.M.P. _____ Pregnancy Due Date: _____

CERTIFICATION STATEMENT:

I, _____ attest that I have read and agree to the above statements and fully realize that the county welfare agency relies upon the truth and accuracy of my statements. I have received a copy and understand the Patient Guidelines.

_____ _____
Applicant Signature *Date*

I certify the above applicant is pregnant and presumptively eligible for limited Medicaid benefits in accordance with N.J.A.C. 10:72-6.1 et seq.

_____ _____ _____
Provider Agency Name *Address* *Telephone*

_____ _____
Provider Signature *Date*

IMPORTANT: THE ORIGINAL FORM MUST BE FORWARDED TO THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, ISS SECTION, AREA #3, PRESUMPTIVE ELIGIBILITY RECORDS, CN-712, TRENTON, NJ 08625, WITHIN TWO (2) DAYS OF COMPLETION.

Form #4 FD-334

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

APPLICATION FOR PAYMENT OF UNPAID MEDICAL BILLS NEW JERSEY HEALTH SERVICES PROGRAM (MEDICAID)

NOTE: THIS FORM (FD-74) IS GIVEN ONLY TO APPLICANTS WHO INDICATE THEY HAVE UNPAID BILLS FOR MEDICAL SERVICES RECEIVED DURING THE THREE (3) MONTHS PRIOR TO APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME. THE FD-74 MUST BE SUBMITTED WITHIN SIX (6) MONTHS FROM THE DATE OF APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME.

The New Jersey Medicaid Program will evaluate this application to determine whether or not payment can be made by the program for covered Medicaid services received by the applicant and/or eligible person(s) living in the same household during the specified period. **This refers only to those services for which bills remain unpaid. The Medicaid Program will not consider payment of bills that have already been paid.**

PART 1 - APPLICANT INFORMATION

1. _____ *Name of Applicant* 2. _____ *Applicant's HSP (Medicaid) Case No.* 3. _____ *Applicant's Birthdate*

4. _____ *Street Address - Apartment Number* *City* *State* *Zip*

_____ *Telephone Number (area code)* _____ *Social Security Account Number* _____ *County of Residence*

5. _____ *Date of Application for Public Assistance or Supplemental Security Income* 6. _____ *Name and address of Agency processing application for Public Assistance or Supplemental Security Income (i.e., County Welfare Agency or Social Security Office, etc.)*

7. If the applicant has applied for Aid to Families with Dependent Children (AFDC) or Assistance to Families of the Working Poor (AFWP), list the full names, ages and relationship of each dependent child or eligible person(s) living with applicant.

_____

_____

_____

PART II - MEDICAL INFORMATION

A. PLEASE COMPLETE ALL QUESTIONS LISTED ON REVERSE SIDE AS ACCURATELY AS POSSIBLE.
B. YOU MUST ATTACH COPIES OF ALL UNPAID MEDICAL BILLS TO THIS APPLICATION.

8. List all unpaid medical bills and the dates incurred during the three (3) months before application for assistance.

Type of Services (Hospital, Physician, Etc.) Name of Hospital, Physician Etc.	Patient	Date(s) of Service	Total Amount Due

SEE OTHER SIDE

FD-74

Form #5

PART III - FINANCIAL INFORMATION

9. Are any of the medical bills listed on this application the result of a job related injury, auto or other accident? Yes ( ) No ( )
If yes, explain and indicate the name of the insurance company and your legal representative.

_____ _____

_____

10. What were your income and resources at the time the medical bills were incurred for the **three month period before your application for Public Assistance or Supplemental Security Income?** If you had no income or resources during the three (3) months prior, please specify in the spaces provided. If you were under 18 years old, you must indicate your parent's income and resources.

Please check below the type of income you received and in which month(s) received. Also, please submit verification of your income (copies of checks, pay stubs, etc.) with your application.

		TOTAL MONTHLY
_____ EMPLOYMENT	WHEN RECEIVED:	AMOUNT RECEIVED:
_____ UNEMPLOYMENT	_____ 1st MONTH BEFORE APPLICATION	$_____
_____ DISABILITY	_____ 2nd MONTH BEFORE APPLICATION	$_____
_____ SOCIAL SECURITY	_____ 3rd MONTH BEFORE APPLICATION	$_____
_____ ALIMONY		
_____ CHILD SUPPORT	**HOW OFTEN RECEIVED:**	
_____ OTHER: _____	_____ WEEKLY _____ BI-WEEKLY _____ MONTHLY	

_____NO INCOME RECEIVED DURING THE THREE MONTHS BEFORE APPLYING FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME.

What resources did you have during this same time period?

_____ CHECKING ACCOUNT $_____ _____ STOCKS, BONDS, ETC. $_____
_____ SAVINGS ACCOUNT $_____ _____ SPECIFY: _____
_____ AUTOMOBILE: 1. Year 19__ make _____ _____ OTHER: _____
2. Year 19__ make _____
_____INSURANCE POLICY 1. Face Falue $_____ Cash Value $_____
2. Face Value $_____ Cash Value $_____
_____NO RESOURCE OF ANY KIND

11. Did you have any type of Medical or Health Insurance coverage, such as Blue Cross or Medicare? Yes ( ) No ( )
(If yes, explain below.)

NAME OF INSURANCE COMPANY OR PROGRAM	POLICY NUMBER OR MEDICARE NUMBER	NAME OF INSURED

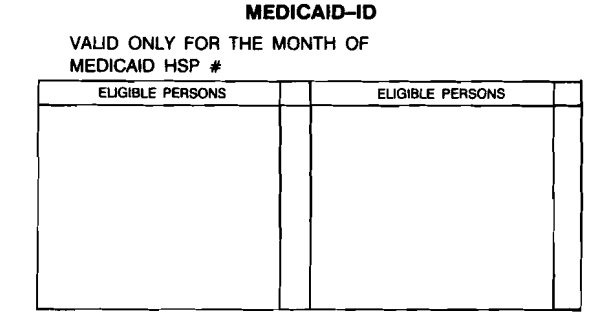
12. I certify that the above information is true and correct to the best of my knowledge and that no facts have knowingly been omitted. I understand that my application may be investigated and I agree to cooperate in such an investigation. I further understand that the law provides for fine or imprisonment, or both, for a person hiding facts or not telling the truth.

_____ _____ _____
Signature of Applicant *Relationship to Applicant* *Date*

NOTE: This application must be signed by the applicant, or relative, or legal guardian or friend acting on behalf of the applicant. ***This application must not be signed by the applicant's physician or anyone representing a hospital or collection agency.***

MAIL THIS COMPLETED APPLICATION, TOGETHER WITH COPIES OF ALL UNPAID MEDICAL BILLS, TO THE RETRO-ACTIVE ELIGIBILITY UNIT, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, CN-712-10, TRENTON, NJ 08625.

*[your MEDICAID ELIGIBILITY CARD is attached



DEPARTMENT OF HUMAN SERVICES
MEDICAID–ID

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

ELIGIBLE PERSONS		ELIGIBLE PERSONS	

NOTICE TO PROVIDER

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT.

PLEASE REPORT THE CASE NAME, CASE NUMBER AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER APPLICATIONS RELATING TO THE CLAIM.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION

CARRY THIS CARD AT ALL TIMES

Present it to the pharmacy, hospital, physician or other providers for medical services rendered in behalf of eligible persons.

RECIPIENT'S SIGNATURE REQUIRED

No es valida si no este firmade. Entréguela a la farmacia, hospital, médicos u otros proveedores de servicios médicos prestados a personas que reunen las condiciones necessaries para poder usar Medicaid.

NOTICE

Federal law makes it a crime and sets punishments to persons who have been found guilty of making false statement or representation of a material fact, to receive any benefit or payment under the medical assistance program. This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or for converting a benefit to the use of any person other than one for whom it was intended.

NON-TRANSFERABLE UNDER PENALTY OF LAW

AVISO

De acuerdo con la ley federal es un debto hacer XX declaración false a fin de reciber un beneficio o XX bajo of programa de assistencia médica, y dicha ley pena a les personas que le XX E Departamento le tiene que informar de XXX ley y tiene que advertir que no haga ninguna XX declaratión en una solicitud para determinar derecho a un beneficio, o para convertir el beneficio uso de otra persona que no XXX destinada a XX mismo.

INTRANSFERIBLE BAJO PENA DE LA LEY

Form #6]*

DEPARTMENT OF HUMAN SERVICES 7841006
MEDICAID-ID

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
1		11	
2		12	
3		13	
4		14	
5	VOID	15	
6		16	
7		17	
8		18	
9		19	
10		20	

NOTICE TO PROVIDER

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT.

PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION

CARRY THIS CARD AT ALL TIMES

Present it to the pharmacy, hospital, physician or other providers for medical services rendered in behalf of eligible persons.

RECIPIENT'S SIGNATURE REQUIRED

No es válida si no está firmada. Entréguela a la farmacia, hospital, médico u otros proveedores de servicios médicos prestados a personas que reunen las condiciones necesarias para poder usar Medicaid.

NOTICE

Federal law makes it a crime and sets punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the medical assistance program. This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

NON-TRANSFERABLE UNDER PENALTY OF LAW

AVISO

De acuerdo con la ley federal es un delito hacer una declaración falsa a fin de recibir un beneficio o pago bajo el programa de asistencia médica, y dicha ley fija pena a las personas que la infrinjan. Este Departamento le tiene que informar de dicha ley y le tiene que advertir que no haga ninguna falsa declaración en una solicitud para determinar su derecho a un beneficio, o para convertir el beneficio al uso de otra persona que no sea la destinada a recibir el mismo.

INTRANSFERIBLE BAJO PENA DE LA LEY

NOTICE TO CLIENT

THIS VALIDATION FORM INDICATES ELIGIBILITY FOR AUTHORIZED HEALTH SERVICES PROVIDED UNDER THE NEW JERSEY HEALTH SERVICES PROGRAM.

THIS VALIDATION MUST BE PRESENTED TO THE DOCTOR, HOSPITAL OR OTHER MEDICAL SERVICES PROVIDER WHEN SERVICES ARE RENDERED.

NOTICE TO PROVIDER OF MEDICAL SERVICES

YOUR CLAIM FOR PAYMENT OF HEALTH SERVICES IS TO BE SUBMITTED TO THE APPROPRIATE CONTRACTOR FOR THE STATE OF NEW JERSEY ON THE REQUIRED VENDOR CLAIM FORM.

PLEASE REPORT THE CASE NAME, CASE NUMBER AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

PLEASE CONTACT THE MEDICAID DISTRICT OFFICE SERVING YOUR AREA IF YOU HAVE QUESTIONS ABOUT THE MEDICAID PROGRAM.

Child's Medicaid No. **Name** **Case No.**

VALID ONLY FOR DATES OF

PLACEMENT REFERENCE

STATE OF NEW JERSEY
DIVISION OF YOUTH AND FAMILY SERVICES

VALIDATION
FOR HEALTH SERVICES PROGRAM

DYFS 16-36
(rev. 10/85)

Form #7

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

VALIDATION OF ELIGIBILITY

Last Name	First Name	Mi	Health Services Program Case No.	Person Number

NOTICE TO PROVIDERS

This form identifies the person listed above as eligible for authorized services under the New Jersey Health Services Program (Medicaid).

This form also serves as a validation of eligibility for up to 31 days from date of issue. All policies and procedures specified in the appropriate New Jersey Health Services Program Provider Manual are to be followed by providers when rendering services to this person.

The signature, title and telephone number of an authorized representative of the State Institution listed below must be included to validate this form.

THIS FORM IS THE PROPERTY OF THE STATE OF NEW JERSEY AND MUST BE RETURNED WITH THE PATIENT.

Signature and Title of State Institution Representative	Date of Issue
Name of State Institution	Telephone No.

FD-34 (rev. 5/83)

Form #8

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

PROVIDER APPLICATION

1. _____ 2. _____
Legal Name of Provider — Type of Business or Facility

_____
Business Name, if Different From Above

3. _____
Address (Service Location Only) Street — City — County — State — Zip Code

4. _____ 5. _____ 6. _____
Employer ID Number — Telephone Number — Length of time at above address

7. _____ 8. _____
Billing Address, if different — Name of Administrator, Chief Executive Officer, or other responsible official.

_____

9. Indicate legal status of your organization: Profit _____, Non-Profit _____, Private _____, Public _____, Municipal _____, State _____, Charity _____, School Nurse _____, County _____, Other _____. If other, please specify: _____

10. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program.

_____

11. Do you operate from more than one location? _____ Yes _____ No. If yes, list all other subsidiary or affiliated organizations below: (Name and service address)

1. _____ _____
2. _____ _____
3. _____ _____
Please attach additional sheet if necessary.

12. Please indicate if you are a member of a chain organization. _____ Yes _____ No. If yes, indicate name: _____

13. Please indicate your preference to receive central or local reimbursement:

_____ to each satellite location;
_____ to central location at _____

Billing through a central location is allowable and left to the provider's discretion. However, if the provider chooses to bill centrally, pre-addressed claims MUST be utilized since they reflect the proper address and provider number for that location.

14. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? _____ Yes _____ No. If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate.

15. If your business or facility requires a license/permit, indicate type _____ and number _____
Please attach a copy of the license/permit, i.e., Independent Laboratory Certification.

16. CERTIFICATION, ACCREDITATION OR APPROVAL Specify type and attach copy. For example JCAHO (hospitals); New Jersey Department of Health (clinics); Division of Mental Health and Hospitals (mental health clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services); American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist). See Item 16.

17. Approved by Medicare? _____ Yes _____ No. If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval.

18. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? _____ Yes _____ No. If Yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

FD-20 (12 90)

Form #9

19. Have any of the entities named in response to questions 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? _____ Yes _____ No. If yes, please explain.

20. Have any of the entities named in response to question 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? _____ Yes _____ No. If yes, please explain.

21. Have any of the entities named in response to questions 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction? _____ Yes _____ No. If yes, please explain. _____

22. Do any of the entities named in response to question 1. or 11. or their officers or partners, or any of the other individuals named in response to questions 8. own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid (Title XIX) Progam of any other state or jurisdiction? _____ Yes _____ No. If yes, please list provider name and nature of relationship.

23. Do you charge for goods and/or services? TO ALL _____, TO NONE _____, TO CERTAIN GROUPS ONLY _____. If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule.

24. List days and hours of operation.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____
PROVIDER

PROVIDER AGREES:

1. To comply with all applicable State and Federal Medicaid laws and policy, and rules and regulations promulgated pursuant thereto:

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the Medicaid Program;

3. To furnish the Division of Medical Assistance and Health Services, the Secretary of Health and Human Services and the Medicaid Fraud Section, Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the Medicaid Program;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242 (c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

The provider may, on thirty days written notice to the Division, terminate this Agreement.

_____ _____
DATE SIGNATURE OF PROVIDER

_____
TITLE

FD-62 (rev. 6/86) Medicaid 3031-M Ed. 6/86

Form #10

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		**City, County, State**		**Zip Code**

(b) *(To be completed by HCFA Regional Office)* Chain Affiliate No. ☐☐☐☐☐ LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB3

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☐ No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
		LB5

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB6
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No LB7

Name	Address	Provider Number

Form HCFA-1513

Form #11

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ ☐ Yes ☐ No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ ☐ Yes ☐ No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ ☐ Yes ☐ No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ ☐ Yes ☐ No LB11

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
☐ Yes ☐ No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN # ☐ Yes ☐ No LB13

Address

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN)
Name EIN # ☐ Yes ☐ No LB18

Address

LB19

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
☐ Yes ☐ No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title

Signature	Date

Remarks

Form HCFA-1513

PATIENT CERTIFICATION FORM

PATIENT'S NAME _____

HIC NO. _____ HSP NO. _____

MEDICARE PATIENT'S AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration, or the Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related claim. I certify that the service(s) covered by this claim has been received and request payment in accordance with Program Policy either to Dr. _____ or myself if the doctor does not accept assignment.

MEDICAID PAYMENTS

Authorization to Release Information and Payment Request. I certify that the service(s) covered by this claim has been received and request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the State Agency or its authorized Agents any information needed for this or a related claim.

Patient or Authorized Representative's Signature	Date of Service	Control Number	Other Comments

THIS FORM TO BE RETAINED IN PROVIDER'S OFFICE
THIS FORM HAS BEEN APPROVED BY
THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES,
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
FOR USE IN THE MEDICAID PROGRAM

7445-M Ed. 7/82 FD-197-N.J. (rev. 7/82

Form #12





YOUR PRESCRIPTION FOR GOOD HEALTH

WELCOME TO THE GARDEN STATE HEALTH PLAN

Thank you for applying for membership in the Garden State Health Plan (GSHP). After your eligibility for enrollment is verified, the GSHP will process your enrollment, which usually takes forty-five days. Your membership, therefore, should begin on . You will know when your membership begins when the message, "HMO-Check GSHP-ID Card," is printed on your Medicaid Identification (ID) Card which you receive each month.

A few weeks before your membership begins, you will receive a gold Garden State Health Plan Membership Card. When your GSHP membership begins, you must show both your Medicaid ID Card and your GSHP gold card each time you receive medical care.

Also, as a Plan member, it is important that you establish and maintain a close relationship with your primary care physician. Remember, all medical services you receive will be coordinated by your primary care physician. You must, therefore, call your physician for authorization before you go to any other health provider, such as an eye doctor, for X-rays, or to have a prescription filled, etc.

The Garden State Health Plan operates a toll-free number: **1-800-525-0047**. Please call if you have any questions or problems. Our goal is to keep each GSHP member healthy and satisfied. In addition, please notify our office immediately if you do not receive your gold card within 45 days of your application.

The Garden State Health Plan physician case manager(s) you have chosen is/are:

Name of Family Member	Physician	Telephone	Address

State of New Jersey
DEPARTMENT OF HUMAN SERVICES

Form #13

SU RECETA PARA LA
BUENA SALUD

UNA CORDIAL BIENVENIDA AL GARDEN STATE HEALTH PLAN

Le agradecemos su solicitud para afiliarse al Garden State Health Plan (GSHP). Después de que se compruebe su elegibilidad para la inscripción, el GSHP tramitará su inscripción, lo que normalmente toma 45 días. Por consiguiente, su afiliación comenzaría el Usted sabrá la fecha del inicio de su afiliación cuando el mensaje "HMO-CHECK GSHP-ID CARD" esté impreso en su tarjeta de identificación de Medicaid, que recibirá mensualmente.

Unas semanas antes de que se inicie su afiliación, usted recibirá una Tarjeta dorada de Identificacion como Miembro del Garden State Health Plan. Cuando se inicie su afiliación en el GSHP, cada vez que reciba atención médica usted deberá presentar su tarjeta de identificación de Medicaid junto con su tarjeta dorada del GSHP.

Además, como miembro del Plan, es importante que usted establezca y mantenga unas relaciones estrechas con su médico de atención primaria. Tenga presente que todos los servicios médicos que usted reciba serán coordinados por su médico de atención primaria. Por consiguiente, usted deberá llamar a su médico para obtener autorización antes de acudir a cualquier proveedor de salud distinto, tal como el oculista, para radiografías o para que se le dispense una receta.

El Garden State Health Plan mantiene un número de teléfono gratis de tarifa: 1-800-525-0047. Le rogamos que llame si tiene preguntas o problemas. Nuestro objetivo es el de mantener sano y satisfecho a cada uno de los miembros del GSHP. Además, le rogamos que avise a nuestra oficina si no recibe su tarjeta dorada en un plazo de 45 días de remitir su solicitud.

El o los gerentes médicos para casos del Garden State Health Plan que usted seleccionó son:

Nombre del familiar	Medico	Teléfono	Dirección

Form #13

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

GARDEN STATE HEALTH PLAN (GSHP)

CONDITIONS FOR MEMBERSHIP

1. I have applied for membership in the Garden State Health Plan (GSHP). I have accepted no money nor rewards to enroll in the Plan, nor have I been forced by anyone to join the Plan.

2. I understand that I may choose my Physician Case Manager (PCM) from a list of participating physicians in my area according to the type of practice and availability of openings for that PCM.

3. I understand that I am eligible for all Medicaid services as a Plan member and I will not lose any Medicaid benefits by enrolling in this plan.

4. I understand and agree, as a Plan member, to *only* go to the doctor I have chosen for *all* medical services no matter what the problem. If an emergency occurs and my doctor cannot be contacted right away, I may go to a hospital emergency room and my PCM will be notified. I *will not* go to the hospital emergency room or to any other doctor if it is not an emergency situation.

5. I understand that the PCM I have chosen will send me for other health services whenever necessary. I will *only* use another physician's services or other health care provider's services (e.g. optometrist, chiropractor, etc.) if I have been sent by or have the approval of my PCM. Only my PCM will write any necessary prescriptions for me or will authorize another physician to write a prescription for me.

6. I understand that if I use any health services (for example, using the hospital emergency room for non-emergency or routine care) without the approval of my PCM, the Medicaid Program will not pay for these unauthorized services and I may become responsible for paying the bills.

7. I understand that my Plan participation begins when I receive my validation stub with the following message, "HMO—Check GSHP ID Card," printed on the stub. My membership in the Plan will automatically continue until my eligibility is terminated or my disenrollment is authorized. If I want to disenroll from the Plan or choose another PCM, I *must* contact the Plan Office listed below. Under certain circumstances, I may be guaranteed twelve (12) months of Medicaid eligibility upon enrollment which has been explained to me.

8. I understand that I am enrolling for six (6) month periods and that I may change my Physician Case Manager for any reason during the first thirty (30) days of membership in the Plan (which begins the first month the Plan message appears on my Medicaid Validation Card) and during the first thirty (30) days of each successive six (6) month period of membership.

9. I understand that in order to participate in the Plan I must be Medicaid eligible on the effective date of my enrollment in the Plan. If I should lose my Medicaid eligibility, my membership becomes null and void.

10. I understand that if I am currently receiving long-range medical services, (such as mental health counseling) or am under a "plan of care" of another physician, I will discuss this matter with my PCM as soon as possible. If there is any disagreement about continuing that care, I may call the designated Plan Office at the toll free number to discuss a possible solution.

11. I understand that under certain circumstances the County Welfare Agency (AFDC clients only) has the right and obligation to invalidate my twelve (12) month guarantee of eligibility if I fail to comply with public law which affect my eligibility for public assistance benefits.

Any questions or complaints about my Plan membership should be directed to:

Office of the Garden State Health Plan

Address: **CN 712, Trenton, New Jersey 08625**

Toll Free Telephone Number: **1 - 800 - 525 - 0047**
(This number can also be found on your GSHP Membership Card.)

Form #14

GSHP-4(a)

CONDICIONES DE MIEMBRO

1. He solicitado ser miembro del Plan de Salud del Estado del Jardín. No he aceptado ningún dinero o recompensa para inscribirme al Plan, ni se me ha obligado a unirme al Plan.

2. Tengo entendido que puedo escoger mi Gerente Médico para Casos (GMC) de un listado de médicos participantes en mi área, de acuerdo al tipo de práctica y a la disponibilidad de plazas exitentes para ese GMC.

3. Tengo entendido que soy elegible para todos los servicios de Medicaid como miembro del Plan y que no voy a perder ningún beneficio de Medicaid al participar en este plan.

4. Tengo entendido y estoy de acuerdo que, como miembro del Plan, visitaré para *todos* los servicios médicos *solamente* al médico que haya escogido, independientemente del problema. En caso de emergencia y no poder comunicarme con mi médico inmediatamente, puedo ir a la sala de emergencia de un hospital y se notificará a mi GMC. *No* iré a la sala de emergencia de un hospital o a ningún otro médico, a menos que sea una emergencia.

5. Tengo entendido que al GMC que haya escogido me enviará a otros servicios de salud cuando sea necesario. *Solamente* recurriré a los servicios de otro médico o de algún otro proveedor de servicios de salud (p.e. optómetra, quiropráctico, etc.), siempre y cuando me haya enviado y tenga la aprobación de mi GMC. Mi GMC será el único que podrá suministrarme las recetas necesarias o autorizar a otro médico a hacerlo.

6. Tengo entendido que si utilizo cualquier servicio de salud (por ejemplo, la utilización de la sala de emergencia hospitalaria para casos que no son de urgencia o para cuidado rutinario) sin la aprobación de mi GMC, el programa de Medicaid no pagará dichos servicios y puede que yo sea responsable de cubrir los gastos incurridos.

7. Tengo entendido que mi Plan de participación comienza en el momento en que reciba mi tarjeta de validación impresa con el siguiente mensaje: "HMO — Check GSHP ID Card," (HMO—Factue la tarjeta de identificación del Plan). Mi participación en el Plan continuará automáticamente hasta que termine mi elegibilidad o hasta que se autorice mi disociación. En caso de que desee disociarme del Plan o escoger a otro GMC, *deberé* comunicarme con la oficina del Plan cuyo nombre aparece al pie de la página. Bajo ciertas circunstanciás, se me podrán garantizar doce (12) meses de elegibilidad con Medicaid, lo cual me fue explicado al momento de la inscripción.

8. Tengo entendido que alisto para un período de seis meses y que puedo cambiar de Gerente Médico para Casos por la razón que sea durante los primeros treinta (30) días de participación en el Plan (el cual comienza a partir del primer mes en que aparezca en mi tarjeta de validación de Medicaid el mensaje de Plan) y durante los primeros treinta (30) días de cada periodo sucesivo de seis meses de participación.

9. Tengo entendido que para particpar en el Plan debo ser elegible para Medicaid en la fecha efectiva de mi subscripción al Plan. Si pierdiera mi elegibilidad de Medicaid, mi membrecía sará nula e inválida.

10. Tengo entendido que si actualmente estoy recibiendo servicos médicos a largo plazo, (tales como consejería de salud mental) o estoy bajo un "plan de cuidado" de otro médico, discutiré este asunto con mi GMC lo más pronto posible. En caso de surgir algún desacuerdo sobre la continuación de dicha atención, podré comunicarme con la oficina del Plan para discutir una posible solución.

11. Tengo entendido que bajo ciertas circunstancias la Agencia de Bienestar del Condado (solamente para clientes del AFDC) tiene el derecho y la obligación de invalidar mi garantía de elegibilidad de doce (12) meses, en caso de que no cumpla con las leyes que gobiernan mi elegibilidad para los beneficios de asistencia pública.

Cualquier pregunta o queja sobre mi membrecia al Plan deberá dirigirse al:

Oficina del Plan de Salud del Estado del Jardín

Dirección: **CN 712, Trenton, New Jersey 08625**

Número del Teléfono Libre de Tarifa: **1-800-525-0047**

(Este número del teléfono lo puede encontrar en su tarjeta de miembro de GSHP)

Form #14

State of New Jersey 10:49-Appendix-FORM #15
Department of Human Services
Division of Medical Assistance and Health Services

Address reply to
HAAAD Program
Cn-715
Trenton, NJ 08625-0715

ELIGIBILITY APPLICATION
HEARING AID ASSISTANCE TO THE AGED AND DISABLED (HAAAD)

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip Code _____

Applicant's Social Security Number _____ Applicant's Pharmaceutical Assistance to the Aged and Disabled Number _____

The following documentation must accompany this application:

1. A receipt for the purchase of the hearing aid.
2. A written statement from your physician attesting to the medical necessity for obtaining a hearing aid. You may obtain your physician's signature below or attach a copy of the prescription for the hearing aid.

TO BE COMPLETED BY YOUR PHYSICIAN

I have examined this applicant and have determined the medical necessity for obtaining a hearing aid.

Physician's Signature _____ Name & Address of Physician (PLEASE PRINT) _____

Applicant's Certification and Waiver: I certify that the information above is true and accurate to the best of my knowledge. I understand that if it is determined that HAAAD benefits have been improperly issued to me, I will be required to repay such benefits. I understand that to verify my eligibility for HAAAD, it may be necessary to obtain certain information from records of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program, and I authorize the release of that information. I hereby assign to the State of New Jersey any right to hearing aid coverage to which I may be entitled under any other plan of assistance or insurance or from any other liable third party.

Applicant's Signature _____ Date _____

HA-1 (rev.4/91) Form #15

What Is Hearing Aid Assistance to the Aged and Disabled?

This is a State of New Jersey program which provides a $100 reimbursement to eligible residents who purchase a hearing aid.

How Do I Apply?

If you are currently enrolled in the Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), you must complete a HAAAD application and submit the following documentation:

1. A receipt for the purchase of your hearing aid.

2. A written statement from your physician attesting to the medical necessity for obtaining a hearing aid.

   If you are not currently enrolled in the PAAD program, you must complete a PAAD application as well. This is needed to verify your age or disability status, state residency, and annual income.

   Applications may be obtained by calling the toll-free number:

   1-800-792-9745

How Is The Term "Hearing Aid" Defined For The Purpose Of This Program?

"Hearing aid" means a custom-fitted ear-level or body-worn electronic device to enhance communication for the hearing impaired.

How Often May I Receive The HAAAD Benefit?

You may receive one $100 payment during a calendar year. If you purchase another hearing aid during a subsequent calendar year, you may reapply.

How Soon Will I Get My $100 Payment After I Apply?

Once your application has been approved, you should receive your payment in approximately six to eight weeks.

Would I Be Eligible If I Have Other Hearing Aid Coverage?

If you are a Medicaid recipient or have other health insurance coverage or retirement benefits that provide full hearing aid coverage, you would not be eligible. If you have only limited or partial coverage, you would be eligible for a supplementary payment

How Do I Know If I Am Eligible?

You must be at least 65 years of age, or receiving Social Security Disability benefits.

You must be a New Jersey resident.

You must have an annual gross income of less than $15,700 if you are single, or less than $19,250 if you are married.

If you have any questions about HAAAD, write to:

HAAAD
CN-715
Trenton, NJ 08625-0715

or telephone the toll-free number:

1-800-792-9745

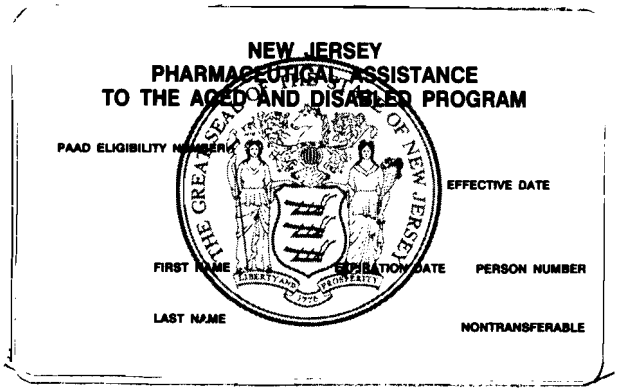
A special Teletypewriter Telephone (TTY) is available for the hearing impaired by calling:

609-588-7180*

NOTE:
This is NOT a toll-free number.

STATE OF NEW JERSEY
PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED

Your plastic PAAD Identification card is attached. Persons violating any provision of the PAAD ACT shall be subject to applicable civil and criminal penalties in N.J.S.A. 30: 40-1 Et Seq., and as may hereafter be amended, and to suspension of their eligibility for one year for a first offense and permanent revocation of their eligibility for a second offense. Names can have no more than 7 letters in the first and 12 in the last.



You must return your eligibility card to PAAD, CN 715, Trenton, New Jersey 08625 if:

1. Your annual income exceeds the limits set by law.
2. You move out of the State of New Jersey.
3. You become eligible for Medicaid or any plan that offers coverage equal to PAAD pharmaceutical services.
4. You are under age 65 and your Social Security Disability benefits are terminated.

Use of your PAAD card if ineligible is a violation of law and will result in your owing the State for benefits paid, plus civil and criminal penalties.

You must notify PAAD if:

1. You change your address.
2. Your marital status changes.

Include your PAAD eligibility number on all correspondence.

250 (3-90)

Form #16

* 

10:49 - Appendix - Form #17

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

MEDICAID DISTRICT OFFICE	PHONE NUMBER	ADDRESS
(01) Atlantic	Tel. 609-441-3620	1601 Atlantic Avenue, 7th Floor Atlantic City, NJ 08401
(02) Bergen	Tel. 201-488-5667	171-173 Main Street Hackensack, NJ 07601
(03) Burlington	Tel. 609-261-0448	50 Rancocas Road Mt. Holly, NJ 08060
(04) Camden	Tel. 609-757-2870	101 Haddon Avenue, 5th Floor Camden, NJ 08103
(05) Cape May (06) Cumberland	Tel. 609-696-6560	108 Landis Avenue Vineland, NJ 08360
(07) Essex-Newark	Tel. 201-648-2470 201-648-3700	153 Halsey Street, 4th Floor Newark, NJ 07102
(07) Essex-Suburban	Tel. 201-761-7441	76 S. Orange Avenue, 2nd Floor South Orange, NJ 07079
(08) Gloucester (17) Salem	Tel. 609-853-4177	251 N. Delsea Drive Deptwood Center Deptford, NJ 08096-1930
(09) Hudson	Tel. 201-433-8011	2815 Kennedy Boulevard, 2nd Floor Jersey City, NJ 07306
(10) Hunterdon (18) Somerset	Tel. 908-782-1130	84 Park Avenue, 2nd Floor Flemington, NJ 08822
(11) Mercer	Tel. 609-292-7315	314-316 E. State Street Trenton, NJ 08608
(12) Middlesex	Tel. 908-549-3541	Bldg. B, Suite 5 & 6 25 S. Main Street Edison, NJ 08837
(13) Monmouth	Tel. 908-308-1159	1003 Route 9 North-Suite 200 Howell, NJ 07731-1113
(14) Morris (19) Sussex (21) Warren	Tel. 201-267-1700	10 Park Place, 4th Floor Morristown, NJ 07960
(15) Ocean	Tel. 908-255-0731	1510 Hooper Avenue Toms River, NJ 08753
(16) Passaic	Tel. 201-977-4077	66 Hamilton Street Paterson, NJ 07505
(20) Union	Tel. 908-820-3135	24-52 Rahway Avenue, 3rd Floor United Jersey Bank Bldg. Elizabeth, NJ 07201
Northern Regional Medicaid Office	Tel. 201-977-4541	100 Hamilton Plaza Room 601, Box 2, Paterson, NJ 07505

Rev. 8/91]*

10:49 - Appendix - Form #17

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

MEDICAID DISTRICT OFFICE	DIRECTOR & PHONE NUMBER	ADDRESS
(01) Atlantic	William Underland, Director	1601 Atlantic Avenue, 7th Floor Atlantic City, NJ 08401
Fax #1-609-344-2268	Tel. 609-441-3620	
(02) Bergen	Kate Buckley, Director	171-173 Main Street Hackensack, NJ 07601
Fax #1-201-996-8084	Tel. 201-996-8060	
(03) Burlington	Eileen Calabro, Acting Director	50 Rancocas Road Mt. Holly, NJ 08060
Fax #1-609-265-0095	Tel. 609-261-0448	
(04) Camden	Daniel Cooperson, Director Ronald Coppola, Regional Director	101 Haddon Avenue, 5th Floor Camden, NJ 08103
Fax #1-609-757-4626	Tel. 609-757-2870	
(05) Cape May (06) Cumberland	Barbara Dils, Director	108 Landis Avenue Vineland, NJ 08360
Fax #1-609-794-2586	Tel. 609-696-6560	
(07) Essex	Diane West, Director Tel. 201-648-2470	153 Halsey Street, 4th Floor Newark, NJ 07102
Fax #1-201-642-6468	201-648-3700	
(08) Gloucester (17) Salem	Joan Suleskey, Acting Director	251 N. Delsea Drive Deptwood Center
Fax #1-609-845-0444	Tel. 609-853-4177	Deptford, NJ 08096-1930
(09) Hudson	William Underland, Director	2815 Kennedy Boulevard, 2nd Floor Jersey City, NJ 07306
Fax #1-201-433-7544	Tel. 201-433-8011	
(10) Hunterdon (18) Somerset	Caroline Krajewski, Director	84 Park Avenue, 2nd Floor Flemington, NJ 08822
Fax #1-90-782-7899	Tel. 908-782-1130	
(11) Mercer	Eileen Calabro, Acting Director	314-316 E. State Street Trenton, NJ 08608
Fax #1-609-599-4627	Tel. 609-292-7315	
(12) Middlesex	Colleen DeMarks, Director John Russell, Regional Director	Bldg. B, Suite 5 & 6 25 S. Main Street Edison, NJ 08837
Fax #1-908-906-8275	Tel. 908-549-3541	
(13) Monmouth	Frances Garrett, Director	1003 Route 9 North-Suite 200 Howell, NJ 07731-1113
Fax #1-908-409-6446	Tel. 908-308-1159	
(14) Morris (19) Sussex (21) Warren	Marie Grubin, Director	10 Park Place, 4th Floor Morristown, NJ 07960
Fax #1-201-631-6448	Tel. 201-631-6440	
(15) Ocean	Gail Dempsey, Acting Director	1510 Hooper Avenue Toms River, NJ 08753
Fax #1-908-255-0743	Tel. 908-255-0731	
(16) Passaic	Kathleen Lohrey, Acting Director	66 Hamilton Street Paterson, NJ 07505
Fax #1-201-684-8182	Tel. 201-977-4077	
(20) Union	Director	24-52 Rahway Avenue, 3rd Floor United Jersey Bank Bldg.
Fax #1-908-353-5340	Tel. 908-820-3135	Elizabeth, NJ 07201
Northern Regional Medicaid Office	Thomas Rafferty Acting Regional Director	100 Hamilton Plaza Room 601, Box 2
Fax #1-201-684-7769	Tel. 201-977-4541	Paterson, NJ 07505

Rev. 7/92 *

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Manual for Hospital Services; Manual for Special Hospital Services

Reimbursement for Hospital Outpatient Laboratory Services

Publication of N.J.A.C. 10:61-3, HCFA Common Procedure Coding System (HCPCS) for Independent Laboratory Services

Adopted Amendments: N.J.A.C. 10:52-1.6 and 10:53-1.5

Adopted New Rules: N.J.A.C. 10:52-4

Proposed: March 16, 1992 at 24 N.J.R. 917(a).
Adopted: July 27, 1992 by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: July 27, 1992 as R.1992 d.327, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-6a(2), 7, 7a, b and c; 30:4D-12.

Effective Date: August 17, 1992.
Operative Date: September 1, 1992.
Expiration Date: February 8, 1995, N.J.A.C. 10:52
April 27, 1995, N.J.A.C. 10:53
February 15, 1996, N.J.A.C. 10:61

Summary of Public Comments and Agency Response:
No comments were received.

Summary of Changes Between Proposal and Adoption:

The Division of Medical Assistance and Health Services is adding a subchapter to the Manual for Hospital Services which will be codified as N.J.A.C. 10:52-4. This subchapter will contain the reimbursement for hospital outpatient laboratory service. The text of N.J.A.C. 10:52-4 will be the same as the text that was proposed as N.J.A.C. 10:61-3, with two modifications, which are necessary to accommodate the 105 laboratory procedures which are subject to the cost-to-charge ratio as indicated in N.J.A.C. 10:52-1.6(c)2. The two modifications are an identifier labeled "S.C.C." (subject cost-to-charge) in N.J.A.C. 10:52-4.1, and the label "S.C.C." next to the appropriate procedure codes. Hospitals are not reimbursed on a fee-for-service basis for these particular laboratory procedures. Therefore, the dollar value which appeared next to the HCPCS (Health Care Financing Administration Common Procedure Coding System) has no relevance for hospital outpatient laboratory services identified by the notation "S.C.C."

In addition, the procedures identified by "S.C.C" are reimbursed facility specific based upon the costs incurred by a particular facility.

The material (in N.J.A.C. 10:52-4) is being added upon adoption to complete the proposed text which appeared at N.J.A.C. 10:52-1.6(c)2. In addition, the proposed text was more in the nature of a technical change because hospital providers have always been reimbursed in this manner for the 105 procedure codes and will continue to be reimbursed in this manner. Therefore, the Division is adding the list of 105 HCPCS codes as a subchapter to N.J.A.C. 10:52 and 10:53 upon adoption.

The Division considers this to be a change not in violation of N.J.A.C. 1:30-4.3 because there is no enlargement or curtailment of who or what is being affected. The subchapter will contain all the HCPCS codes that were proposed as N.J.A.C. 10:61-3, and will identify the 105 HCPCS codes that are subject to the cost-to-charge ratio with the notation "S.C.C."

The Division also had to make technical amendments to N.J.A.C. 10:52-1.6 and 10:53-1.5 to insure that the codification references would be consistent with N.J.A.C. 10:52-4.

The text of N.J.A.C. 10:52-1.6(c)4 is being amended to correctly refer to the New Jersey Medicaid Program Fee Schedule as the Medicaid maximum fee allowance which is codified in the Dental Manual, N.J.A.C. 10:56-3. The reference in the hospital manual is only intended to refer the reader to the reimbursement methodology and maximum fee allowances codified in the Dental Manual. Since there is no change in the Dental Manual, there will be no enlargement or curtailment on those hospitals that provide dental services.

Full text of adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

10:52-1.6 Outpatient hospital services—basis of payment

(a) (No change.)

(b) The New Jersey Medicaid Program reimburses providers for covered services in a hospital outpatient department consistent with the following conditions and reimbursement methodology:

1. Establishment of a final rate of reimbursement: The final rate of reimbursement is based on the lower of cost or charges as defined by Medicare principles of reimbursement at 42 CFR 447.321;

2. Establishment of an interim rate of reimbursement: The charge for an outpatient service is subject to a reduction based on the application of a cost-to-charge ratio determined for each individual hospital by the New Jersey Medicaid Program, in accordance with Medicare principles of reimbursement at 42 CFR 447.321. This cost-to-charge ratio is used to assure that reimbursement for outpatient services does not exceed the lower of cost or charges.

3. (No change.)

(c) Certain outpatient services, that is, most laboratory services, all renal dialysis services, all dental services, some HealthStart services, and the Medicare deductible and coinsurance amounts, are excluded from a reduction based on the cost-to-charge reimbursement methodology and have their own reimbursement methodology as follows:

1. Most outpatient laboratory services are reimbursed on the basis of a fee-for-service using the (HCPCS) procedure codes and the Medicaid *[Laboratory/Pathology Maximum Fee Allowance Schedule at N.J.A.C. 10:61-3]* ***Hospital Outpatient Laboratory Services maximum fee allowance schedule located in N.J.A.C. 10:52-4, HCFA Common Procedure Coding System (HCPCS)***. If the hospital charge is less than the fee allownace, reimbursement shall be based upon the actual billed charge. In addition, there are situations which have unique billing arrangements, as follows:

i. Specimen collection, that is, a routine venipuncture for collection of specimen(s) or a catheterization for collection of urine specimen(s) is reimbursed at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day;

ii. Automated, Multi-Channel Laboratory Tests are grouped. Multi-channel grouping may start with two tests. Hospitals shall group the individual test codes into one multichannel group and bill the group code only. A laboratory test that cannot be grouped into a multi-channel group code shall be billed using the HCPCS codes assigned for that laboratory test. Laboratory test codes that are billed separately but should be billed as a multi-channel group code, are combined into the appropriate multi-channel group code during claims processing and are reimbursed accordingly.

2. Some outpatient laboratory services which use laboratory HCPCS procedure codes that are reimbursed based on actual billed charges*[,]* are subject to the cost-to-charge ratio. These include procedure codes such as:

i. For those HCPCS codes submitted for payment on the same claim with charges for blood products (if no blood product is provided and/or billed for on the same claim, the codes are reimbursed according to the fee allowance schedule); and

ii. For some ***HCPCS*** codes associated with other laboratory services, such as, for organ or disease oriented panels; clinical pathology consultations; unlisted chemistry or toxicology procedures; certain bone marrow testing; certain specific or unlisted hematology procedures; certain immunology testing; unlisted microbiology procedures; and certain procedures under anatomic pathology.

iii. In order to identify the laboratory HCPCS code whose reimbursement is subject to the cost-to-charge ratio, refer to the notation S.C.C. (subject/cost-to-charge) in N.J.A.C. 10:52-4 aside each HCPCS code.

3. All renal dialysis services for end-stage renal disease (ESRD), as follows:

i. Reimbursement is at 100 percent of the Medicare composite rate and includes any add-on charge to the composite rate approved by Medicare.

(1) Renal dialysis services provided on an emergency basis in a hospital center not approved to provide renal dialysis services for ESRD are reimbursed actual billed charges, subject to the cost-to-charge ratio.

4. All dental services are reimbursed in accordance with the New Jersey Medicaid Program Dental *Maximum* Fee *Allowance* Schedule. This fee-for-service schedule is consistent with the New Jersey Medicaid Program fees paid to the private practitioners and independent dental clinics. (For policies and procedures for dental services, see the Manual for Dental Services, N.J.A.C. 10:56.)

5. All HealthStart Maternity Health Support Services and HealthStart Pediatric Continuity of Care are reimbursed on a fee-for-service basis in the hospital outpatient department.

i. All other HealthStart Maternity Medical Care Services and all other HealthStart Pediatric Care Services are reimbursed based on the cost-to-charge ratio. (For policies and procedures for HealthStart Services, see Administration, N.J.A.C. 10:49-3.)

6. All deductible and coinsurance amounts for Medicare/Medicaid crossover claims are not subject to the cost-to-charge ratio.

*SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:52-4.1 Introduction

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (narratives found in CPT-4): These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4, which is incorporated herein by reference, as amended and supplemented.

2. Level II Codes (narratives found at N.J.A.C. 10:52-4.3): These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4.

3. Level III Codes (narratives found at N.J.A.C. 10:52-4.3): These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

(b) The responsibility of the provider when rendering specific services and requesting reimbursement is listed in the first three subchapters of the Hospital Services Manual, N.J.A.C. 10:52.

(c) Regarding specific elements of HCPCS codes which requires attention of provider, the lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

COLUMN TITLE	DESCRIPTION
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Porgram's qualifications and requirements when a procedure or services code is used. Explanation of indicators and qualifiers used in this column are given below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. "L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A of this Pathology and Laboratory section. "M" preceding any procedure code indicates that this service is a medical necessity procedure. Refer to Appendix D of this Pathology and Laboratory section. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B of this Pathology and Laboratory section.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed at N.J.A.C. 10:52-4.5.
DESCRIPTION	Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found at N.J.A.C. 10:52-4.3).
MAXIMUM FEE ALLOWANCE	Lists New Jersey Medicaid Program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form. If the symbols "S.C.C." are listed instead of a dollar amount, it means subject to the cost-to-charge ratio (see N.J.A.C. 10:52-1.6).

1. The fee listed under "Office Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

2. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp." and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

(d) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code as written in CPT-4. The provider will then be liable for the additional requirements and not just the CPT/HCPCS code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

10:52-4.2 HCPCS code numbers and maximum fee schedules; pathology/laboratory (CPT-4)

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE TOTAL FEE	$	PROF. COMP.
>N	80002		5.00		
>N	80003		6.20		
>N	80004		6.20		
>N	80005		6.20		
>N	80006		6.20		
N	80007		7.50		
N	80008		7.50		
N	80009		7.50		
N	80010		7.50		
N	80011		7.50		
N	80012		7.50		
N	80016		7.50		
N	80018		11.00		
N	80019		11.00		
	80031		4.50		
	80032		4.50		
	80033		4.50		
	80052		S.C.C.		
N	80055		15.00		
N	80055	22	19.00		
N	80055	52	10.00		
>N	80059		30.00		
	80061		15.00		
	80061	22	23.00		
N	80070		12.00		
N	80072		12.00		
>	80090		28.80		
N	81000		1.20		
	81010		1.20		
	81030		3.00		
N	82011		3.90		
	82024		30.00		
	82030		34.00		
>	82035		24.00		
A	82040		1.80		
	82055		4.50		
	82060		4.50		
	82065		4.50		
	82070		4.50		
	82087		40.00		
	82088		40.00		
	82089		40.00		
	82112		12.60		
	82137		15.00		
	82138		15.00		
	82140		6.00		
	82141		6.00		
	82143		4.20		
	82145		12.00		
	82150		4.50		
	82155		4.50		
	82156		2.40		
>	82157		29.00		
>	82163		21.00		
>N	82173		11.20		
	82175		7.20		
	82180		3.60		
	82205		12.00		
	82210		12.00		
A	82250		3.00		
A	82251		4.50		
	82265		3.00		
	82270		1.20		
>	82273		3.70		
	82290		3.00		
	82291		3.00		
	82308		34.00		
A	82310		3.00		
	82315		3.00		
	82320		3.00		
	82335		.90		
	82340		3.60		
N	82365		9.00		
N	82370		9.00		
A	82374		3.30		
	82375		6.00		
	82380		6.00		
	82382		12.00		
	82383		12.00		
	82384		18.00		
	82390		6.00		
A	82435		3.00		
	82436		3.00		
>N	82437		2.60		
	82438		3.00		
A	82465		3.00		
	82470		7.00		
	82480		4.50		
>	82486		4.40		
	82525		9.00		
	82526		9.00		
	82533		17.00		
	82534		17.00		
	82540		3.00		
	82545		3.00		
	82546		3.00		
A	82550		4.80		
>	82552		7.80		
	82555		4.80		
A	82565		3.00		
	82570		3.00		
	82575		4.50		
	82595		1.50		
	82607		15.00		
	82608		15.00		
>	82626		37.00		
	82628		15.00		
>	82633		48.00		
	82634		39.00		
	82640		15.00		
	82641		15.00		
	82643		15.00		
	82656		15.00		
	82660		9.00		
	82670		25.00		
>	82671		41.00		
	82672		25.00		
	82673		10.20		
>	82674		17.50		
	82676		10.20		
>	82677		28.00		
>	82678		30.00		
>	82679		25.00		
	82705		.60		
	82710		7.80		
	82715		7.80		
	82728		16.00		
	82730		5.70		
	82746		16.00		
	82785		16.00		
	82791		6.00		
	82792		6.00		
	82793		6.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE TOTAL FEE	$	PROF. COMP.
	82800		5.20		
	82801		3.30		
	82926		6.00		
	82931		6.00		
	82941		16.00		
>	82943		23.00		
N	82946		13.00		
A	82947		3.00		
	82949		.60		
	82954		1.50		
	82955		6.00		
A	82977		4.80		
	82985		6.60		
	82995		1.80		
	82996		3.00		
	82998		18.00		
	83001		17.00		
	83002		17.00		
	83003		16.00		
	83004		16.00		
>	83008		27.00		
	83010		12.00		
	83011		12.00		
	83012		12.00		
	83015		10.20		
	83020		6.00		
	83036		6.60		
	83040		3.00		
	83050		3.00		
N	83051		1.20		
>	83052		1.80		
>N	83053		1.80		
	83060		3.00		
	83093		3.00		
	83094		3.00		
	83095		3.00		
	83150		12.00		
	83491		12.60		
	83493		12.60		
	83494		12.60		
	83495		12.60		
	83496		12.60		
	83497		6.00		
>	83498		30.50		
>	83499		30.50		
	83523		15.00		
	83525		12.00		
N	83526		10.00		
	83530		6.00		
A	83540		4.50		
	83545		4.50		
A	83550		7.20		
	83555		7.20		
	83570		6.00		
	83571		6.00		
	83578		12.60		
	83582		6.00		
	83583		12.00		
	83586		7.50		
	83587		15.00		
	83589		7.50		
>	83590		9.40		
	83593		6.00		
>	83597		9.40		
	83610		4.20		
A	83615		4.20		
	83620		4.20		
	83625		9.00		
	83626		9.00		
	83629		4.20		
	83631		4.20		
	83632		16.00		
	83645		3.00		
	83650		3.00		
	83655		9.00		
	83660		9.00		
	83661		10.50		
	83670		2.10		
	83675		2.10		
	83680		2.10		
	83690		4.50		
A	83700		3.00		
	83715		7.50		
	83718		8.00		
	83720		10.00		
	83725		9.00		
	83727		17.00		
	83735		4.50		
	83740		4.50		
	83755		4.50		
	83760		4.50		
	83795		.90		
	83825		8.40		
	83830		8.40		
	83835		10.20		
	83840		4.50		
	83915		6.00		
	83970		54.00		
	83971		12.60		
	84005		3.00		
	84030		6.00		
	84031		6.00		
>	84045		19.00		
A	84060		3.60		
	84065		3.60		
A	84075		3.60		
	84078		3.60		
	84080		3.60		
	84090		3.00		
A	84100		3.00		
	84105		3.00		
	84106		1.80		
	84110		7.50		
	84118		3.00		
	84119		3.00		
	84120		7.50		
	84121		7.50		
A	84132		3.90		
	84133		3.90		
	84135		12.00		
	84136		12.00		
	84138		12.00		
	84139		12.00		
	84142		15.00		
	84144		20.00		
	84146		20.00		
A	84155		1.80		
	84160		1.80		
	84165		6.00		
A	84170		6.00		
	84180		2.40		
	84185		.60		
	84190		7.50		
	84200		7.50		
>	84202		10.40		
	84203		3.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE TOTAL FEE	$	PROF. COMP.
	84205		15.00		
	84230		15.00		
	84233		16.00		
	84234		20.00		
	84244		25.00		
	84246		25.00		
A	84295		3.90		
	84300		3.90		
M	84317		.60		
	84403		32.00		
>	84405		30.00		
>	84408		15.00		
	84420		15.00		
	84430		3.60		
	84435		6.00		
	84436		6.00		
	84437		6.00		
>	84439		10.00		
	84442		12.00		
	84443		25.00		
A	84450		3.00		
	84455		3.00		
A	84460		3.00		
	84465		3.00		
A	84478		8.30		
	84479		6.00		
	84480		15.00		
	84481		15.00		
	84485		3.30		
	84488		3.30		
	84490		3.30		
A	84520		3.00		
	84525		3.00		
	84540		3.00		
	84545		6.00		
A	84550		3.00		
	84555		3.00		
	84560		3.00		
	84577		6.00		
	84580		2.10		
	84583		2.10		
	84585		12.00		
	84590		6.00		
	84605		3.60		
	84610		3.60		
	84695		12.60		
>	84701		15.00		
	84800		25.00		
	84810		12.60		
	85000		1.20		
	85002		1.20		
	85005		3.00		
N	85007		2.40		
N	85009		1.20		
	85012		1.80		
N	85014		1.50		
N	85018		1.20		
	85021		1.80		
>	85022		3.00		
>	85027		4.80		
>	85028		4.80		
>N	85028	22	8.40		
N	85031		3.00		
N	85041		1.20		
	85044		1.80		
N	85048		1.20		
>	85060		S.C.C.		8.00
>	85095		S.C.C.		24.00
>	85097		S.C.C.		24.00
>	85100		S.C.C.		48.00
>	85101		S.C.C.		24.00
>	85102		S.C.C.		24.00
>	85103		S.C.C.		24.00
>	85105		S.C.C.		24.00
	85150		1.80		
	85170		.60		
	85171		.60		
	85210		3.00		
	85345		1.80		
	85347		3.00		
	85348		1.20		
	85362		3.00		
	85363		3.00		
	85364		8.40		
	85376		5.70		
	85377		5.70		
	85544		6.00		
	85555		4.80		
	85557		4.80		
>	85560		3.00		
	85575		1.80		
	85577		1.80		
	85580		1.80		
	85590		1.80		
	85595		1.80		
	85610		3.00		
	85614		3.00		
	85615		4.50		
	85650		1.50		
	85651		1.50		
	85660		1.80		
	85700		9.00		
	85730		3.00		
	85732		3.00		
	86000		.90		
	86002		1.80		
	86004		1.80		
	86006		2.70		
	86008		6.00		
	86009		3.00		
	86017		S.C.C.		
	86024		S.C.C.		
	86028		S.C.C.		
	86031		3.00		
	86032		3.00		
	86033		3.00		
	86038		7.80		
	86060		3.60		
	86063		1.20		
	86064		7.80		
	86067		7.80		
	86068		S.C.C.		
>	86077		S.C.C.		25.00
>	86078		S.C.C.		17.00
>	86079		S.C.C.		17.00
	86080		1.80		
	86082		1.80		
	86090		1.80		
	86095		1.80		
	86100		S.C.C.		
	86105		1.80		
	86115		1.80		
	86120		S.C.C.		
	86140		3.00		
N	86151		22.40		
	86162		15.60		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE TOTAL FEE	$	PROF. COMP.
	86163		7.80		
	86164		9.00		
	86171		4.50		
	86225		13.00		
	86244		10.20		
	86255		7.80		
	86256		9.00		
	86277		16.00		
	86280		5.40		
	86281		3.00		
>	86285		7.50		
	86286		10.00		
	86287		10.00		
>	86288		12.00		
>	86289		15.00		
>	86291		15.00		
>	86293		12.00		
>	86295		12.00		
>	86296		10.00		
>	86298		12.00		
>	86299		12.00		
	86300		3.00		
	86305		4.50		
	86310		4.50		
>	86312		14.84		
>	86314		32.33		
	86320		10.50		
	86329		16.80		
	86335		6.00		
	86337		12.00		
	86376		6.60		
	86377		6.60		
>N	86421		20.00		
>N	86422		4.00		
	86423		16.00		
	86430		1.80		
	86490		S.C.C.		
	86510		S.C.C.		
	86540		S.C.C.		
>	86580		S.C.C.		
	86585		S.C.C.		
A	86592		1.50		
	86593		3.00		
	86594		6.00		
	86595		S.C.C.		
	86600		7.80		
	86650		12.00		
	86660		12.00		
	86662		12.00		
>	86800		13.00		
	86812		12.60		
	86813		12.60		
	87001		9.00		
	87015		5.10		
N	87040		9.00		
N	87045		9.00		
N	87060		9.00		
N	87070		9.00		
>	87072		6.00		
>	87075		9.00		
	87076		6.00		
>	87081		10.00		
>	87082		4.00		
>	87083		4.00		
	87084		3.00		
>	87085		4.00		
	87086		3.00		
	87087		2.70		
	87088		2.70		
	87101		8.00		
	87102		8.00		
	87106		8.00		
>	87109		14.00		
	87116		6.00		
	87117		9.00		
	87140		3.00		
	87143		3.00		
	87145		3.00		
	87147		3.00		
	87151		3.00		
	87155		3.00		
	87158		3.00		
	87164		6.00		
	87166		6.00		
	87177		5.10		
N	87184		9.00		
	87188		6.00		
	87190		.60		
	87205		4.20		
	87206		4.20		
	87207		3.00		
	87208		5.10		
	87210		2.40		
	87211		5.10		
	87220		2.40		
>	87250		32.00		
>	88104		S.C.C.		7.00
>	88106		S.C.C.		7.00
>	88107		S.C.C.		7.00
>	88108		S.C.C.		7.00
>	88125		S.C.C.		7.00
>	88130		9.65		7.00
>	88140		4.20		3.00
	88150		6.00		6.00
	88151		6.00		6.00
N	88155		6.00		6.00
>	88160		S.C.C.		7.00
>	88161		S.C.C.		7.00
>	88162		S.C.C.		
>	88170		S.C.C.		30.00
>	88171		S.C.C.		61.00
>	88172		S.C.C.		8.00
>	88173		S.C.C.		25.00
>N	88260		120.00		86.00
>N	88261		120.00		86.00
>N	88262		120.00		86.00
>N	88265		85.00		41.00
>N	88267		172.00		123.00
>N	88268		172.00		60.00
>N	88270		172.00		60.00
>	88300		S.C.C.		7.00
>	88302		S.C.C.		15.00
>	88304		S.C.C.		19.00
>	88305		S.C.C.		30.00
>	88307		S.C.C.		44.00
>	88309		S.C.C.		66.00
>	88311		S.C.C.		4.00
>	88312		S.C.C.		8.00
>	88313		S.C.C.		5.00
>	88314		S.C.C.		7.00
>	88318		S.C.C.		7.00
>	88319		S.C.C.		7.00
>	88321		S.C.C.		28.00
>	88323		S.C.C.		33.00
>	88325		S.C.C.		44.00
>	88329		S.C.C.		33.00

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE TOTAL FEE	$	PROF. COMP.
>	88331		S.C.C.		41.00
>	88332		S.C.C.		15.00
>	88342		S.C.C.		7.00
>	88346		8.00		8.00
>N	88348		S.C.C.		
	89050		.90		
	89051		.90		
	89105		S.C.C.		
	89125		.60		
	89132		S.C.C.		
	89135		S.C.C.		
	89136		S.C.C.		
	89141		S.C.C.		
	89160		2.10		
	89205		1.20		
	89300		2.40		
	89310		4.80		
	89320		3.00		
M	89355		.60		
N	89360		S.C.C.		
L N	P7001		6.00		
>L	W8010		43.75		
L N	W8200		2.00		
L N	W8205		9.00		
L N	W8210		12.00		
L A	W8215		4.00		
L	W8225		18.00		
L	W8615		7.80		
L	W8620		7.80		
L	W8621		12.60		
>L	W8622		25.00		
L	W8700		3.00		
L	W8710		3.00		
>L	W8720		15.00		
>L	W8725		30.00		
L	W8900		10.00		
L	W8920		1.80		
L	W8925		.60		

10:52-4.3 HCPCS code numbers, procedure description and maximum fee schedule; pathology/laboratory (codes and narratives not found in CPT-4)

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE
N	P7001		CULTURE, BACTERIAL, URINE; QUANTITATIVE, SENSITIVITY STUDY	6.00
>	W8010		HEPATITIS B PROFILE; HEPATITIS B SURFACE ANTIGEN; HEPATITIS B SURFACE ANTIBODY; HEPATITIS B ANTIGEN AND ANTIBODY; HEPATITIS B CORE ANTIBODY	43.75
N	W8200		GLUCOSE, SERUM (SEPARATE TUBE, GREY TOP) NOTE: SUBMITTED ON SAME CLAIM, AND PERFORMED ON SAME DATE AS CHEMISTRY PROFILES	2.00
N	W8205		3 HR. GLUCOSE TOLERANCE TEST, PER 4 SPECIMENS	9.00
N	W8210		5 HR. GLUCOSE TOLERANCE TEST, PER 6 SPECIMENS	12.00
A	W8215		T-4 (THYROXINE) BY IMMUNOASSAY (ENZYME IMMUNOASSAY) (EMIT)	4.00
	W8225		THYROXINE—BINDING GLOBULIN WITH T4 (THYROBINDING-GLOBULIN WITH T4) (RIA) (TBG AND T4)	18.00
	W8615		ANTI-DNA, ANTI-DEOXYRIBONUCLEIC ACID, (CHEMICAL METHOD, NON-RIA)	7.80
	W8620		HERPES SIMPLEX ANTIBODIES: (HERPES SIMPLEX VIRUS, I OR II)	7.80
	W8621		HERPES SIMPLEX VIRUS, I AND II	12.60
>	W8622		HERPES SIMPLEX VIRUS ISOLATION AND IDENTIFICATION, TOTAL STUDY	25.00
	W8700		YEAST SCREEN (NOT DEFINITIVE) FROM URINE, VAGINAL OR THROAT CULTURES ONLY (EG., GERM TUBE)	3.00
	W8710		TRICHOMONAS PREPARATION—SMEAR OR HANGING DROP (SMEAR NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IF PAP SMEAR DONE ON THE SAME DAY)	3.00
>	W8720		CHLAMYDIA DIRECT SPECIMEN TEST; MICROTRACK; CHLAMYDIAZIME; CHLAMYDIA A.G. DIRECT; CHLAMYDIA TITER: CHLAMYDIA CF; CHLAMYDIA ASSAYS BY IFA AND CIS; CHLAMYDIA ISOLATION; FLUORESCENT ANTIBODY FA	15.00
>	W8725		CHLAMYDIA CULTURE	30.00
	W8900		HOUSE CALL TO HOME BOUND PATIENT IN HOME OR SHELTERED BOARDING HOME FOR PURPOSE OF OBTAINING BLOOD BY VENOUS OR ARTERIAL PUNCTURE REIMBURSEMENT LIMITED TO ONCE PER TRIP REGARDLESS OF NUMBER OF PATIENTS	10.00
	W8920		VISIT TO OBTAIN BLOOD SPECIMENS BY VENOUS OR ARTERIAL PUNCTURE "FIRST PERSON IN NURSING HOME"	1.80
	W8925		EACH ADDITIONAL PERSON IN NURSING HOME	.60

10:52-4.4 Pathology and Laboratory HCPCS Codes—Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Chemistry Automated, Multichannel Tests: Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting (for handling of specimen, see 99000 and 99001).

Albumin
Alkaline Phosphatase
Bilirubin, Total
Bilirubin, Direct
Blood Urea Nitrogen (BUN)
Calcium
Carbon Dioxide (CO_2)

Chlorides (Cl)
Cholesterol
Creatinine
Gamma Glutamyl Transpeptidase (GGTP)
Glucose (Sugar)
Iron
Lactic Dehydrogenase (LDH)
Phosphorus
Potassium (K)
Protein, Total
Sodium (NA)
Total Lipids
Transaminase, Glutamic Oxalacetic (SGOT)
Transaminase, Glutamic Pyruvic (SGPT)
Triglycerides
T4 by Immune Assay (EMIT)
Uric Acid

i. If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded $5.00: the maximum reimbursement will not be more than $5.00; 82251, 82374, 82801, 83540, 83545, 83610, 83615, 83620, 83629, 83631, 84075, 84078, 84080, 84132, 84133, 84295, 84300, 84478, 82977, W8215.

ii. The following calculations and ratios are not eligible for separate or additional reimbursement, and, therefore, should not be included in determining the calculations alloted to the above Procedure Codes.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

iii. Any additional automated multichannel chemistry tests (other than those listed) performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be reimbursed at the current allowable fee for each added test.

iv. Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional $2.00.

2. Code 80072—Arthritis Panel should include as a minimum four of the following tests:

ASO Titer	
C-Reactive Protein (CRP)	Uric Acid
RA Latex	Alkaline Phosphatase
(Rheumatoid Arthritis factor)	Calcium

3. Code 80070—Thyroid Panel—T4 by RIA, plus T3 uptake, resin (T3RU) (RT3U).

i. The following calculations will be included in the fee for the Thyroid Panel:
"T7" Free Thyroxine
Index (FTI), Calculated Free Thyroxine
Index (CFT4) or Calculated Thyroxine
Iodine (T4I)

ii. T3 by uptake, resin (T3RU) is eligible for reimbursement only when done in conjunction with T4 by RIA as part of Thyroid profile.

4. Code 80055-52—Obstetric profile.

i. At least four of the following tests must be included in the profile:
Blood Group (ABO)
RH Factor
Antibody screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)

5. Code 80055—Obstetric profile with Rubella HI Antibody Titer.

6. Code 80055-22—Expanded Obstetric profile.

i. For reimbursement purposes the following must be included:
Blood Group (ABO)
RH Factor
Antibody screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)
Cytology (Pap smear)
Urinalysis
Urea Nitrogen (BUN)
Glucose
Sickle Cell with Rubella II Antibody Titer

7. Code 81000—Urinalysis.

i. Stick, dip or tablet tests done on urine are considered part of the urinalysis, and therefore, are not eligible for separate reimbursement. Microscopy is required for reimbursement.

8. Code 86151—(CEA-RIA) Carcinoembryonic Antigen.

i. "CEA is not useful to diagnose cancer. Claims are eligible for reimbursement only when CEA is used to follow treated cases of cancer (for example, gastro-intestinal, breast, lung) primary detection of recurrence, or for estimate of prognosis in certain cases." (Documentation required)

9. Code 88155—pap smear.

i. Obtaining a specimen is not a separate eligible service.

10. Cultures, Codes 87040, 87045, 87060, 87070, 87184, P7001.

i. These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture.

11. Code 82173 and 82946—Glucagon Tolerance Test.

i. Total payment is not to exceed $65.00.

12. Code 83526—Insulin Tolerance Test.

i. Total payment is not to exceed $70.00 (RIA).

13. Code 85031—Complete Blood Count—CBC.

i. Components of a CBC—the maximum fee for any of the following combinations of components is $3.00. (83051, 83053, 85007, 85009, 85014, 85018, 85041, 85048).

ii. For reimbursement purposes, CBC testing is all-inclusive and covers tests performed either by automation and manually.

14. Code 82365 and 82370—Calculus (stone), Quantitative: (Infra-red spectroscopy) X-ray diffraction.

i. Reimbursement for this code is not eligible for chemical methods.

15. Code 82437 and 89360—Sweat (without iontophoresis) Test.

i. Reimbursement for this code is not eligible for qualitative tests.

16. Code 82011—Salicylates, quantitative only.

i. Reimbursement for this code is not eligible for screening (Qualitative) tests for salicylates (82012).

17. Code W8205 and W8210—Glucose Tolerance.

i. For reimbursement purposes includes all urines for sugar.

18. Code 88260, 88261 and 88262—Chromosome Analysis: Peripheral blood.

i. Rule out numerical and structural abnormalities.

ii. For Medicaid reimbursement purposes. The provider must include an average of 20 cells and two or three karyotypes analyzed, including banding.

19. Code 88265—Chromosome Analysis: Various leukemias, bone marrow and peripheral blood (includes Philadelpia Chromosome study).

i. For reimbursement purposes. The provider must include a minimum of 10 cells and two karyotypes analyzed, including banding.

20. Code 88267—Chromosome Analysis: Amniotic Fluid Cells (Prenatal Chromosome Analysis).

i. For reimbursement purposes. The provider must include 20 cells and two or three karyotypes analyzed, including banding.

21. Code 88268 and 88270—Chromosome Analysis: Tissue Biopsy, Abortuses, etc. (Documentation report required).

i. For reimbursement purposes as a minimum, the provider include 15-20 cells and two or three karyotypes analyzed, including banding.

22. Code 88280, 88285.

i. Additional karyotyping and cells counted are not reimbursable for Medicaid payment.

23. Code 80059—Hepatitis Panel: For reimbursement purposes includes:

i. Hepatitis Profile:

Hepatitis B Surface Antigen (Australian)
Hepatitis B Surface Antigen Antibody
Hepatitis B Core Antibody
Hepatitis A Antibody

24. Code 85028-22 (8630) Hemogram 22—Service Greater than Usual.

i. The definition of a complete Hemogram is: supravital morphological study of the formed elements of the blood, hematocrit, reticulocyte count, platelet count, hemoglobin, total white count, supravital differential or phase, regular differential, total red count and indicies, MCV, MCH, MCHC. A Hemogram will be reimbursed at $8.40. Providers must indicate on the claim form what components are part of their Hemogram and use the Modifier 22.

25. Code 86421 (8525) Radioallergosorbent Test (Rast); up to five Antigens.

i. For reimbursement purposes, payment for each individual Antigen is $4.00 up to the first five Antigens. List number of Antigens in the appropriate box of the claim form.

26. Code 86422 (8526) Six or more Antigens.

i. For reimbursement purposes, payment is per each additional Antigen.

27. Code 88348.

i. Not reimbursable when used as a research tool.

ii. For payment purposes, the Department will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, that is, gold, mercury, etc., and also when examining tissue specimens in occassional cases of malabsorption.

10:52-4.5 Pathology and Laboratory HCPS Codes—Modifiers

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric charaters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are:

MODIFIER CODE	DESCRIPTION
22	**Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.**
52	**Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.**
90	**Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.***

10:53-1.5 Special (Classification A and B) and private psychiatric outpatient hospital services; general provisions and basis of payment

(a) Special (Classification A and B) and private psychiatric outpatient hospital services are:

1. Those preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist licensed pursuant to the laws of the State of New Jersey.

2.-3. (No change.)

(b) The New Jersey Medicaid Program reimburses providers for covered services in a hospital outpatient department consistent with the following conditions and reimbursement methodology:

1. The final rate of reimbursement is based on the lower of cost or charges as defined by Medicare principles of reimbursement at 42 CFR 447.321;

2. The charge for an outpatient service is subject to a reduction based on the application of a cost-to-charge ratio determined for each individual hospital by the New Jersey Medicaid Program, in accordance with Medicare principles of reimbursement at 42 CFR 447.321. This cost-to-charge ratio is used to assure that reimbursement for outpatient services does not exceed the lower of cost or charges.

(c) Certain outpatient services, that is most laboratory services, all renal dialysis services, all dental services, some HealthStart services, and the Medicare deductible and coinsurance amounts, are excluded from a reduction based on the cost-to-charge reimbursement methodology and have their own reimbursement methodology as follows:

1. Most outpatient laboratory services are reimbursed on the basis of a fee-for-service using the Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes and the Medicaid *[Laboratory/Pathology Maximum Fee Allowance Schedule at N.J.A.C. 10:61-3]* ***Hospital Outpatient Laboratory Services maximum fee allowance schedule is located in N.J.A.C. 10:52-4, HCFA Common Procedure Coding System (HCPCS)***. If the hospital charge is less than the amount on the fee schedule, reimbursement is based upon the actual billed charge. In addition, there are situations which have unique billing arrangements, as follows:

i. Specimen collection, that is, a routine venipuncture for collection of specimen(s) or a catheterization for collection of urine specimen(s), is reimbursed at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day;

ii. Automated, multi-channel laboratory tests are grouped. Multi-channel grouping may start with two tests. Hospitals shall group the individual test codes into one multi-channel group and bill the group code only. A laboratory test that cannot be grouped into a multi-channel group code, shall be billed using the HCPCS code assigned for that laboratory test. Laboratory test codes that are billed separately but should be billed as a multi-channel group code, are combined into the appropriate multi-channel group code during claims processing and are reimbursed accordingly.

2. Some outpatient laboratory services which use HCPCS procedure codes, that are reimbursed based on actual billed charges, are subject to the cost-to-charge ratio. These include procedure codes such as:

i. Those HCPCS codes submitted for payment on the same claim with charges for blood products (if no blood product is provided and/or billed for on the same claim, the codes are reimbursed according to the fee allowance schedule); and

ii. Some codes associated with other laboratory services, such as, for organ or disease oriented panels; clinical pathology consultations; unlisted chemistry or toxicology procedures; certain bone marrow testing; certain specific or unlisted hematology procedures; certain immunology testing; unlisted microbiology procedures; and certain procedures under anatomic pathology.

iii. In order to identify the laboratory HCPCS code whose reimbursement is subject to the cost-to-charge ratio, refer to the notation S.C.C. (subject/cost-to-charge) in N.J.A.C. 10:52-4 aside each HCPCS code.

3. All deductible and coinsurance amounts for Medicare/Medicaid crossover claims are not subject to the cost-to-charge ratio.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:61-3.1 Introduction

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many

as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (narratives found in CPT-4): These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4, which is incorporated herein by reference, as amended and supplemented.

2. Level II Codes (narratives found at N.J.A.C. 10:61-3.3): These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4.

3. Level III Codes (narratives found at N.J.A.C. 10:61-3.3): These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

(b) The responsibility of the provider when rendering specific services and requesting reimbursement is listed in both subchapter 1 and subchapter 2 of the Independent Laboratory Services Manual, N.J.A.C. 10:61.

(c) Regarding specific elements of HCPCS codes which requires attention of provider, the lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

COLUMN TITLE	DESCRIPTION
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Porgram's qualifications and requirements when a procedure or services code is used. Explanation of indicators and qualifiers used in this column are given below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. "L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A of this Pathology and Laboratory section. "M" preceding any procedure code indicates that this service is a medical necessity procedure. Refer to Appendix D of this Pathology and Laboratory section. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B of this Pathology and Laboratory section.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed at N.J.A.C. 10:61-3.5.
DESCRIPTION	Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found at N.J.A.C. 10:61-3.3).
MAXIMUM FEE ALLOWANCE	Lists New Jersey Medicaid Program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the MC-13A C2 claim form.

1. The fee listed under "Office Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

2. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp." and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

(d) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code as written in CPT-4. The provider will then be liable for the additional requirements and not just the CPT/HCPCS code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

10:61-3.2 HCPCS code numbers and maximum fee schedules; pathology/laboratory (CPT-4)

			MAXIMUM FEE ALLOWANCE		
IND	HCPCS CODE	MOD	OFFICE TOTAL FEE	$	PROF. COMP.
>N	80002		5.00		
>N	80003		6.20		
>N	80004		6.20		
>N	80005		6.20		
>N	80006		6.20		
N	80007		7.50		
N	80008		7.50		
N	80009		7.50		
N	80010		7.50		
N	80011		7.50		
N	80012		7.50		
N	80016		7.50		
N	80018		11.00		
N	80019		11.00		
	80031		4.50		
	80032		4.50		
	80033		4.50		
	80052		3.00		
N	80055		15.00		
N	80055	22	19.00		
N	80055	52	10.00		
>N	80059		30.00		
	80061		15.00		
	80061	22	23.00		
N	80070		12.00		
N	80072		12.00		
>	80090		28.80		
N	81000		1.20		
	81010		1.20		
	81030		3.00		
N	82011		3.90		
	82024		30.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE OFFICE TOTAL FEE	$	PROF. COMP.
	82030		34.00		
>	82035		24.00		
A	82040		1.80		
	82055		4.50		
	82060		4.50		
	82065		4.50		
	82070		4.50		
	82087		40.00		
	82088		40.00		
	82089		40.00		
	82112		12.60		
	82137		15.00		
	82138		15.00		
	82140		6.00		
	82141		6.00		
	82143		4.20		
	82145		12.00		
	82150		4.50		
	82155		4.50		
	82156		2.40		
>	82157		29.00		
>	82163		21.00		
>N	82173		11.20		
	82175		7.20		
	82180		3.60		
	82205		12.00		
	82210		12.00		
A	82250		3.00		
A	82251		4.50		
	82265		3.00		
	82270		1.20		
>	82273		3.70		
	82290		3.00		
	82291		3.00		
	82308		34.00		
A	82310		3.00		
	82315		3.00		
	82320		3.00		
	82335		.90		
	82340		3.60		
N	82365		9.00		
N	82370		9.00		
A	82374		3.30		
	82375		6.00		
	82380		6.00		
	82382		12.00		
	82383		12.00		
	82384		18.00		
	82390		6.00		
A	82435		3.00		
	82436		3.00		
>N	82437		2.60		
	82438		3.00		
A	82465		3.00		
	82470		7.00		
	82480		4.50		
>	82486		4.40		
	82525		9.00		
	82526		9.00		
	82533		17.00		
	82534		17.00		
	82540		3.00		
	82545		3.00		
	82546		3.00		
A	82550		4.80		
>	82552		7.80		
	82555		4.80		
A	82565		3.00		
	82570		3.00		
	82575		4.50		
	82595		1.50		
	82607		15.00		
	82608		15.00		
>	82626		37.00		
	82628		15.00		
>	82633		48.00		
	82634		39.00		
	82640		15.00		
	82641		15.00		
	82643		15.00		
	82656		15.00		
	82660		9.00		
	82670		25.00		
>	82671		41.00		
	82672		25.00		
	82673		10.20		
>	82674		17.50		
	82676		10.20		
>	82677		28.00		
>	82678		30.00		
>	82679		25.00		
	82705		.60		
	82710		7.80		
	82715		7.80		
	82728		16.00		
	82730		5.70		
	82746		16.00		
	82785		16.00		
	82791		6.00		
	82792		6.00		
	82793		6.00		
	82800		5.20		
	82801		3.30		
	82926		6.00		
	82931		6.00		
	82941		16.00		
>	82943		23.00		
N	82946		13.00		
A	82947		3.00		
	82949		.60		
	82954		1.50		
	82955		6.00		
A	82977		4.80		
	82985		6.60		
	82995		1.80		
	82996		3.00		
	82998		18.00		
	83001		17.00		
	83002		17.00		
	83003		16.00		
	83004		16.00		
>	83008		27.00		
	83010		12.00		
	83011		12.00		
	83012		12.00		
	83015		10.20		
	83020		6.00		
	83036		6.60		
	83040		3.00		
	83050		3.00		
N	83051		1.20		
>	83052		1.80		
>N	83053		1.80		
	83060		3.00		
	83093		3.00		
	83094		3.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE OFFICE TOTAL FEE	$	PROF. COMP.
	83095		3.00		
	83150		12.00		
	83491		12.60		
	83493		12.60		
	83494		12.60		
	83495		12.60		
	83496		12.60		
	83497		6.00		
>	83498		30.50		
>	83499		30.50		
	83523		15.00		
	83525		12.00		
N	83526		10.00		
	83530		6.00		
A	83540		4.50		
	83545		4.50		
A	83550		7.20		
	83555		7.20		
	83570		6.00		
	83571		6.00		
	83578		12.60		
	83582		6.00		
	83583		12.00		
	83586		7.50		
	83587		15.00		
	83589		7.50		
>	83590		9.40		
	83593		6.00		
>	83597		9.40		
	83610		4.20		
A	83615		4.20		
	83620		4.20		
	83625		9.00		
	83626		9.00		
	83629		4.20		
	83631		4.20		
	83632		16.00		
	83645		3.00		
	83650		3.00		
	83655		9.00		
	83660		9.00		
	83661		10.50		
	83670		2.10		
	83675		2.10		
	83680		2.10		
	83690		4.50		
A	83700		3.00		
	83715		7.50		
	83718		8.00		
	83720		10.00		
	83725		9.00		
	83727		17.00		
	83735		4.50		
	83740		4.50		
	83755		4.50		
	83760		4.50		
	83795		.90		
	83825		8.40		
	83830		8.40		
	83835		10.20		
	83840		4.50		
	83915		6.00		
	83970		54.00		
	83971		12.60		
	84005		3.00		
	84030		6.00		
	84031		6.00		
>	84045		19.00		
A	84060		3.60		
	84065		3.60		
A	84075		3.60		
	84078		3.60		
	84080		3.60		
	84090		3.00		
A	84100		3.00		
	84105		3.00		
	84106		1.80		
	84110		7.50		
	84118		3.00		
	84119		3.00		
	84120		7.50		
	84121		7.50		
A	84132		3.90		
	84133		3.90		
	84135		12.00		
	84136		12.00		
	84138		12.00		
	84139		12.00		
	84142		15.00		
	84144		20.00		
	84146		20.00		
A	84155		1.80		
	84160		1.80		
	84165		6.00		
A	84170		6.00		
	84180		2.40		
	84185		.60		
	84190		7.50		
	84200		7.50		
>	84202		10.40		
	84203		3.00		
	84205		15.00		
	84230		15.00		
	84233		16.00		
	84234		20.00		
	84244		25.00		
	84246		25.00		
A	84295		3.90		
	84300		3.90		
M	84317		.60		
	84403		32.00		
>	84405		30.00		
>	84408		15.00		
	84420		15.00		
	84430		3.60		
	84435		6.00		
	84436		6.00		
	84437		6.00		
>	84439		10.00		
	84442		12.00		
	84443		25.00		
A	84450		3.00		
	84455		3.00		
A	84460		3.00		
	84465		3.00		
A	84478		8.30		
	84479		6.00		
	84480		15.00		
	84481		15.00		
	84485		3.30		
	84488		3.30		
	84490		3.30		
A	84520		3.00		
	84525		3.00		
	84540		3.00		
	84545		6.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE OFFICE TOTAL FEE	$	PROF. COMP.
A	84550		3.00		
	84555		3.00		
	84560		3.00		
	84577		6.00		
	84580		2.10		
	84583		2.10		
	84585		12.00		
	84590		6.00		
	84605		3.60		
	84610		3.60		
	84695		12.60		
>	84701		15.00		
	84800		25.00		
	84810		12.60		
	85000		1.20		
	85002		1.20		
	85005		3.00		
N	85007		2.40		
N	85009		1.20		
	85012		1.80		
N	85014		1.50		
N	85018		1.20		
	85021		1.80		
>	85022		3.00		
>	85027		4.80		
>	85028		4.80		
>N	85028	22	8.40		
N	85031		3.00		
N	85041		1.20		
	85044		1.80		
N	85048		1.20		
>	85060		8.00		8.00
>	85095		24.00		24.00
>	85097		24.00		24.00
>	85100		53.00		48.00
>	85101		29.00		24.00
>	85102		24.00		24.00
>	85103		29.00		24.00
>	85105		24.00		24.00
	85150		1.80		
	85170		.60		
	85171		.60		
	85210		3.00		
	85345		1.80		
	85347		3.00		
	85348		1.20		
	85362		3.00		
	85363		3.00		
	85364		8.40		
	85376		5.70		
	85377		5.70		
	85544		6.00		
	85555		4.80		
	85557		4.80		
>	85560		3.00		
	85575		1.80		
	85577		1.80		
	85580		1.80		
	85590		1.80		
	85595		1.80		
	85610		3.00		
	85614		3.00		
	85615		4.50		
	85650		1.50		
	85651		1.50		
	85660		1.80		
	85700		9.00		
	85730		3.00		
	85732		3.00		
	86000		.90		
	86002		1.80		
	86004		1.80		
	86006		2.70		
	86008		6.00		
	86009		3.00		
	86017		4.20		
	86024		3.00		
	86028		3.00		
	86031		3.00		
	86032		3.00		
	86033		3.00		
	86038		7.80		
	86060		3.60		
	86063		1.20		
	86064		7.80		
	86067		7.80		
	86068		4.50		
>	86077		25.00		25.00
>	86078		17.00		17.00
>	86079		17.00		17.00
	86080		1.80		
	86082		1.80		
	86090		1.80		
	86095		1.80		
	86100		1.80		
	86105		1.80		
	86115		1.80		
	86120		3.00		
	86140		3.00		
N	86151		22.40		
	86162		15.60		
	86163		7.80		
	86164		9.00		
	86171		4.50		
	86225		13.00		
	86244		10.20		
	86255		7.80		
	86256		9.00		
	86277		16.00		
	86280		5.40		
	86281		3.00		
>	86285		7.50		
	86286		10.00		
	86287		10.00		
>	86288		12.00		
>	86289		15.00		
>	86291		15.00		
>	86293		12.00		
>	86295		12.00		
>	86296		10.00		
>	86298		12.00		
>	86299		12.00		
	86300		3.00		
	86305		4.50		
	86310		4.50		
>	86312		14.84		
>	86314		32.33		
	86320		10.50		
	86329		16.80		
	86335		6.00		
	86337		12.00		
	86376		6.60		
	86377		6.60		
>N	86421		20.00		
>N	86422		4.00		
	86423		16.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE OFFICE TOTAL FEE	$	PROF. COMP.
	86430		1.80		
	86490		4.00		
	86510		4.00		
	86540		4.00		
>	86580		4.00		
	86585		4.00		
A	86592		1.50		
	86593		3.00		
	86594		6.00		
	86595		6.00		
	86600		7.80		
	86650		12.00		
	86660		12.00		
	86662		12.00		
>	86800		13.00		
	86812		12.60		
	86813		12.60		
	87001		9.00		
	87015		5.10		
N	87040		9.00		
N	87045		9.00		
N	87060		9.00		
N	87070		9.00		
>	87072		6.00		
>	87075		9.00		
	87076		6.00		
>	87081		10.00		
>	87082		4.00		
>	87083		4.00		
	87084		3.00		
>	87085		4.00		
	87086		3.00		
	87087		2.70		
	87088		2.70		
	87101		8.00		
	87102		8.00		
	87106		8.00		
>	87109		14.00		
	87116		6.00		
	87117		9.00		
	87140		3.00		
	87143		3.00		
	87145		3.00		
	87147		3.00		
	87151		3.00		
	87155		3.00		
	87158		3.00		
	87164		6.00		
	87166		6.00		
	87177		5.10		
N	87184		9.00		
	87188		6.00		
	87190		.60		
	87205		4.20		
	87206		4.20		
	87207		3.00		
	87208		5.10		
	87210		2.40		
	87211		5.10		
	87220		2.40		
>	87250		32.00		
>	88104		12.00		7.00
>	88106		12.00		7.00
>	88107		12.00		7.00
>	88108		12.00		7.00
>	88125		7.00		7.00
>	88130		9.65		7.00

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE OFFICE TOTAL FEE	$	PROF. COMP.
>	88140		4.20		3.00
	88150		6.00		6.00
	88151		6.00		6.00
N	88155		6.00		6.00
>	88160		7.00		7.00
>	88161		12.00		7.00
>	88162		BR		BR
>	88170		30.00		30.00
>	88171		61.00		61.00
>	88172		8.00		8.00
>	88173		25.00		25.00
>N	88260		120.00		86.00
>N	88261		120.00		86.00
>N	88262		120.00		86.00
>N	88265		85.00		41.00
>N	88267		172.00		123.00
>N	88268		172.00		60.00
>N	88270		172.00		60.00
>	88300		9.35		7.00
>	88302		21.00		15.00
>	88304		26.00		19.00
>	88305		40.00		30.00
>	88307		59.00		44.00
>	88309		89.00		66.00
>	88311		4.00		4.00
>	88312		13.00		8.00
>	88313		10.00		5.00
>	88314		12.00		7.00
>	88318		7.00		7.00
>	88319		7.00		7.00
>	88321		28.00		28.00
>	88323		33.00		33.00
>	88325		44.00		44.00
>	88329		33.00		33.00
>	88331		48.00		41.00
>	88332		15.00		15.00
>	88342		9.00		7.00
>	88346		8.00		8.00
>N	88348		BR		BR
	89050		.90		
	89051		.90		
	89105		6.00		
	89125		.60		
	89132		6.00		
	89135		6.00		
	89136		6.00		
	89141		6.00		
	89160		2.10		
	89205		1.20		
	89300		2.40		
	89310		4.80		
	89320		3.00		
M	89355		.60		
N	89360		9.00		
L N	P7001		6.00		
>L	W8010		43.75		
L N	W8200		2.00		
L N	W8205		9.00		
L N	W8210		12.00		
L A	W8215		4.00		
L	W8225		18.00		
L	W8615		7.80		
L	W8620		7.80		
L	W8621		12.60		
>L	W8622		25.00		
L	W8700		3.00		
L	W8710		3.00		
>L	W8720		15.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE OFFICE TOTAL FEE	$	PROF. COMP.
>L	W8725		30.00		
L	W8900		10.00		
L	W8920		1.80		
L	W8925		.60		

10:61-3.3 HCPCS code numbers, procedure description and maximum fee schedule; pathology/laboratory (codes and narratives not found in CPT-4)

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE
N	P7001		CULTURE, BACTERIAL, URINE; QUANTITATIVE, SENSITIVITY STUDY	6.00
>	W8010		HEPATITIS B PROFILE; HEPATITIS B SURFACE ANTIGEN; HEPATITIS B SURFACE ANTIBODY; HEPATITIS B ANTIGEN AND ANTIBODY; HEPATITIS B CORE ANTIBODY	43.75
N	W8200		GLUCOSE, SERUM (SEPARATE TUBE, GREY TOP) NOTE: SUBMITTED ON SAME CLAIM, AND PERFORMED ON SAME DATE AS CHEMISTRY PROFILES	2.00
N	W8205		3 HR. GLUCOSE TOLERANCE TEST, PER 4 SPECIMENS	9.00
N	W8210		5 HR. GLUCOSE TOLERANCE TEST, PER 6 SPECIMENS	12.00
A	W8215		T-4 (THYROXINE) BY IMMUNOASSAY (ENZYME IMMUNOASSAY) (EMIT)	4.00
	W8225		THYROXINE–BINDING GLOBULIN WITH T4 (THYROBINDING-GLOBULIN WITH T4) (RIA) (TBG AND T4)	18.00
	W8615		ANTI-DNA, ANTI-DEOXYRIBONUCLEIC ACID, (CHEMICAL METHOD, NON-RIA)	7.80
	W8620		HERPES SIMPLEX ANTIBODIES: (HERPES SIMPLEX VIRUS, I OR II)	7.80
	W8621		HERPES SIMPLEX VIRUS, I AND II	12.60
>	W8622		HERPES SIMPLEX VIRUS ISOLATION AND IDENTIFICATION, TOTAL STUDY	25.00
	W8700		YEAST SCREEN (NOT DEFINITIVE) FROM URINE, VAGINAL OR THROAT CULTURES ONLY (EG., GERM TUBE)	3.00
	W8710		TRICHOMONAS PREPARATION–SMEAR OR HANGING DROP (SMEAR NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IF PAP SMEAR DONE ON THE SAME DAY)	3.00
>	W8720		CHLAMYDIA DIRECT SPECIMEN TEST; MICROTRACK; CHLAMYDIAZIME; CHLAMYDIA A.G. DIRECT; CHLAMYDIA TITER: CHLAMYDIA CF; CHLAMYDIA ASSAYS BY IFA AND CIS; CHLAMYDIA ISOLATION; FLUORESCENT ANTIBODY FA	15.00
>	W8725		CHLAMYDIA CULTURE	30.00
	W8900		HOUSE CALL TO HOME BOUND PATIENT IN HOME OR SHELTERED BOARDING HOME FOR PURPOSE OF OBTAINING BLOOD BY VENOUS OR ARTERIAL PUNCTURE REIMBURSEMENT LIMITED TO ONCE PER TRIP REGARDLESS OF NUMBER OF PATIENTS	10.00
	W8920		VISIT TO OBTAIN BLOOD SPECIMENS BY VENOUS OR ARTERIAL PUNCTURE "FIRST PERSON IN NURSING HOME"	1.80
	W8925		EACH ADDITIONAL PERSON IN NURSING HOME	.60

10:61-3.4 Pathology and Laboratory HCPCS Codes–Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Chemistry Automated, Multichannel Tests: Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting (for handling of specimen, see 99000 and 99001).

Albumin
Alkaline Phosphatase
Bilirubin, Total
Bilirubin, Direct
Blood Urea Nitrogen (BUN)
Calcium
Carbon Dioxide (CO_2)
Chlorides (Cl)
Cholesterol
Creatinine
Gamma Glutamyl Transpeptidase (GGTP)
Glucose (Sugar)
Iron
Lactic Dehydrogenase (LDH)
Phosphorus
Potassium (K)
Protein, Total
Sodium (NA)
Total Lipids
Transaminase, Glutamic Oxalacetic (SGOT)
Transaminase, Glutamic Pyruvic (SGPT)
Triglycerides
T4 by Immune Assay (EMIT)
Uric Acid

i. If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded $5.00: the maximum reimbursement will not be more than $5.00; 82251, 82374, 82801, 83540, 83545, 83610, 83615, 83620, 83629, 83631, 84075, 84078, 84080, 84132, 84133, 84295, 84300, 84478, 82977, W8215.

ii. The following calculations and ratios are not eligible for separate or additional reimbursement, and, therefore, should not be

included in determining the calculations alloted to the above Procedure Codes.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

iii. Any additional automated multichannel chemistry tests (other than those listed) performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be reimbursed at the current allowable fee for each added test.

iv. Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional $2.00.

2. Code 80072—Arthritis Panel should include as a minimum four of the following tests:

ASO Titer	
C-Reactive Protein (CRP)	Uric Acid
RA Latex	Alkaline Phosphatase
(Rheumatoid Arthritis factor)	Calcium

3. Code 80070—Thyroid Panel—T4 by RIA, plus T3 uptake, resin (T3RU) (RT3U).

i. The following calculations will be included in the fee for the Thyroid Panel:

"T7" Free Thyroxine
Index (FTI), Calculated Free Thyroxine
Index (CFT4) or Calculated Thyroxine
Iodine (T4I)

ii. T3 by uptake, resin (T3RU) is eligible for reimbursement only when done in conjunction with T4 by RIA as part of Thyroid profile.

4. Code 80055-52—Obstetric profile.

i. At least four of the following tests must be included in the profile:

Blood Group (ABO)
RH Factor
Antibody screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)

5. Code 80055—Obstetric profile with Rubella HI Antibody Titer.

6. Code 80055-22—Expanded Obstetric profile.

i. For reimbursement purposes the following must be included:
Blood Group (ABO)
RH Factor
Antibody screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)
Cytology (Pap smear)
Urinalysis
Urea Nitrogen (BUN)
Glucose
Sickle Cell with Rubella II Antibody Titer

7. Code 81000—Urinalysis.

i. Stick, dip or tablet tests done on urine are considered part of the urinalysis, and therefore, are not eligible for separate reimbursement. Microscopy is required for reimbursement.

8. Code 86151—(CEA-RIA) Carcinoembryonic Antigen.

i. "CEA is not useful to diagnose cancer. Claims are eligible for reimbursement only when CEA is used to follow treated cases of cancer (for example, gastro-intestinal, breast, lung) primary detection of recurrence, or for estimate of prognosis in certain cases." (Documentation required)

9. Code 88155—pap smear.

i. Obtaining a specimen is not a separate eligible service.

10. Cultures, Codes 87040, 87045, 87060, 87070, 87184, P7001.

i. These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture.

11. Code 82173 and 82946—Glucagon Tolerance Test.

i. Total payment is not to exceed $65.00.

12. Code 83526—Insulin Tolerance Test.

i. Total payment is not to exceed $70.00 (RIA).

13. Code 85031—Complete Blood Count—CBC.

i. Components of a CBC—the maximum fee for any of the following combinations of components is $3.00. (83051, 83053, 85007, 85009, 85014, 85018, 85041, 85048).

ii. For reimbursement purposes, CBC testing is all-inclusive and covers tests performed either by automation and manually.

14. Code 82365 and 82370—Calculus (stone), Quantitative: (Infrared spectroscopy) X-ray diffraction.

i. Reimbursement for this code is not eligible for chemical methods.

15. Code 82437 and 89360—Sweat (without iontophoresis) Test.

i. Reimbursement for this code is not eligible for qualitative tests.

16. Code 82011—Salicylates, quantitative only.

i. Reimbursement for this code is not eligible for screening (Qualitative) tests for salicylates (82012).

17. Code W8205 and W8210—Glucose Tolerance.

i. For reimbursement purposes includes all urines for sugar.

18. Code 88260, 88261 and 88262—Chromosome Analysis: Peripheral blood.

i. Rule out numerical and structural abnormalities.

ii. For Medicaid reimbursement purposes. The provider must include an average of 20 cells and two or three karyotypes analyzed, including banding.

19. Code 88265—Chromosome Analysis: Various leukemias, bone marrow and peripheral blood (includes Philadelpia Chromosome study).

i. For reimbursement purposes. The provider must include a minimum of 10 cells and two karyotypes analyzed, including banding.

20. Code 88267—Chromosome Analysis: Amniotic Fluid Cells (Prenatal Chromosome Analysis).

i. For reimbursement purposes. The provider must include 20 cells and two or three karyotypes analyzed, including banding.

21. Code 88268 and 88270—Chromosome Analysis: Tissue Biopsy, Abortuses, etc. (Documentation report required).

i. For reimbursement purposes as a minimum, the provider include 15-20 cells and two or three karyotypes analyzed, including banding.

22. Code 88280, 88285.

i. Additional karyotyping and cells counted are not reimbursable for Medicaid payment.

23. Code 80059—Hepatitis Panel: For reimbursement purposes includes:

i. Hepatitis Profile:
Hepatitis B Surface Antigen (Australian)
Hepatitis B Surface Antigen Antibody
Hepatitis B Core Antibody
Hepatitis A Antibody

24. Code 85028-22 (8630) Hemogram 22—Service Greater than Usual.

i. The definition of a complete Hemogram is: supravital morphological study of the formed elements of the blood, hematocrit, reticulocyte count, platelet count, hemoglobin, total white count, supravital differential or phase, regular differential, total red count and indicies, MCV, MCH, MCHC. A Hemogram will be reimbursed at $8.40. Providers must indicate on the claim form what components are part of their Hemogram and use the Modifier 22.

25. Code 86421 (8525) Radioallergosorbent Test (Rast); up to five Antigens.

i. For reimbursement purposes, payment for each individual Antigen is $4.00 up to the first five Antigens. List number of Antigens in the appropriate box of the claim form.

26. Code 86422 (8526) Six or more Antigens.

i. For reimbursement purposes, payment is per each additional Antigen.

27. Code 88348.

i. Not reimbursable when used as a research tool.

ii. For payment purposes, the Department will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, that is, gold,

mercury, etc., and also when examining tissue specimens in occassional cases of malabsorption.

10:61-3.5 Pathology and Laboratory HCPS Codes—Modifiers

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric charaters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are:

MODIFIER CODE	DESCRIPTION
22	Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.

(a)

DIVISION OF YOUTH AND FAMILY SERVICES

Personal Attendant Services Program

Adopted New Rules: N.J.A.C. 10:123A

Proposed: July 15, 1991 at 23 N.J.R. 2091(b).
Adopted: July 10, 1992 by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: July 13, 1992, as R.1992, d.314, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4G-21.

Effective Date: August 17, 1992.
Expiration Date: August 17, 1997.

The Division of Youth and Family Services has proposed rules on the Personal Attendant Services Program three times. The first proposal was made on February 6, 1989 at 21 N.J.R. 273(b). As a result of the comments received, and the Division of Youth and Family Services' own internal and continuing review, the Division developed reproposed rules that incorporated significant changes, primarily in the sliding fee scale and the provider fees. This reproposal was published on May 21, 1990, at 22 N.J.R. 1527(a). Due to the interest expressed by the public, the comment period was extended to October 1, 1990 (22 N.J.R. 2082(a)). Additionally, a request for a public hearing was made by the Public Advocate.

The Division commenced a thorough review of the Personal Attendant Services Program, and so advised the Public Advocate. The internal Division review resulted in the formation of a Personal Attendant Services Task Force, which met monthly beginning in October, 1990, and produced the rules proposed on July 15, 1991 at 23 N.J.R. 2091(b), the third version.

To comply with the request of the Public Advocate, and to allow the fullest public participation possible, the Division scheduled three public hearings. These hearings were held on July 16, 1991 in Paramus, New Jersey, on July 23, 1991 in Lawrenceville, New Jersey, and on July 31, 1991 in Sewell, New Jersey and a total of 21 people attended. The Division also accepted written and oral comments through the close of the comment period.

Notice of these public hearings and of the publication of the proposed rules in the July 15, 1991 edition of the New Jersey Register was provided by distribution of a notice, on June 26, 1991, to all the county offices on the handicapped and to all the county PASP coordinators. The county Office on the Handicapped Directors and the county PASP Coordinators were asked to post copies of the notice in their offices in an area that was visible to the public, and to distribute copies of the notice to all program applicants and consumers, members of local advisory councils, attendant provider agencies, and any other interested party.

Also, notice of these hearings and of the publication of the proposed rules appeared in the July 1, 1991 editions of the following newspapers of general circulation in this State—Newark Star Ledger, Asbury Park Press, Camden Courier Post and The Trentonian.

Summary of Hearing Officer's Recommendations and Agency Responses:

Kathryn Clark was the hearing officer at the July 16 and July 23, 1991 hearings, and Terence Duffy was the hearing officer at the July 31, 1991 hearing. Tapes of the hearings, as well as the written comments, may be reviewed by contacting Kathryn A. Clark, at the Division of Youth and Family Services, CN 717, Trenton, New Jersey 08625-0717. Both Miss Clark and Mr. Duffy recommended that the comments be referred to appropriate Division staff for response, which has been done. A summary follows.

Summary of Public Comments and Agency Responses:

The Division received comments from 21 individuals, in writing or from the regional public hearings in response to the July 15, 1991 proposal governing the Personal Attendant Services Program (Program). Four commenters were affiliated with county offices for the disabled; three were consumers of personal attendant services; four were from independent living centers; three were from a state disabled advisory council; three were from personal attendant provider agencies; one was a program assessor; one was a personal attendant; one was a prospective applicant for personal attendant services; and one was the spouse of a personal attendant services consumer. The individuals who commented were:

Anne Ciavaglia, DIAL (Disabled Information, Awareness and Living), Inc., (member of the PASP Task Force)
Paula Walsh, HIP (Heightened Independence and Progress)
Lucille Kent, Office of the Disabled, Bergen County (member of the PASP Task Force)
Shelley Anne Krayer, DIAL, Inc.
Karyn Silverstein, personal attendant, United Cerebral Palsy
Ardeth Ebeling, consumer, United Cerebral Palsy
Stanley Obritski, Jr., PASP Advisory Council (co-chair of the PSAP Task Force)
Richard G. Stoner, PASP Advisory Council
Dee Clark, Atlantic County Division of Aging and Disabled (member of the PASP Task Force)
Jacquelyn Love, Director, Gloucester County Office for the Disabled
Vince Latini, husband of PASP consumer
Ronald Bowers, DPAC, consumer
Chandler Ford, Jr., Special Care of New Jersey
Mike Kennedy, Center for Independent Living of South Jersey
Mary L. Keubler, prospective consumer
Sarah Hart, Gloucester County Health Department
Robbie Friedner, Camden County Office on the Disabled
Daniel Dunn, Somerset County Association of Retarded Citizens
Belinda Malone, Somerset County Association of Retarded Citizens
Barbara Esposito, New Jersey State Developmental Disabilities Council
Leah Klein, PASP Advisory Council, consumer

As a result of the Division's review of the commenters' remarks with respect to the proposal, the suggested recommendations and concerns were brought before the Statewide Personal Attendant Services Task Force and the Personal Attendant Services Advisory Council for consideration.

COMMENT: Three commenters expressed their support of the proposal and stated that many improvements have been made over the earlier proposal.

RESPONSE: The Division appreciates the support and is in agreement with the commenters' opinion that major improvements have been made to the rules for the betterment of the Program.

COMMENT: Three commenters criticized the Program's limitation on transportation services, as specified in N.J.A.C. 10:123A-3.5(b)2, which prohibits a person serving as an attendant under the Program from providing driving or transportation services using his or her own vehicle.

One of those commenters further requested that the rules be amended to allow transportation services for consumers using the attendant's vehicle in order to provide greater mobility for consumers on the Program.

RESPONSE: The Division, in concert with the Personal Attendant Services Task Force, has examined this provision. While transportation services are available under the Program, such services should not take the place of services made available by existing public transportation and paratransit systems. The request made by the commenter to allow transportation services in the attendant's vehicle raises several issues of insurance liability and may create additional financial burdens for the attendant.

COMMENT: One commenter expressed concerns with the eligibility requirements with regard to age as specified in N.J.A.C. 10:123A-2.1(a)1, which states that a person shall be between the ages of 18 through 65 to be eligible. The same commenter also requested that amendments be made to this provision to enable services beyond the age limits.

RESPONSE: The Division must comply with the enabling legislation, N.J.S.A. 30:4G-13 et seq., in which eligibility is limited to those individuals between the ages of 18 and 65. Any changes to this provision would not be allowable without legislative amendment.

COMMENT: One commenter expressed concern with the problems of recruiting attendants under the Program.

RESPONSE: While the Division acknowledges the difficulties in recruiting attendants for consumers, this issue cannot be addressed through the rule process. The enabling legislation gives the designated county agency the responsibility for establishing the method for the provision of attendant services; therefore, it is more appropriate to address the issue of attendant recruitment at the county level.

COMMENT: One commenter questioned whether or not family members would be allowed to be paid as attendants under the Program.

RESPONSE: The Division emphasizes that the Personal Attendant Services Program is designed to foster independent living in which consumers are given the opportunity to manage and direct the activities of a personal attendant and are provided with the experience of serving in the role of an "employer." In view of this, the Division has determined that family members may be paid as attendants, but only upon the recommendation of the designated county agency and with the approval of the State Program Administrator. N.J.A.C. 10:123A-2.2(b) and (c), Eligibility standards, and N.J.A.C. 10:123A-2.3, Exceptions to eligibility standards, have been amended accordingly.

COMMENT: Two commenters expressed concern with the establishment of a training program for coordinators, attendants and consumers.

RESPONSE: The Division has established a request for proposal process in order to enter into a contract with an appropriate agency to develop a training curriculum and coordinate the delivery of training under the Program Statewide.

COMMENT: One commenter questioned whether or not a "grandfathering" provisions would be allowed for attendants to continue working on the Program without requiring additional certification or the passing of an examination.

RESPONSE: Because the Division intends to establish a new Statewide training program for attendants and consumers, in the interest of providing services in a standardized manner, all personal attendants will be required to complete the training program.

COMMENT: Two commenters expressed a concern with the limits imposed by law with regard to administrative costs under the Program. One commenter felt that the county office and the attendant provider agency are both taking administrative funds from their contract allocation, producing a "double-dip" effect.

RESPONSE: The Division must comply with the specific language of the enabling legislation, which states that "no more than 15 percent shall be expended by the state and the designated county agencies to meet administrative costs.

COMMENT: One commenter indicated that the salaries paid to attendants are too low to attract and maintain quality attendants to work under the Program.

RESPONSE: The fees for attendant services are based on the designated county agency's method for securing providers and the contracted hourly rate for attendant services, under N.J.A.C. 10:123A-4.2. In response to the commenter's opinion that the attendant salaries are too low, in this proposal the Division has already taken action by raising the rate of reimbursement to the designated county agency, to a maximum of $11.00 per hour on weekdays and $14.00 per hour on weekends and holidays. N.J.A.C. 10:123A-4.2(b). It should be noted that potential increases in rates of reimbursement will not guarantee higher salaries for attendants, and in fact, may reduce the number of attendant hours that can be provided within Program funding limits. Because the authorizing legislation is silent with regard to attendant salaries, the ability of the designated county agencies to negotiate satisfactory wages with attendant provider agencies and/or independently hired attendants will be a major factor in determining attendants' salaries.

COMMENT: One commenter objected to having applicants living in a group home setting being denied the opportunity to receive services under the Program, stating that this rule is discriminatory.

RESPONSE: The enabling legislation for the Program states only "a person with a chronic physical disability who is between 18 and 65 years of age and is a resident of this State is eligible for the Personal Attendant Services Program if . . . (t)he person lives in a private house or apartment, rooming or boarding house or residential health care facility." Therefore, under the enabling legislation, a person residing in a group home setting is not eligible under the Program.

COMMENT: One commenter expressed concern with the wording in N.J.A.C. 10:123A-1.1 and requested that the phrase ". . . to live independently and assure quality of service" be amended to read "to live independently by assuring quality of service."

RESPONSE: The Division has re-examined this text and has determined that the existing phrasing is clear in its intent; therefore, the language will be retained. The ability of individuals to live independently is based on a number of factors. Quality of service is one of these factors. The Division intends, through the application of these rules, to assure quality of care.

COMMENT: One commenter expressed concern with the standard in N.J.A.C. 10:123A-1.3(a)3, that states that all consumers, and, as appropriate, all applicants, are to receive services in compliance with all State laws on non-discrimination. The same commenter pointed out that not all disabled persons are self-directing, and for that reason alone are precluded from being eligible for services under the Program. The commenter questioned whether this was impermissibly discriminatory.

RESPONSE: The legislation that created the Personal Attendant Services Program requires that eligible applicants must be certified as self-directing by a physician, and must be determined to be self-directing by a qualified assessor. The Division must comply with the specific requirements of the law. The law was intended to provide Personal Attendant Services to those handicapped people who are self-directing, and this more specific requirement governs the Program.

COMMENT: One commenter requested an amendment of N.J.A.C. 10:123A-1.3(a)5, adding the word "confidentiality" to the standard which affords privacy to consumers while receiving services, in communications and in all daily activities.

RESPONSE: The Division has re-examined the noted provision and feels that, in conjunction with N.J.A.C. 10:123A-1.3(a)7, it is clear with regard to the issue of confidentiality. Therefore, the existing language will be retained.

COMMENT: One commenter requested an amendment of N.J.A.C. 10:123A-1.3(a)14 to add the phrase "for any legitimate reason" to the standard that allows consumers to terminate a personal attendant for any reason. The commenter felt that disabled consumers, as employers, have an obligation to the attendants, as employees, not to dismiss them unreasonably.

RESPONSE: While the Division agrees with the commenter that consumers, as employers, have certain obligations to their attendants, the rules already provide limitations on consumers who unreasonably dismiss attendants. Under N.J.A.C. 10:123A-3.8(c)4, services under the Program may be terminated for "continued . . . dismissal of personal attendants without proper justification." Since the Division feels the additional language suggested by the commenter is unnecessary, the existing language will be retained.

COMMENT: One commenter objected to the use of the term "personal values" as specified in N.J.A.C. 10:123A-1.4 ("values of the applicant or consumer") and requested that the term be removed, due to the anticipated difficulty of evaluating each consumer's values.

RESPONSE; The Division emphasizes that the Personal Attendant Services Program is intended to provide services to eligible persons in order for them to live independently. In determining what services are required to achieve or maintain living independently, a person's choices in achieving and maintaining an independent lifestyle should be given full consideration. These choices, expressed by the applicant or consumer, constitute that person's values, as defined in N.J.A.C. 10:123A-1.4. There is no need to evaluate each consumer's values; there

is a need to understand what these values are and to consider them when working with, or for, the consumer. Therefore, the existing language will be retained.

COMMENT: One commenter requested clarification of the definition of the term "designated county agency," stating that it appears that the designated county agency is required to recruit and train personal attendants. The commenter stated that, if this was a requirement, then any county office that only uses sub-contract services, and does not hire and train attendants directly, would be in conflict with that definition.

RESPONSE: The enabling legislation defines "designated county agency" as a county office on the handicapped or other county agency designated by the county government, subject to approval by the Commissioner of the Department of Human Services, to administer in that county the Personal Attendant Services Program. The definition in the proposal restates the definition in the law. Counties may train as they choose, pending the promulgation of rules regarding training, at Subchapter 7.

COMMENT: One commenter expressed concern with N.J.A.C. 10:123A-1.5, regarding target population and priority for services, and asked that broad guidelines for prioritization for service delivery be set forth.

RESPONSE: The Division acknowledges the need for the development of standards for prioritization of service delivery, and will be working with the Personal Attendant Services Advisory Council in establishing a Policy Review and Development Committee to achieve Statewide guidelines, which will be added to this chapter when they are developed. The Division believes that the designated county agencies are well informed regarding community needs and will be able to prioritize appropriately for their counties.

COMMENT: One commenter criticized the requirement specified in N.J.A.C. 10:123A-2.1(a)7 that a physician certify an individual as self-directing and has requested elimination of this certification by amending the current legislation. This same commenter stated that a physician usually sees the person infrequently, so the physician would not be able to determine whether or not the person is self-directing.

RESPONSE: The Division must comply with the enabling legislation, which states that a physician must certify that a person is self-directing. The commenter correctly noted that changes in the enabling legislation must be made in order to address the issue. The Division believes that the consumer's physician will be able to assess the consumer's ability to coordinate therapeutic regimes, as well as the adequacy of the personal attendant services to meet consumer needs, and that such an assessment, in the case of a person with a chronic physical disability, is very appropriate.

COMMENT: One commenter requested that changes be made to N.J.A.C. 10:123A-3.2(a) which requires that a member of the staff of the designated county agency perform the assessment under the Program. The same commenter pointed out that in several county offices, the assessment process is performed by an independent assessor/contractor.

RESPONSE: While the commenter correctly notes the provision regarding performance of the assessment, the language is taken verbatim from Program legislation. The Division points out that the assessor may be an independent contractor, a consultant or a member of the staff of the designated county agency.

COMMENT: One commenter criticized the provision for negotiation in N.J.A.C. 10:123A-3.3, which implies that there is a problem in the system that needs to be worked out with each consumer, and suggested that the term "negotiation" be removed.

RESPONSE: The Division has re-examined this provision and disagrees with the commenter's suggestion that the word "negotiation" implies that a problem exists. While the consumer is responsible for the design of the plan of service, the designated county agency has a responsibility to utilize its expertise in reviewing the plan of service, to ensure that it is reasonable and appropriate with regard to the consumer's specified needs. In determining whether or not a plan of service is reasonable and appropriate, the designated county agency and consumer may be involved in a negotiation process in order to resolve any issue. This required negotiation process benefits the consumer and the personal attendant, and assures that the purpose of the legislation, and of this chapter, is carried out. Therefore, the existing language will be retained.

COMMENT: One commenter questioned the purpose of the requirement that the consumer be notified as to an estimate of the total cost of the personal attendant services under N.J.A.C. 10:123A-3.4(b)2. The same commenter stated that this creates additional work for the county administration and suggested that the consumer would receive no value from this information.

RESPONSE: The enabling legislation states that the plan of service shall include "an estimate of the total cost of services." This provision complies with this part of law, which is consistent with the goal of informing and involving the consumer as much as is possible.

COMMENT: One commenter expressed concern with N.J.A.C. 10:123A-3.4(c), which says that an applicant's position on a waiting list shall be determined by the designated county agency. The same commenter stated there was a need for broad guidelines in order to prevent disparate treatment from county to county.

RESPONSE: The Division acknowledges the need for the development of standards for the prioritization of consumers on a waiting list, and anticipates working with the Personal Attendant Services Advisory Council in establishing a Policy Review and Development Committee to achieve Statewide guidelines on this issue, which will be added to this chapter.

COMMENT: One commenter criticized N.J.A.C. 10:123A-3.9 on adverse agency actions in which the proposed rule states that written notice and, if appropriate, oral notice, be provided.

RESPONSE: Any oral notice given to a consumer will be followed by written notice to be sent to the consumer in order to establish a written record of the adverse action taken by the agency. The designated county agency shall retain a copy of the written action in the consumer's case file.

COMMENT: One commenter criticized N.J.A.C. 10:123A-3.10, Hearings and appeals, which allows consumers to initiate the hearing process by contacting the Division's Administrative Hearings Coordinator by telephone. The commenter stated that the consumer should be required to follow-up the telephone conversation with a written request, to create a record.

RESPONSE: While the Division agrees with the commenter's suggestion to require the consumer to follow-up a phone call request for an Administrative Hearing with a written request, there may be circumstances in which the consumer would experience difficulty in developing a written documentation of the request. In such cases, the Administrative Hearings Coordinator will create the written record to confirm the consumer's request for an administrative hearing, and thus be able to take necessary steps to follow-up on the process.

COMMENT: One commenter requested clarification under N.J.A.C. 10:123A-7.1(b), asking what kind of background "check" was intended, suggesting that this could be misinterpreted.

RESPONSE: Since the enabling legislation is silent as to the performance of background checks, the Division feels that county agencies should be permitted the flexibility to determine the nature and degree of background checks of personal attendants. There is no licensing or regulatory agency that sets background check requirements for personal attendants. Therefore, the counties should conduct a check or form an agreement with providers with whom they contract to conduct a check that satisfies them as to the appropriateness of each personal attendant.

COMMENT: One commenter expressed disagreement with the requirement under N.J.A.C. 10:123A-3.3(d) which requires a yearly social reevaluation.

RESPONSE: The enabling legislation requires the designated county agency to "perform a comprehensive social and financial evaluation of the eligible person annually." The Division must comply with the enabling legislation, and has further specified these requirements in this subchapter.

COMMENT: One commenter recommended that the reimbursement rates for personal attendant services under N.J.A.C. 10:123A-4.2(b) be lowered.

RESPONSE: The Division disagrees with the commenter's suggestion to lower the reimbursement rates for personal attendant services. In examining this issue, the Division found that several county agencies have experienced difficulty in obtaining qualified provider agencies at the previous rates, thus placing consumers at risk. In response to this concern, the Division feels that raising the reimbursement rates will enable the county agencies to be in a better competitive position in obtaining service providers. In addition, county agencies would be afforded the flexibility to negotiate reimbursement at the existing market rates within the reimbursement ceiling.

COMMENT: One commenter questioned the necessity of fees for assessments, in N.J.A.C. 10:123A-4.2(c), and stated that fees should be covered by the administrative costs of the Program.

RESPONSE: When a county agency contracts with a provider to perform assessment services, the $70.00 fee noted in N.J.A.C. 10:123A-4.2(c) is payable to the provider out of direct client service funds. When the county performs the assessment directly using employee time funded in whole or in part by Program dollars, the assessment is considered to have been performed as part of the administrative duties of that employee, and there is no fee charged.

COMMENT: One commenter expressed concern with Subchapter 6, Training, which is currently reserved, recommending that full opportunity for input from interested parties be provided prior to completion of that subchapter.

RESPONSE: The Division agrees and will be working with the Personal Attendant Services Advisory Council and other interested parties in order to obtain input into the pending training subchapter.

COMMENT: One commenter requested clarification of N.J.A.C. 10:123A-5.1(c), specifically whether, if the attendant is a passenger in a consumer's vehicle, the consumer has to give the attendant the consumer's insurance information.

RESPONSE: Since the legislation is silent as to the requirements of consumers who transport their attendant in their own vehicle, the Division has determined that, since the attendant is required to have a liability policy in order to cover personal injury and/or property damage, no requirement would be placed on the consumer by these rules to routinely provide the attendant with automobile insurance information.

COMMENT: One commenter expressed disagreement with N.J.A.C. 10:123A-3.8(c), termination of service, in that the rule as written sounded punitive and recommended the conditions be listed under consumer's responsibilities, in a more positive mode.

RESPONSE: The Division emphasizes that the Personal Attendant Services Program provides services for those eligible persons who are capable of self-direction, and as such, consumers are required under these rules to carry out responsibilities that are necessary to continue receiving services under the Program. The language in N.J.A.C. 10:123A-3.8(c) is clear in that consumers are required to comply with specified Program rules and procedures, and that failure to carry out those responsibilities specified in the rules will result in termination of service.

Summary of Agency-Initiated Changes/Clarifications:

A statement has been added at N.J.A.C. 10:123A-3.1(c) to clarify that if an applicant's name is placed on a waiting list, the social and financial evaluations (see N.J.A.C. 10:123A-3.2(b) and (c)) shall not be performed until services can be provided to the applicant, in order to assure current accuracy of the information.

Further, at N.J.A.C. 10:123A-4.5(f), a statement has been added clarifying that a consumer who requests an adjustment in fees shall continue to pay the original fee until the dispute is resolved.

The following changes have been made upon adoption for clarification and correction of typographical errors:

In N.J.A.C. 10:123A-3.3, the phrase "individual personal attendant" has been inserted, as a clarification. The Division wishes to take this opportunity to explain the review process which will be provided under these rules. The administrative review provided by N.J.A.C. 10:123A-3.9 is an informal process which will attempt to identify and resolve the issues in dispute. This process may include, for example, a review of papers, telephone contacts and/or a meeting with one or more of the parties. If the matter is not resolved, the right to a formal hearing before the Office of Administrative Law is provided by N.J.A.C. 10:123A-3.10. Typographical errors have been corrected. N.J.A.C. 10:123A-3.9(d) now contains a clarification that requests for administrative hearings may be made by telephone or letter in order to allow the consumer or applicant greater access. Further, a citation to N.J.A.C. 10:120-2, Administrative Hearings, is provided, and duplicative language is deleted. Additionally, the phrase "at a minimum" has been added to N.J.A.C. 10:123A-5.1, to emphasize the minimum requirements for personal attendants.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 123A
PERSONAL ATTENDANT SERVICES PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

10:123A-1.1 Purpose

Pursuant to the provisions of N.J.S.A. 30:4G-13 et seq., the Department of Human Services intends to provide support to individuals with chronic physical disabilities in meeting their daily needs for personal care and assistance with activities of daily living in order to live independently and assure quality of service. The Personal Attendant Services Program has been created to make a wide range of service options available so that choices among these options may be made on the basis of an individual's needs and desires, since people vary widely in their abilities and circumstances.

10:123A-1.2 Scope

These rules apply to all activities and persons participating in the Personal Attendant Services Program, including, but not limited to, the designated State contracting agency, applicants, recipients, personal attendants, and county agencies administering the program, and subcontracted provider agencies.

10:123A-1.3 Standards

(a) Each consumer, and, as appropriate, each applicant, is:

1. To be treated with courtesy, respect, and full recognition of one's dignity, individuality, and right to control one's own household and lifestyle, including the identification and determination of one's own needs, schedules and the services necessary to meet these needs;

2. To be served by personal attendants who are properly trained and competent to perform their duties;

3. To receive services in compliance with all State laws and regulations without discrimination based on race, religion, gender, age, creed or disability in the provision or quality of services;

4. To be free from mental and physical abuse, neglect and exploitation, and to be free from chemical and physical restraints;

5. To be accorded privacy while receiving services, in communications and in all daily activities;

6. To be accorded respect for one's property rights;

7. To have one's personal, financial and medical records treated as confidential;

8. To be free to fully exercise one's civil and due process rights and to be assisted by a personal attendant as appropriate and necessary;

9. To receive in a timely manner all decisions regarding eligibility and amount and kind of services and the reasons therefore in writing and, if appropriate, orally, along with the administrative hearings and appeals procedure;

10. To have access to a fair appeals process through which disputes can be resolved;

11. To receive written information regarding consumer standards and responsibilities in the Personal Attendant Services Program and to have them verbally explained as needed;

12. To have as few personal attendants entering one's home as possible;

13. To have the right to interview, screen and select one's personal attendant; and

14. To terminate those personal attendants that do not respect consumer rights.

10:123A-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context indicates otherwise:

"Advisory Council" means the Advisory Council on Personal Attendant Services, created by N.J.S.A. 30:4G-20.

"Applicant" means a person who applies for services under the Personal Attendant Services Program.

"Assessor" means a person with a master's of social work degree, or a person with a bachelor's degree and three years of experience in rehabilitation services, or a registered nurse with a bachelor of science degree in nursing.

"Available" means physically present, willing, able, and appropriate, as determined with full consideration of the consumer's personal values.

"Chore service" means light housekeeping activities. This service does not include inside or outside maintenance of the dwelling or property.

"Chronic physical disability" means a severe impairment of a permanent nature which so restricts a person's ability to perform essential activities of daily living that the person needs assistance to maintain the person's independence and health.

"Consumer" means an individual who meets the standards of N.J.A.C. 10:123A-2.1, or has received an exemption under N.J.A.C. 10:123A-2.2, and is receiving services.

"Commissioner" means the Commissioner of the Department of Human Services.

"Department" means the Department of Human Services.

"Designated county agency" means a county office on the handicapped or other county agency designated by the county government, subject to approval by the Commissioner, to administer in that county the Personal Attendant Services Program. Approval by the Commissioner is based on the agency's experience in working with the disabled population and the capacity to comply with program requirements, provide information and referral services to disabled individuals, recruit and train personal care attendants and subcontract with provider agencies.

"Designated State agency" means a division or bureau of State government, designated by the Commissioner of the Department of Human Services. The program is currently administered by the Division of Youth and Family Services, Office of Adult and County Social Services.

"Eligible individual" means a person who meets the standards of N.J.A.C. 10:123A-2.1, or who has received an exemption under N.J.A.C. 10:123A-2.2.

"Employment" means full time employment; part time employment; the practice of a profession; volunteer work; self-employment; homemaking; farm work home-based employment; or other gainful work, and includes work for which payment is in kind rather than cash.

"Informal caregiver" means an individual who is 18 years of age or older residing in the household for other than the purpose of sharing expenses.

"Personal attendant" means a person who meets the qualifications with regard to training, equivalent work experience or certification established in these rules (see N.J.A.C. 10:123A-5) and who provides personal attendant services to a person who is eligible for the Personal Attendant Services Program.

"Personal attendant service" includes, but is not limited to, personal care, daily living and chore service.

"Program" means the Personal Attendant Services Program.

"Program administrator" means the professional employee of the designated State agency charged with the administration of the Personal Attendant Services Program.

"Relative" means a person residing in the household, who is 18 years of age or older and is related to the eligible individual by blood or by law.

"Resident" means a person who is a domiciliary of New Jersey for other than a temporary purpose and who has no present intention of moving from the State.

"Self-directing" means a person's ability to make decisions and accept the consequences of his or her own decisions regarding daily activities as well as major life decisions.

"Statement of understanding" means a document which sets forth the terms and conditions of the program and the responsibilities of the consumer under these rules, and the consumer's acceptance of the same.

"Values of the applicant or consumer" means the applicant's or consumer's choices in achieving and maintaining an independent life style.

10:123A-1.5 Target population and priority for services

(a) For the purposes of the Personal Attendant Services Program, the target population is composed of those residents of the State of New Jersey from the age of 18 through the age of 65, who have a chronic physical disability.

(b) Prioritization for service delivery shall be determined by the designated county agency.

SUBCHAPTER 2. ELIGIBILITY

10:123A-2.1 Eligibility standards

(a) For the purposes of the Personal Attendant Services Program, an eligible individual shall meet the following standards:

1. An eligible individual shall be from the age of 18 through the age of 65 and shall have a chronic physical disability;

2. An eligible individual shall be a resident of the State of New Jersey;

3. An eligible individual shall be in need of personal attendant services pursuant to a written personal attendant services plan, prepared by the applicant or consumer, and approved by the staff of the designated county agency;

4. An eligible individual shall be one who is capable of managing and supervising his or her personal attendant services, as determined by an assessment conducted by an assessor;

5. A relative or other informal caregiver shall not be available to provide the services that the eligible individual needs;

6. An eligible individual shall live in a private house or apartment, educational facility, rooming or boarding house, or residential health care facility, and the personal attendant services that the eligible individual receives are supplemental to, and not duplicative of, services provided to the person in the rooming or boarding house or residential health care facility pursuant to licensure requirements;

7. The attending physician for the eligible individual shall confirm in writing that the eligible individual is self-directed and requires no assistance in the coordination of therapeutic regimes, and that the personal attendant services will be adequate and appropriate to meet the eligible individual's needs; and

8. The eligible individual shall require no less than 10 and no more than 40 hours per week of personal attendant services from the program.

10:123A-2.2 Exceptions to eligibility standards

(a) Exceptions to the eligibility standard in N.J.A.C. 10:123A-2.1(a)8 above *[shall be:

1. Initiated by the applicant or consumer;

2. Reviewed on a case-by-case basis by the designated county agency; and

3. Determined by the designated county agency, with notification to the State Program Administrator.]*

***may be granted as follows:**

1. The applicant or consumer must initiate the request for an exception;

2. The designated county agency shall review the request on a case-by-case basis; and

3. The designated county agency shall make the determination whether to allow the exception. The designated county agency shall notify the State Program Administrator and the applicant or consumer of this determination.

(b) Exceptions to the eligibility standard in N.J.A.C. 10:123A-2.1(a)5 above may be granted as follows:

1. The applicant or consumer must initiate the request for an exception;

2. The designated county agency shall review the request on a case-by-case basis. The designated county agency shall make a recommendation to the State Program Administrator as to whether such exception should be allowed; and

3. The State Program Administrator shall make the determination whether to allow the exception. The State Program Administrator shall notify the designated county agency and the applicant or consumer of this determination.*

[(b)]**(c)* *In making the determinations and recommendations on exception requests under (a) and (b) above, the *[The]* designated county agency ***and the State Program Administrator*** shall:

1. Give consideration to the values of the applicant or consumer, in making determinations ***or recommendations*** on exception requests;

2. Require a showing of unusual or emergent circumstances before granting ***or making a positive recommendation on*** an exception request;

3. Make the determination ***or recommendation*** based on funding available;

4. Make the determination ***or recommendation*** based upon other services received by the client or applicant through other funding sources; and

5. Make the determination ***or recommendation*** based upon a review of the facts presented on a case-by-case basis.

10:123A-2.3 Procedures for requesting and granting exceptions to eligibility standards

(a) Eligible individuals or consumers requesting exceptions shall follow the following procedures:

1. Requests for exceptions pursuant to N.J.A.C. 10:123A-2.2***(a) and*** (b) shall be made in writing***[.]**; and***

2. The written request for an exception shall be made to the director of the designated county agency and shall indicate the specific exception requested and provide justification.

(b) The Director of the designated county agency shall review the request and respond to the request within 30 days.

(c) If the request is for an exception under N.J.A.C. 10:123A-2.2(b), the Director of the designated county agency shall thereupon forward his or her recommendation to the State Program Administrator, who shall review the request and respond to the request within 30 days.

SUBCHAPTER 3. SCREENING, SERVICES AND APPEALS

10:123A-3.1 Screening

(a) Upon applicant inquiry to the designated county agency regarding the Personal Attendant Services Program, county agency staff shall elicit information necessary to conduct pre-application screening and shall complete the screening within five working days of applicant inquiry.

(b) The applicant shall be notified in writing within five working days after completion of the county screening as to the results of the applicant's inquiry regarding participation in the Personal Attendant Services Program.

1. If the applicant is determined to be ineligible, the applicant shall be informed in writing of this determination and the right to appeal (see N.J.A.C. 10:120).

2. If the applicant appears eligible as a result of the screening, staff from the designated county agency shall inform the applicant in writing of this determination and ***if funding under the Personal Attendant Services Program is available to provide services to the applicant (see (c) below), shall*** enclose all documents necessary to process the application. The disposition letter shall also advise the applicant that application does not guarantee services under this program.

(c) In the event the applicant appears to be eligible as a result of the screening, and Personal Attendant Services Program funding in the designated county is not presently available to provide services to the applicant, the applicant's name shall be placed on the waiting list maintained by the designated county agency. The social and financial evaluations, under N.J.A.C. 10:123A-3.2(b) and (c), shall not be conducted at this time. Staff from the designated county agency shall inform the applicant in writing of this determination and advise the applicant that the documents necessary to process the application will be forwarded to the applicant and the social and financial evaluations will be performed at the appropriate time. The position of applicant's names on the designated county agency's waiting list shall be determined by the designated county agency.

10:123A-3.2 Assessment

(a) A member of the staff of the designated county agency shall perform an assessment within 30 days upon notification from the applicant to the designated county agency of completion of the application package which includes the following:

1. An Application and Statement of Understanding;

2. An Income Declaration with proof of income;

3. A Physician's Certification; and

4. A Consumer Plan of Service.

(b) Within 30 days of notification from the applicant of the completion of the application package, the county designated assessor shall perform a social evaluation of the applicant to determine if the applicant meets the eligibility criteria.

(c) Within 30 days of notification from the applicant of the completion of the application package, a member of the staff of the designated county agency shall perform a financial evaluation to determine the ability of the person or the person's spouse to pay for personal attendant services according to the sliding fee scale established pursuant to N.J.A.C. 10:123A-4.3.

10:123A-3.3 Individual personal attendant services plan

(a) The ***individual personal attendant*** services plan shall be designed by the consumer to meet his or her specific needs for personal attendant services and negotiated and approved by the consumer and designated county agency.

(b) A personal attendant services plan shall include both of the following:

1. A list of the personal attendant services to be provided; and

2. An estimate of the time needed and frequency of personal attendant services.

(c) The consumer and the designated county agency shall review the plan within 90 days after start-up of services and revise the plan upon request of the consumer or the designated county agency.

(d) The designated county agency shall perform a social and financial evaluation and revise the consumer's cost share responsibilities at 12-month intervals, commencing with the date of eligibility.

10:123A-3.4 Disposition of application

(a) The designated county agency shall notify the applicant in writing within 15 days from the date of completion of the assessment regarding the findings of the social and financial evaluations performed pursuant to N.J.A.C. 10:123A-3.2(a), (b) and (c) and the applicant's right to appeal.

(b) If an applicant is determined eligible, in addition to (a) above the notification shall include the following:

1. An approved plan of service listing the services to be provided including an estimate of the time needed and frequency of personal attendant services;

2. An estimate of the total cost of the personal attendant services; and

3. If applicable, an estimate of the amount of money that the eligible individual or that individual's spouse is required to pay toward personal attendant services.

(c) In the event an applicant is determined eligible for the personal attendant services program and funding prohibits the start-up of services within 30 days from the date of the county agency notification to the applicant regarding the results of the social and financial evaluation performed pursuant to N.J.A.C. 10:133-3.1(a) and (b), such applicant shall be placed on a waiting list for services. An applicant's position on a waiting list shall be determined by the designated county agency.

10:123A-3.5 Services

(a) Services provided to eligible individuals shall be supplemental to and not duplicative of services available through relatives, other informal caregivers or other service programs.

(b) For the purposes of the Personal Attendant Services Program, the following service standards shall be met:

1. Program funds shall not be used for medically related services, including the supervision of registered nurses. It is not the responsibility of the Personal Attendant Services Program to arrange for or provide skilled nursing, therapy, or related medical care and treatment services which the eligible individual may need.

2. Using an attendant as a personal driver may be allowed. In no instance shall any person serving as an attendant under the Personal Attendant Services Program provide driving or transportation services using his or her own vehicle. In addition, the eligible individual's motor vehicle insurance policy must show that the attendant is a fully covered driver under that insurance policy.

3. Personal attendant services provided for the purpose of receiving training or education shall not replace those services provided by an educational institution as mandated by Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794.

10:123A-3.6 Exceptions to service standards

(a) Exceptions to the services standards in N.J.A.C. 10:123A-3.5(a) shall be:

1. Initiated by the applicant or consumer;

2. Reviewed on a case-by-case basis by the designated county agency; and

3. Determined by the designated county agency, with notification to the State Program Administrator.

(b) The designated county agency shall:

1. Give consideration to the values of the applicant or consumer, in making determinations on exception requests;

2. Require a showing of unusual or emergent circumstances before granting an exception request;

3. Make the determination based on funding available;

4. Make the determination based upon other services received by the client or applicant through other funding sources; and

5. Make the determination based upon a review of the facts presented on a case-by-case basis.

10:123A-3.7 Procedures for requesting and granting exceptions to service standards

(a) Eligible individuals or consumers requesting exceptions shall follow the procedures listed below:

1. Requests for exceptions to N.J.A.C. 10:123A-3.5(a) shall be made in writing.

2. The written request for an exception shall be made to the director of the designated county agency and shall indicate the specific exception requested and provide justification.

(b) The director of the designated county agency shall review the request and respond to the request within 30 days.

10:123A-3.8 Termination of service

(a) Termination of service may be either voluntary or involuntary. Voluntary terminations involve verifiable situations in which eligible individuals agree to cessation of services. All other terminations are considered to be involuntary.

(b) Persons terminated from services shall receive written notice from the designated county agency prior to termination.

(c) Involuntary terminations shall be a result of non-compliance with program regulations and procedures which include, but are not limited to:

1. Failure to submit information necessary to determine or reaffirm social and financial program eligibility in a timely fashion;

2. Failure to comply with N.J.A.C. 10:123A-4.3(b) and (g);

3. Verifiable abuse or misuse of personal attendant services;

4. Continued non-acceptance and/or dismissal of personal attendants without proper justification; or

5. Aging out of program eligibility requirements.

10:123A-3.9 Adverse agency actions

(a) An applicant or consumer may request an administrative review of an agency denial, reduction or termination of services, denial of a request for an exemption, or a failure to act upon a request for services within a reasonable time.

(b) If services received or requested are to be denied, reduced or terminated, the county office shall provide written notice and, if appropriate, oral notice to the applicant or consumer at least 30 days prior to such an action.

(c) The written *[ntoice]* ***notice of such adverse action*** shall indicate the reason(s) for the action to be taken, citing the basis for the decision.

(d) In addition, all written notices ***of such adverse action*** shall contain the following statement:

"An applicant to or recipient of the Personal Attendant Services Program, who is dissatisfied with any decision regarding an eligibility determination or other matters pertaining to participation in the Personal Attendant Services Program, may file a request for an administrative review of that decision.

A request for an administrative review must be made within thirty (30) days of the date of written notice of an adverse agency action.

Requests for an administrative review may be made ***by telephone or letter*** to the:

Administrative Hearings Coordinator
Division of Youth and Family Services
CN 717
Trenton, New Jersey 08625-0717
(609) 292-8715"

(e) A request for a review will operate as a stay of any adverse agency action pending the outcome of the administrative review or any subsequent appeal.

(f) Upon completion of the administrative review, the applicant or consumer shall receive a copy of the written decision within 30 days from the date the written request for an administrative review was received by the Administrative Hearings Coordinator.

(g) Applicants or consumers who disagree with the decision of the administrative review may request a hearing before an Administrative Law Judge pursuant to N.J.A.C. 10:123A-3.10. Instructions for such requests shall be incorporated into the written results noted in (d) above.

10:123A-3.10 Hearings and appeals

(a) Hearings under this chapter shall be conducted pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) A hearing may be requested by calling or writing to the:

Administrative Hearings Coordinator
Division of Youth and Family Services
CN 717
50 East State Street
Trenton, New Jersey 08625
(609) 292-8715

(c) In all cases, a hearing must be requested within 30 days of receiving the adverse agency decision noted in N.J.A.C. 10:123A-3.9.

10:123A-3.11 Confidentiality and disclosure of information

(a) All personally identifiable information regarding applicants or consumers under this program obtained or maintained under this program shall be confidential and shall not be released without the written consent of the applicant or consumer or their authorized agent except as noted in (b) and (c) below. In the case of applicants or consumers who have AIDS or are HIV positive, release of any information shall also be subject to the provisions of N.J.S.A. 26:5C-5 et seq.

(b) Disclosure of information without the consent of the applicant, consumer, or his or her authorized agent shall be limited to purposes directly connected with the program pursuant to State law and regulations.

(c) The prohibition of (a) above against unauthorized disclosure shall not be construed to prevent:

1. The release of statistical or summary data or information in which applicants or consumers cannot be identified;

2. The release to the Attorney General or other legal representative of this State of information or files relating to the claim of any applicant, consumer or his or her authorized agent challenging the program's statutory or regulatory authority or a determination made pursuant thereto; or

3. The release of information or files to the State Treasurer or to his or her duly authorized representatives for an audit, review of expenditures, or similar activity authorized by law.

SUBCHAPTER 4. CONTRACTING AND FEES

10:123A-4.1 Contracting for services

(a) The designated county agency shall either:

1. Contract with other service providers, including, but not limited to, private individuals, for the provision of personal attendant services; or

2. Employ individuals as personal attendants where appropriate and shall develop employment policies consistent with N.J.A.C. 10:123A-5 for individuals working as personal attendants.

10:123A-4.2 Provider fees

(a) Fees for services under the Personal Attendant Services Program shall be based on an hourly rate to be paid to the contracting service provider or contracting individual attendant for each hour of personal attendant service provided under this program.

(b) The reimbursement for personal attendant services shall not exceed $11.00 per hour on weekdays and $14.00 per hour on weekends and holidays.

(c) The fee for assessments of eligible individuals shall be $70.00 for each initial assessment authorized by the designated county agency; $35.00 for annual re-assessments; and $20.00 for each follow-up assessment authorized by the designated county agency.

10:123A-4.3 Consumer fees

(a) The consumer fee for personal attendant services shall be based on the ability of the consumer and/or the consumer's spouse to pay for these services. The consumer fee shall apply only to a consumer and that consumer's spouse whose combined annual gross income exceeds the State's applicable income eligibility limit for social services established pursuant to the Social Services Block Grant Act (P.L. 97-35, 42 U.S.C. 1397 et seq.) and set forth at (d) below.

(b) Consumer failure to pay the appropriate consumer fee within 60 days of the date of billing pursuant to the consumer sliding fee scale at (d) below, without good cause, shall be grounds for termination or suspension from the Personal Attendant Services Program.

(c) The consumer sliding fee scale schedule at (d) below shall be applied to eligible individuals and their spouses. The percentage column indicated on the fee scale denotes the percentage of the total cost of the service to be paid by the consumer.

(d) The consumer sliding fee scale is as follows:

CLIENT SLIDING FEE SCALE

Single (One Person)	Family (Size 2)	Family (Size 3)	Family (Size 4)	Family (Size 5)	Percentage
0-15,162	0-19,827	0-24,493	0-29,158	0- 33,823	0%
15,163-18,163	19,828-22,828	24,494-27,494	29,159-32,159	33,824- 36,824	1%
18,164-21,164	22,829-25,829	27,495-30,495	32,160-35,160	36,825- 39,825	2%
21,165-24,165	25,830-28,830	30,496-33,496	35,161-38,161	39,826- 42,826	3%
24,166-27,166	28,831-31,831	33,497-36,497	38,162-41,162	42,827- 45,827	4%
27,167-29,167	31,832-33,832	36,498-38,498	41,163-43,163	45,828- 47,828	5%
29,168-31,168	33,833-35,833	38,499-40,499	43,164-45,164	47,829- 49,829	6%
31,169-33,169	35,834-37,834	40,500-42,500	45,165-47,165	49,830- 51,830	7%
33,170-35,170	37,835-39,835	42,501-44,501	47,166-49,166	51,831- 53,831	8%
35,171-36,171	39,836-40,836	44,502-45,502	49,167-50,167	53,832- 54,832	9%
36,172-37,172	40,837-41,837	45,503-46,503	50,168-51,168	54,833- 55,833	10%
37,173-38,173	41,838-42,838	46,504-47,504	51,169-52,169	55,834- 56,834	11%
38,174-39,174	42,839-43,839	47,505-48,505	52,170-53,170	56,835- 57,835	12%
39,175-39,675	43,840-44,340	48,506-49,006	53,171-53,671	57,836- 58,336	13%
39,676-40,176	44,341-44,841	49,007-49,507	53,672-54,172	58,337- 58,837	14%
40,177-40,677	44,842-45,342	49,508-50,008	54,173-54,673	58,838- 59,338	15%
40,678-41,178	45,343-45,843	50,009-50,509	54,674-55,174	59,339- 59,839	16%
41,179-41,679	45,844-46,344	50,510-51,010	55,175-55,675	59,840- 60,340	17%
41,680-42,180	46,345-46,845	51,011-51,511	55,676-56,176	60,341- 60,841	18%
42,181-42,681	46,846-47,346	51,512-52,012	56,177-56,677	60,842- 61,342	19%
42,682-43,182	47,347-47,847	52,013-52,513	56,678-57,178	61,343- 61,843	20%
43,183-43,683	47,848-48,348	52,514-53,014	57,179-57,679	61,844- 62,344	21%
43,684-44,184	48,349-48,849	53,015-53,515	57,680-58,180	62,345- 62,845	22%
44,185-44,685	48,850-49,350	53,516-54,016	58,181-58,681	62,846- 63,346	23%
44,686-45,186	49,351-49,851	54,017-54,517	58,682-59,182	63,347- 63,847	24%
45,187-45,687	49,852-50,352	54,518-55,018	59,183-59,683	63,848- 64,348	25%
45,688-46,188	50,353-50,853	55,019-55,519	59,684-60,184	64,349- 64,849	26%
46,189-46,689	50,854-51,354	55,520-56,020	60,185-60,685	64,850- 65,350	27%
46,690-47,190	51,355-51,855	56,021-56,521	60,686-61,186	65,351- 65,851	28%
47,191-47,691	51,856-52,356	56,522-57,022	61,187-61,687	65,852- 66,352	29%
47,692-48,192	52,357-52,857	57,023-57,523	61,688-62,188	66,353- 66,853	30%
48,193-48,693	52,858-53,358	57,524-58,024	62,189-62,689	66,854- 67,354	31%
48,694-49,194	53,359-53,859	58,025-58,525	62,690-63,190	67,355- 67,855	32%
49,195-49,695	53,860-54,360	58,526-59,026	63,191-63,691	67,856- 68,356	33%
49,696-50,196	54,361-54,861	59,027-59,527	63,692-64,192	68,357- 68,857	34%
50,197-50,697	54,862-55,362	59,528-60,028	64,193-64,693	68,858- 69,358	35%
50,698-51,198	55,363-55,863	60,029-60,529	64,694-65,194	69,359- 69,859	36%
51,199-51,699	55,864-56,364	60,530-61,030	65,195-65,695	69,860- 70,360	37%
51,700-52,200	56,365-56,865	61,031-61,531	65,696-66,196	70,361- 70,861	38%
52,201-52,701	56,866-57,366	61,532-62,032	66,197-66,697	70,862- 71,362	39%
52,702-53,202	57,367-57,867	62,033-62,533	66,698-67,198	71,363- 71,863	40%
53,203-53,703	57,868-58,368	62,534-63,034	67,199-67,699	71,864- 72,364	41%
53,704-54,204	58,369-58,869	63,035-63,535	67,700-68,200	72,365- 72,865	42%
54,205-54,705	58,870-59,370	63,536-64,036	68,201-68,701	72,866- 73,366	43%
54,706-55,206	59,371-59,871	64,037-64,537	68,702-69,202	73,367- 73,867	44%
55,207-55,707	59,872-60,372	64,538-65,038	69,203-69,703	73,868- 74,368	45%
55,708-56,208	60,373-60,873	65,039-65,539	69,704-70,204	74,369- 74,869	46%
56,209-56,709	60,874-61,374	65,540-66,040	70,205-70,705	74,870- 75,370	47%
56,710-57,210	61,375-61,875	66,041-66,541	70,706-71,206	75,371- 75,871	48%
57,211-57,711	61,876-62,376	66,542-67,042	71,207-71,707	75,872- 76,372	49%
57,712-58,212	62,377-62-877	67,043-67,543	71,708-72,208	76,373- 76,873	50%

58,213-58,713	62,878-63,378	67,544-68,044	72,209-72,709	76,874- 77,374	51%
58,714-59,214	63,379-63,879	68,045-68,545	72,710-73,210	77,375- 77,875	52%
59,215-59,715	63,880-64,380	68,546-69,046	73,211-73,711	77,876- 78,376	53%
59,716-60,216	64,381-64,881	69,047-69,547	73,712-74,212	78,377- 78,877	54%
60,217-60,717	64,882-65,382	69,548-70,048	74,213-74,713	78,878- 79,378	55%
60,718-61,218	65,383-65,883	70,049-70,549	74,714-75,214	79,379- 79,879	56%
61,219-61,719	65,884-66,384	70,550-71,050	75,215-75,715	79,880- 80,380	57%
61,720-62,220	66,385-66,885	71,051-71,551	75,716-76,216	80,381- 80,881	58%
62,221-62,721	66,886-67,386	71,552-72,052	76,217-76,717	80,882- 81,382	59%
62,722-63,222	67,387-67,887	72,053-72,553	76,718-77,218	81,383- 81,883	60%
63,223-63,723	67,888-68,388	72,554-73,054	77,219-77,719	81,884- 82,384	61%
63,724-64,224	68,389-68,889	73,055-73,555	77,720-78,220	82,385- 82,885	62%
64,225-64,725	68,890-69,390	73,556-74,056	78,221-78,721	82,886- 83,386	63%
64,726-65,226	69,391-69,891	74,057-74,557	78,722-79,222	83,387- 83,887	64%
65,227-65,727	69-892-70,392	74,558-75,058	79,223-79,723	83,888- 84,388	65%
65,728-66,228	70,393-70,893	75,059-75,559	79,724-80,224	84,389- 84,889	66%
66,229-66,729	70,894-71,394	75,560-76,060	80,225-80,725	84,890- 85,390	67%
66,730-67,230	71,395-71,895	76,061-76,561	80,726-81,226	85,391- 85,891	68%
67,231-67,731	71,896-72,396	76,562-77,062	81,227-81,727	85,892- 86,392	69%
67,732-68,232	72,397-72,897	77,063-77,563	81,728-82,228	86,393- 86,893	70%
68,233-68,733	72,898-73,398	77,564-78,064	82,229-82,729	86,894- 87,394	71%
68,734-69,234	73,399-73,899	78,065-78,565	82,730-83,230	87,395- 87,895	72%
69,235-69,735	73,900-74,400	78,566-79,066	83,231-83,731	87,896- 88,396	73%
69,736-70,236	74,401-74,901	79,067-79,567	83,732-84,232	88,397- 88,897	74%
70,237-70,737	74,902-75,402	79,568-80,068	84,233-84,733	88,898- 89,398	75%
70,738-71,238	75,403-75,903	80,069-80,569	84,734-85,234	89,399- 89,899	76%
71,239-71,739	75,904-76,404	80,570-81,070	85,235-85,735	89,900- 90,400	77%
71,740-72,240	76,405-76,905	81,071-81,571	85,736-86,236	90,401- 90,901	78%
72,241-72,741	76,906-77,406	81,572-82,072	86,237-86,737	90,902- 91,402	79%
72,742-73,242	77,407-77,907	82,073-82,573	86,738-87,238	91,403- 91,903	80%
73,243-73,743	77,908-78,408	82,574-83,074	87,239-87,739	91,904- 92,404	81%
73,744-74,244	78,409-78,909	83,075-83,575	87,740-88,240	92,405- 92,905	82%
74,245-74,745	78,910-79,410	83,576-84,076	88,241-88,741	92,906- 93,406	83%
74,746-75,246	79,411-79,911	84,077-84,577	88,742-89,242	93,407- 93,907	84%
75,247-75,747	79,912-80,412	84,578-85,078	89,243-89,743	93,908- 94,408	85%
75,748-76,248	80,413-80,913	85,079-85,579	89,744-90,244	94,409- 94,909	86%
76,249-76,749	80,914-81,414	85,580-86,080	90,245-90,745	94,910- 95,410	87%
76,750-77,250	81,415-81,915	86,081-86,581	90,746-91,246	95,411- 95,911	88%
77,251-77,751	81,916-82,416	86,582-87,082	91,247-91,747	95,912- 96,412	89%
77,752-78,252	82,417-82,917	87,083-87,583	91,748-92,248	96,413- 96,913	90%
78,253-78,753	82,918-83,418	87,584-88,084	92,249-92,749	96,914- 97,414	91%
78,754-79,254	83,419-83,919	88,085-88,585	92,750-93,250	97,415- 97,915	92%
79,255-79,755	83,920-84,420	88,586-89,086	93,251-93,751	97,916- 98,416	93%
79,756-80,256	84,421-84,921	89,087-89,587	93,752-94,252	98,417- 98,917	94%
80,257-80,757	84,922-85,422	89,588-90,088	94,253-94,753	98,918- 99,418	95%
80,758-81,258	85,423-85,923	90,089-90,589	94,754-95,254	99,419- 99,919	96%
81,259-81,759	85,924-86,424	90,590-91,090	95,255-95,755	99,920-100,420	97%
81,760-82,260	86,425-86,925	91,091-91,591	95,756-96,256	100,421-100,921	98%
82,261-82,761	86,926-87,426	91,592-92,092	96,257-96,757	100,922-101,422	99%
82,762-83,762	87,427-87,927	92,093-92,593	96,758-97,258	101,423-101,923	100%

(e) Each consumer and that consumer's spouse shall provide verification of his or her income for determination of applicable fees upon application to the Personal Attendant Services Program and annually thereafter.

1. Acceptable verification includes, but is not limited to, pay stubs, W-2 forms or photostatic copies of the actual 1040 form filed with the Internal Revenue Service, business records, pension statements and/or correspondence from employers or agencies (for example, Social Security Administration, State employment agencies).

(f) If the costs of an eligible individual's personal attendant services are covered in whole or in part by another State or Federal government program or insurance contract, the government program or insurance carrier shall be the primary payer and the Personal Attendant Services Program shall be the secondary payer.

(g) The consumer receiving personal attendant services shall sign weekly vouchers attesting to the hours of service rendered, and the personal attendant or provider agency shall then be paid by the designated county agency.

10:123A-4.4 Standards for adjustments in consumer fees

(a) Adjustments in consumer fees shall be based on verifiable increased or decreased expenses which result from the consumer's disability which may include, but are not limited to, items such as:

1. Unreimbursed or unreimbursable medical expenses;
2. Transportation expenses;
3. Adaptations to home or vehicle; or
4. Unreimbursed or unreimbursable additional hours of personal attendant services over and above those hours authorized to the consumer by this program, if certified as necessary by the designated county agency.

(b) Adjustments in consumer fees may also be considered when the following verifiable expenses are increased or decreased:

1. College tuition;
2. Alimony/child support; or
3. Emergency home repair expenses.

(c) Adjustments in consumer fees shall be re-evaluated annually or more frequently if necessary.

10:123A-4.5 Procedures for requesting adjustments in consumer fees

(a) A consumer requesting adjustments in consumer fees shall submit a written request and justification to the designated county agency.

(b) Upon receipt of a written request and justification for a consumer fee adjustment, the designated county agency shall review the request and submit to the State Program Administrator materials pertaining to the request along with a recommendation regarding the appropriateness of the request and the amount of the adjustment.

(c) Upon receipt of the information described in N.J.A.C. 10:123A-4.5(b), the State Program Administrator shall review the request and recommendation and render a decision based on the facts presented.

(d) Upon receipt of a decision by the designated county agency from the State Program Administrator, the consumer shall be provided written notice regarding the disposition of the request for an adjustment in consumer fee.

(e) Adjustments in consumer fee which are approved shall be effective as of the first day of the calendar month succeeding the month in which the written request is received by the designated county agency.

(f) A consumer requesting adjustment in his or her consumer fee shall continue to pay the original percentage of the total cost of service assessed pursuant to N.J.A.C. 10:123A-4.3(a), (b), (c), and (d), pending the consumer's submission of written justification under N.J.A.C. 10:123A-4.5(a) and (b) and approval by the State Program Administrator of the consumer's request for an adjustment under N.J.A.C. 10:123A-4.5(c).

SUBCHAPTER 5. PERSONAL ATTENDANTS

10:123A-5.1 Requirements for personal attendants

(a) All persons desiring to serve as personal attendants under the Personal Attendant Services Program shall be at least 18 years of age and shall meet at least one of the following requirements:

1. The personal attendant shall complete an approved training course authorized by the State Board of Nursing as a homemaker/home health aide, or a long-term facility nurse aide course authorized by the Department of Health;

2. The personal attendant shall complete a certified training program in a hospital, rehabilitation facility, or a long-term care facility as an aide or personal attendant;

3. The personal attendant shall complete a training course offered by the Department of Human Services for personal attendants; or

4. The personal attendant shall have at least one year of experience in the provision of personal attendant services for adults.

(b) Personal attendants who have not completed the training program described in (a)3 above shall be required to complete***, at a minimum,*** a training session on the philosophy of the personal attendant service program.

(c) Personal attendants shall have a current liability policy which covers personal injury and/or property damage, prior to employment. This liability policy shall be paid for by the attendant, when he or she is under an independent vendor contract with the county, or by the provider agency, when the attendant is an agency employee.

SUBCHAPTER 6. TRAINING (RESERVED)

SUBCHAPTER 7. COMPLIANCE WITH LAWS

10:123A-7.1 Requirements of designated county agency

(a) All designated county agencies shall abide by all laws and regulations concerning employment of persons hired to administer or work in the Personal Attendant Services Program including, but not limited to, the Rehabilitated Convicted Offenders Act, N.J.S.A. 2A:168A-1 et seq., and the Immigration Reform and Control Act of 1986 (P.L. 99-603).

(b) All designated county agencies shall conduct a check, or form an agreement with providers with whom they contract to conduct a check, that satisfies them as to the appropriateness of each personal attendant.

(c) All designated county agencies shall establish a separate accounting regarding receipt and use of cost share monies collected to ensure that cost share monies are used to expand or enhance program services in that county. These funds shall not supplant any existing allocation. This separate accounting and supporting documentation shall be made available to the designated State agency.

10:123A-7.2 Duties of designated county agency

(a) Under the direction of the designated State agency, the designated county agency shall perform the following duties:

1. Ensure that the operation and performance of the county's personal attendant service program is in compliance with law and rules as specified by the Division;

2. Provide information and outreach for the personal attendant services program;

3. Complete the necessary forms to determine eligibility of applicants and provide appropriate assistance to applicants and consumers in completing all necessary forms;

4. Determine cost share amount when applicable;

5. Maintain and up-date individual consumer files;

6. Designate a staff person to serve as primary contact person for applicants, eligible individuals, consumers and attendants involved in the program and document such contacts;

7. At the request of eligible individuals or consumers, arrange for attendant services and upon request of the consumer, provide individual assistance in arranging for back-up attendant services. The back-up plan shall be coordinated and mutually agreed upon by the consumer and the designated county agency;

8. Refer persons to other agencies, programs and services for which they may be eligible;

9. Maintain fiscal records for the program or provide data for others to do so;

10. Prepare monthly reports for timely submission to the designated State agency;

11. Serve as liaison to the designated State agency for the program; and

12. Oversee the local program including verification of weekly vouchers signed by eligible individuals and attendants attesting to hours of services rendered.

10:123A-7.3 Duties of Advisory Council

(a) The Advisory Council shall:

1. Serve as a resource to the Commissioner on matters pertaining to personal attendant services, and the development, implementation and evaluation of such services;

2. Advise the designated State agency on issues relevant to the development, implementation and evaluation of the Personal Attendant Services Program;

3. Evaluate the effectiveness of the personal attendant services program in meeting its objectives and share that evaluation with the Commissioner; and

4. Implement the above through utilization of stenographic and clerical staff, administrative assistants, and other such professional staff as provided by the Department.

10:123A-7.4 Designated county agency disqualification

(a) A designated county agency may be disqualified from participation in Personal Attendant Service Program funding for good cause including, but not limited to, the following:

1. Failure or refusal to comply with program rules and/or contract requirements; or

2. Refusal to furnish the designated State agency with required reports, or to make available for review such files and records as required.

(b) The designated State agency shall provide a 60-day written notice to the designated county agency if it intends to pursue disqualification. The notice shall specify the designated State agency's reasons for such action, and shall specify corrective actions required. A copy of this notice shall also be sent to the Advisory Council.

(c) The process of designated county agency disqualification should not result in loss or interruption of services to those eligible individuals currently receiving services.

10:123A-7.5 Disqualification appeal process

If the designated State agency seeks to disqualify a designated county agency for failure to comply with N.J.A.C. 10:123A-6.3(a)1 and 2, said designated county agency shall be afforded an opportunity to request an administrative hearing, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

LABOR

(a)

OFFICE OF WAGE AND HOUR COMPLIANCE

Wage and Hour

Employment of Learners; Sub-minimum Wage

Adopted Repeal and New Rules: N.J.A.C. 12:56-10

Proposed: June 15, 1992 at 24 N.J.R. 2129(b).

Adopted: July 27, 1992 by Raymond L. Bramucci, Commissioner, Department of Labor.

Filed: July 27, 1992 as R.1992 d.328, **without change.**

Authority: N.J.S.A. 34:1-20; 34:1A-3(e); 2A:150A-1; and 34:11-56(a), specifically 34:11-56a17.

Effective Date: August 17, 1992.

Expiration Date: September 26, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

SUBCHAPTER 10. EMPLOYMENT OF LEARNERS; SUB-MINIMUM WAGE

12:56-10.1 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Good cause" means any violation of any Federal or New Jersey labor law or regulation, or any Federal or New Jersey law or regulation pertaining to discrimination in the work place.

"On-the-job training" means training that is offered to an individual while employed in productive work that provides training, technical and other related skills, and personal skills that are essential to the full and adequate performance of such employment.

"Special learner permit" means authorization to employ a learner at wages no less than 85 percent of the current minimum wage for such period of time as listed at N.J.A.C. 12:56-3.1.

12:56-10.2 Application for permit

(a) Application for a special learner permit shall be filed for each learner on properly executed prescribed forms with the Office of Wage and Hour Compliance, Division of Workplace Standards of the Department of Labor. Such forms may be obtained from the Office of Wage and Hour Compliance.

1. The application shall include a description of the training program to be conducted by the employer, proof that the learner is 20 years old or younger and a certification by the employer that the learner shall be employed for not less than 14 calendar days and not more than 90 calendar days or for 480 hours of work, whichever comes first, at a training wage of not less than 85 percent of the current minimum wage. In addition, the employer must indicate on the application that it has complied with all of the requirements under the criteria for a permit as provided in N.J.A.C. 12:56-10.3.

12:56-10.3 Criteria for permit

(a) The criteria used in issuing a special learner permit shall be:

1. The employee shall not be older than 20 years of age; and

2. The employee shall be employed for not less than 14 calendar days and not more than 90 calendar days or for 480 hours of work, whichever comes first, at a training wage of not less than 85 percent of the current minimum wage, subject to the following conditions:

i. The employee is immediately provided with a copy of the rules regarding employment of learners at sub-minimum wages;

ii. No other employee has been laid off from the position or a substantially equivalent position;

iii. No other employee has been terminated or had his or her hours of work, wages, benefits, or employment conditions reduced or changed for the purpose of hiring an employee under 20 years of age or any other individual at the training wage;

iv. The employee is not a migrant or seasonal agricultural worker admitted to the United States under the H-2 A Program;

v. The employee has not previously been employed by the current employer at the training wage for up to 90 calendar days;

vi. The employee has furnished the employer with proof of age and a signed statement or documentation about the starting and ending dates of previous employment since January 1, 1992, and the hourly wages they earned, or if none, a signed statement to that effect;

vii. The employee is given information on the hours of work and the type of work permitted under Federal, State, and local child labor laws;

viii. The total number of hours worked by all employees paid at the training wage in any month does not exceed 25 percent of the total number of hours worked by all employees in the establishment. It is the employer's responsibility to assure the training wages do not exceed the 25 percent statutory limitations; and

ix. The employment provided by the employer shall not consist primarily of menial work.

(b) If the employee is age 20 or under and has been employed for up to 90 calendar days at the training wage, the employee may be employed at the training wage for up to an additional 90 calendar days provided that all of the conditions mentioned above are met and that:

1. The employer is not the employer who employed the worker for the initial training period;

2. The employer provides on-the-job training to each worker under the training program;

3. The employer provides a written copy of the on-the-job training program to the employee and retains a copy for the file; and

4. The employer posts in the establishment a notice of the types of jobs for which on-the-job training is being provided, and sends a copy of the same to the New Jersey Department of Labor, Division of Workplace Standards, Office of Wage and Hour Compliance annually.

(c) Unless the employer complies with (b)1 through 4 above, then the employee shall be paid the minimum wage if he or she is age 20 or under and has been employed for up to 90 calendar days at the training wage.

12:56-10.4 Compliance

(a) All terms and conditions shall be complied with under which a special learner permit is granted.

(b) No individual who is not a learner shall be employed under a special learner permit at wages lower than the minimum required by this chapter.

(c) Any violation of the provisions of this subchapter shall be considered a violation of the Wage and Hour Regulations, under N.J.A.C. 12:56-1.2, Violations, and the employer shall be subject to the administrative penalties under N.J.A.C. 12:56-1.3, and the administrative fees under N.J.A.C. 12:56-1.4.

12:56-10.5 Cancellation of permit

(a) The Commissioner or his or her designee may cancel any special learner permit for cause as outlined in (b) below.

(b) A special learner permit may be cancelled:

1. As of the date of issuance, if it is found that fraud has been exercised in obtaining the special learner permit or in permitting a learner to work thereunder;
2. As of the date of violation, if it is found that any provisions of the Act, or of the terms of the special learner permit, have been violated;
3. As of the effective date of revocation, if the Commissioner or his or her designee, for good cause, revokes the special learner permit; or
4. As of the effective date of cancellation, if in the judgment of the Commissioner or his or her designee, the special learner permit is no longer in the best interests of the employees covered.

PUBLIC UTILITIES

(a)

BOARD OF REGULATORY COMMISSIONERS OFFICE OF CABLE TELEVISION

Regulations of Cable Television Interest on Uncorrected Billing Errors

Adopted Amendment: N.J.A.C. 14:18-3.19

Proposed: April 30, 1992, at 24 N.J.R. 1470(b).
Adopted: July 8, 1992, by Celeste M. Fasone, Director, Office of Cable Television, with the approval of the Board of Regulatory Commissioners, Dr. Edward H. Salmon, Chairman.
Filed: July 17, 1992 as R.1992 d.319, **without change.**

Authority: N.J.S.A. 48:5A-10.

Effective Date: August 17, 1992.
Expiration Date: July 26, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

A public hearing concerning the proposal was held on May 5, 1992 by the Board of Regulatory Commissioners at Two Gateway Center, Newark, N.J. No one testified at that time.

Full text of the adoption follows:

14:18-3.19 Interest on uncorrected billing errors
(a) (No change.)
(b) The interest rate shall be equal to the average yields on new six-month Treasury Bills for the 12-month period ending each September 30. Said rate shall become effective on January 1 of the following year.
(c) (No change.)

TREASURY-GENERAL

(b)

OFFICE OF THE TREASURER

Notice of Administrative Correction

Charitable Fund-Raising among Employees of Local Units of Government

Distribution of Contributions

N.J.A.C. 17:29-4.7

Take notice that the Department of Treasury has discovered an error in the text of N.J.A.C. 17:29-4.7(b). As originally adopted on an emergency basis, and concurrently proposed (see 17 N.J.R. 2294(a), effective August 16, 1985), this subsection reads as follows, reiterating the requirements of N.J.S.A. 52:14-15.9c12c:

(b) Undesignated contributions shall be distributed to participating or nonparticipating charitable fund-raising organizations or charitable agencies in such amounts as the local Campaign Steering Committee shall determine.

However, in the adoption of the concurrent proposal (see R.1985 d.577, 17 N.J.R. 2785(a)) and the subsequent incorporation of the permanent rule into the New Jersey Administrative Code, the text of N.J.A.C. 17:28-4.7(b), governing distribution of contributions for the State employee charitable campaign, was inadvertently substituted for the text of N.J.A.C. 17:29-4.7(b). In order to correct this erroneous adoption, and to conform the requirements of the subsection to N.J.S.A. 52:14-15.9c12c, this notice of administration correction is published pursuant to N.J.A.C. 1:30-2.7.

Full text of the corrected rule follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

17:29-4.7 Distribution of contributions
(a) (No change.)
(b) Undesignated contributions shall be distributed to participating **or nonparticipating** [campaign] **charitable fund-raising** organizations **or charitable agencies** in [the same proportion that these organizations received designated funds] **such amounts as the local Campaign Steering Committee shall determine.**

OTHER AGENCIES

(c)

CASINO CONTROL COMMISSION

Rules of the Games Blackjack; Splitting Pairs

Adopted Amendment: N.J.A.C. 19:47-2.11

Proposed: May 18, 1992 at 24 N.J.R. 1872(a).
Adopted: July 16, 1992 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: July 20, 1992 as R.1992 d.320, **without change.**

Authority: N.J.S.A. 5:12-63, 69, 70(f) and 100(e).

Effective Date: August 17, 1992.
Expiration Date: April 28, 1993.

Summary of Public Comment and Agency Response:
COMMENT: Resorts International Hotel, Inc. (Resorts) and Adamar of New Jersey, Inc. (TropWorld) support the proposed amendment, as published. Greate Bay Hotel and Casino (Sands) and the Division of Gaming Enforcement have no objection to adoption of the proposed amendment.
RESPONSE: Accepted.

Full text of the adoption follows:

19:47-2.11 Splitting pairs
(a)-(d) (No change.)
(e) Notwithstanding the provisions of (c)1 above, a casino licensee may, at its discretion, permit a player to split pairs up to three times (a total of four hands) at a blackjack table with up to six player boxes or twice (a total of three hands) at a blackjack table with seven player boxes if notice of the option is provided as set forth in N.J.A.C. 19:47-8.3. If a casino licensee elects to offer this option, it may, at its discretion, prohibit a player from splitting a pair of aces more than once (a total of two hands) if notice is provided as set forth in N.J.A.C. 19:47-8.3. All other requirements of this section shall apply to each hand which is formed as a result of splitting pairs more than once.

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF PARKS AND FORESTRY
OFFICE OF NEW JERSEY HERITAGE

Procedures Concerning the New Jersey Register of Historic Places

Adopted New Rules: N.J.A.C. 7:4

Proposed: July 15, 1991 at 23 N.J.R. 2103(b).
Adopted: July 15, 1992 by Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.
Filed: July 15, 1992 as R.1992 d.318, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 13:1B-3, 13:1D-9, and 13:1B-15.128 et seq.

DEPE Docket Number: 025-91-06.
Effective Date: August 17, 1992.
Expiration Date: August 17, 1997.

Summary of Public Comments and Agency Responses:

On July 15, 1991, the Department of Environmental Protection and Energy (the "Department") proposed new rules, N.J.A.C. 7:4. The rules establish procedures for the listing of historic properties in the New Jersey Register of Historic Places (the "New Jersey Register") and the protection of those historic properties from "encroachment by undertakings of State, county, municipal governments or any agency or instrumentality thereof," in accordance with the New Jersey Register of Historic Places Act, N.J.S.A. 13:1B-15.128 et seq. In large part, the rules codify procedures, standards, and policies presently used by the Department for implementing the New Jersey Register of Historic Places Act. The Department received comments from the following people and agencies:

Burlington County Board of Chosen Freeholders
Kevin Hale, Esq.
Heritage Studies, a preservation consulting firm
Hunterdon County Planning Board
Montgomery Landmarks Commission
New Jersey Department of Transportation (NJDOT)
New Jersey Pinelands Commission
Van Harlingen Historical Society of Montgomery

The period to submit comments ended on September 13, 1991. A summary of the comments and the Department's responses follow. The comments and responses follow the order of the rules.

COMMENT: Heritage Studies was concerned that the estimated cost of preparing New Jersey Register of Historic Places nomination forms was stated in specific dollar amounts rather than in general terms, since inflation or changes in requirements for preparation of nomination forms might affect fees charged by consultants.

RESPONSE: The Department believes that it is most fair to the public to provide specific cost estimates for preparing nominations. A range of potential fees has been given based on consultant charges for different types of projects over the last several years. The Department believes the estimates are reasonably accurate. The final published rules will not include the Economic Impact section, in which the specific dollar figures were included.

COMMENT: NJDOT noted that the New Jersey Register of Historic Places Act referenced "areas, sites, structures, and objects" but not buildings, per se. Therefore NJDOT suggested that buildings be included under the definition of "structures."

RESPONSE: The Department has changed the definitions to indicate that a building is a form of a structure. There is no substantive impact from this change.

COMMENT: NJDOT suggested that the definitions of "contributing property" and "noncontributing property" should be changed to refer only to their use in distinguishing properties within a district, not within a property, which is a more general term encompassing both districts and buildings.

RESPONSE: The more general term "property" is used since the Department and the National Park Service also evaluate buildings as contributing or noncontributing when examining a small group of buildings consisting of a main building and subsidiary buildings that are functionally and historically related, such as a house and barn. Such a small group of buildings falls under the category of "building(s)" rather than "district" according to the definitions used by the Department and the National Park Service. To further clarify and remove any possibility of confusion between "contributing property," "noncontributing property," and "building(s)," the Department has removed from the proposed definition of "building(s)" the requirement that buildings in a related group must all be contributing in order for the group to be classified as buildings.

COMMENT: Heritage Studies noted that the definition of "historic preservation review commission" included approval by the Department and the National Park Service, approvals which are only needed for Certified Local Government commissions.

RESPONSE: The Department agrees. Reference in the rules to "adopted by the local governing body and approved by the Department and the National Park Service" has been deleted. Instead, the Department has clarified that the term means a commission created by municipal ordinance pursuant to the State's Municipal Land Use Law. This clarification corrects a technical oversight, and has no substantive impact.

COMMENT: Kevin Hale suggested that the definition of "local government" could be construed to exclude townships and villages and also suggested that "municipality" was not an official form of local government recognized by statutes.

RESPONSE: The Department has added the words "village" and "township" in the definition of "local government." The Department disagrees with the suggestion that the term "municipality" should be excluded from the definition of "local government." The term is in common usage to describe a form of local government and does not conflict with any of the other examples given in the definition.

COMMENT: Kevin Hale suggested adding a definition of the "National Park Service" since that agency was frequently mentioned in the proposed rules.

RESPONSE: The Department agrees and has added a definition of the "National Park Service" to the rules.

COMMENT: Kevin Hale suggested substituting the term "State Register" for "New Jersey Register" because he thought there would be confusion between the "New Jersey Register" (of Historic Places) referred to in the proposed rules and the New Jersey Register, a publication of the Office of Administrative Law.

RESPONSE: The Department believes that the context of rules for historic properties is so different from the use of the New Jersey Register that confusion is unlikely to arise. Further, the rules should be consistent with the New Jersey Register of Historic Places Act, which refers throughout to the "New Jersey Register of Historic Places."

COMMENT: Kevin Hale suggested adding a definition of "National Act" to eliminate the need to refer to the "National Historic Preservation Act" throughout the rules.

RESPONSE: The Department believes that the term "National Act" would be too vague and that use of the term "National Historic Preservation Act" is not cumbersome.

COMMENT: Kevin Hale noted a typographical error in the definition of "National Register Nomination Form"; an apostrophe was omitted from the word "Services".

RESPONSE: In the definition of "National Register Nomination Form" an apostrophe has been added to the word "Services," so that the word correctly reads: "Service's."

COMMENT: Kevin Hale suggested adding a definition of the "Office of New Jersey Heritage" since that office was frequently mentioned in the proposed rules.

RESPONSE: The Department agrees and has added a definition of the "Office of New Jersey Heritage."

COMMENT: Heritage Studies noted that while the proposed rules call for the State Historic Preservation Officer to establish Statewide priorities for preparation and submittal of nominations to the New Jersey and National Registers in accordance with the State Historic Preservation Plan, no definition of the "State Historic Preservation Plan" was provided in the rules.

RESPONSE: The Department agrees that such a definition would be useful and therefore has added a definition of the "State Historic Preservation Plan."

COMMENT: The Burlington County Board of Freeholders commented that the explanation of "indirect effect," found in the definition

of "undertaking," was so nebulous in nature that all projects would fall under the purview of the proposed rules. Further, the County suggested that since indirect effects were not quantifiable, reviewable undertakings should be limited to those with direct effects.

RESPONSE: The Department recognizes the commenter's concern that the definition of "undertaking," or the phrase "indirect effect" included in that definition, may cause uncertainty in administering and complying with the rules. However, the Department believes that the rules as proposed address the commenter's concern. First, the definition describes indirect effects as those caused by the undertaking, that are farther removed in distance or later in time, but still reasonably foreseeable. The definition then provides examples of indirect effects. Further, the definition provides examples of types of actions that would be considered undertakings and types of actions that would not be considered undertakings.

There is no requirement that direct or indirect effects be quantified. In addition, the Department disagrees with the commenter's suggestion that only those undertakings with direct effects should be reviewable. The suggestion would unacceptably narrow the scope of the rule, by allowing a substantial portion of actions affecting the characteristics of historic properties to be taken without any review. Frequently, an action will foreseeably affect the characteristics of a historic property, though the effect will not occur at the same place and time as the undertaking; if the Department implemented the commenter's suggestion, those actions would pass unreviewed despite the foreseeable effect.

COMMENT: NJDOT suggested that in the definition of "undertaking," the Department reconsider the exemption of "changes in local zoning ordinances" from undertakings.

RESPONSE: The Department disagrees. The New Jersey Register of Historic Places Act applies to actions of public entities, not local ordinances governing private actions. There would be no statutory basis to require Departmental authorization of changes in local zoning ordinances.

COMMENT: The Pinelands Commission commented that the changes embodied in Subchapter 2, Registration Procedures and Criteria, would speed up the registration process and eliminate redundancies in the parallel reviews by the State Historic Preservation Officer of National Register and New Jersey Register nominations.

RESPONSE: The Department agrees.

COMMENT: NJDOT commented that references to the "State Historic Preservation Officer" in the rules (Subchapters 2 through 5) were inconsistent with the New Jersey Register of Historic Places Act and should be changed to the "Commissioner" (of the Department of Environmental Protection and Energy).

RESPONSE: The Department disagrees. The term "State Historic Preservation Officer" is used for the sake of clarity wherever the procedures for the New Jersey and National Register are integrated. The definition of "State Historic Preservation Officer" clearly states that the term means the Commissioner of the Department of Environmental Protection and Energy. Further, the dual role of the Commissioner, as State Historic Preservation Officer, is clearly explained in proposed N.J.A.C. 7:4-2.1(a) and (d).

COMMENT: Kevin Hale thought that the Administrator of the Office of New Jersey Heritage should be designated as the "Keeper of the New Jersey Register of Historic Places," in order to parallel the Federal position of "Keeper of the National Register of Historic Places."

RESPONSE: The Department disagrees. The New Jersey Register of Historic Places Act specifies that the Commissioner of the Department of Environmental Protection (and Energy) shall administer the nomination and approval of properties for listing in the New Jersey Register of Historic Places. The Commissioner, as State Historic Preservation Officer, is also responsible for recommending nominations for inclusion in the National Register of Historic Places by his or her signature on the nomination.

COMMENT: NJDOT expressed concern that there was not a mechanism for State, county, or municipal property owners to be notified of an impending nomination and approved registration. NJDOT noted that in the past NJDOT and counties have not received notice of impending nominations.

RESPONSE: The rules require the Department to make notifications and the Department acted in that fashion in the past. The Department has always notified all known property owners from a list attached to the nomination form. The Department believes that the new requirement in the rules for a nomination to contain an up-to-date list of property owners named in municipal tax records and notarized by the appropriate municipal official will substantially eliminate any of the past problems alluded to by NJDOT. The Department has also strengthened the wording of proposed N.J.A.C. 7:4-2.2(c)4 and 7.1(d) by changing "list of property owners" to "list of all private and public property owners (including right-of-way owners)" and by changing "municipal tax records" to "municipal tax records and maps."

COMMENT: Kevin Hale noted an error in proposed N.J.A.C. 7:4-2.2(c)7, line eight (23 N.J.R. 2107), where a citation, "N.J.A.C. (c)2" is incomplete.

RESPONSE: In proposed N.J.A.C. 7:4-2.2(c)7, the citation "N.J.A.C. (c)2" has been corrected to read "N.J.A.C. 7:4-2.2(c)21".

COMMENT: Heritage Studies suggested that notices of nominated properties include the time and place, in addition to the date, of State Review Board meetings.

RESPONSE: For clarity, the Department has added the words "time and place" to proposed N.J.A.C. 7:4-2.2(c)9 and the words "on a specific date, time and place" to proposed N.J.A.C. 7:4-2.2(c)10.

COMMENT: NJDOT suggested that when a nomination has more than 50 property owners the Department should notify all property owners by direct mail, rather than by published public notice as allowed in proposed N.J.A.C. 7:4-2.2(c)9, due to "literacy, language, health or other problems."

RESPONSE: The Department disagrees. The option of a less unwieldy but still effective means of notification through a general published notice is allowed in the Federal National Register regulations for nominations with more than 50 owners. There is a high likelihood of full public awareness of a pending district nomination due to the additional requirement in proposed N.J.A.C. 7:4-2.2(c)12 that the Department hold a public hearing for a district of 50 or more property owners and that public notice also be provided for said hearing. However, to ensure that general public notice of the nomination received sufficient visibility, the following sentence has been added to N.J.A.C. 7:4-2.2(c)9: "Such public notice must be published in one or more local newspapers of general circulation in the area of the nomination."

COMMENT: The Hunterdon County Planning Board felt that county planning boards should be notified directly of proposed historic districts. In addition, the Board suggested that the rules specifically require a map of a proposed district be sent with all district notifications.

RESPONSE: The Department disagrees. The rules require notice not only to owners but to the chief elected local official of both the county and municipality, who can then distribute the notice to concerned county or municipal agencies or boards such as planning boards. The Department feels that such notice is both efficient and sufficient. However, to answer this concern the Office of New Jersey Heritage will amend its standard letter of notice to recommend that planning boards and historic preservation commissions receive distributed copies of the notice. The Department agrees that the notice of a historic district nomination which is sent to a county municipality should include a map in order to assist with local and regional planning. This has been the Department's past practice. The Department has revised proposed N.J.A.C. 7:4-2.2(c)10 to indicate that a map of a nominated historic district will be sent to the county and municipality as part of their notice. A map will not be routinely sent to private property owners as they do not have responsibility for local and regional planning.

COMMENT: NJDOT was concerned that the proposed rules provided for consideration of owner objections only from private owners and only with regards to National Register listing.

RESPONSE: The Department believes that the proposed wording is justifiable. To allow owner objection and prevention of listing in the rules would not be authorized under the New Jersey Register of Historic Places Act. Allowing a public owner of a nominated property to object and prevent listing on the New Jersey Register would undermine the very protection of historic properties that the New Jersey Register of Historic Places Act intended in N.J.S.A. 13:18-15.131.

COMMENT: NJDOT noted that the rules have no requirement for regular meetings of the State Review Board and that there is no guarantee that action will be taken on a nomination at a given meeting.

RESPONSE: The minimum number of meetings per year (three) of the State Review Board is determined by Federal regulations. The Department cannot require that action be taken on a nomination as the State Review Board may table a nomination, pending receipt of more information, or at the applicant's request.

COMMENT: The Pinelands Commission suggested that in proposed N.J.A.C. 7:4-2.4, the Pinelands Commission should be provided notice of registration in the New Jersey Register of any sites in the Pinelands

Area. The Commission also suggested that since New Jersey Register properties automatically become Pinelands Designated and subject to the standards of the Comprehensive Management Plan, notice should be given to owners of properties in the Pinelands Area that additional conditions apply pursuant to the Pinelands Protection Act.

RESPONSE: The Department agrees, in part. Because of the difficulty in determining overlapping boundaries, the Department simply proposes adding the following sentence to proposed N.J.A.C. 7:4-2.4(a): "Notification of all registrations in counties under the jurisdiction of the Pinelands Commission shall also be sent to the Pinelands Commission." With regards to notice to owners of registered properties in the Pinelands Area of Pinelands Commission requirements, the Department will add mention of those requirements to the general text used for all notices of registration, rather than introducing a change to the proposed rules requiring specific notice to owners in the Pinelands.

COMMENT: NJDOT and Kevin Hale suggested that proposed N.J.A.C. 7:4-2.6 should be more explicit in requiring annual updating and publication of the New Jersey and National Registers.

RESPONSE: The Department agrees that the rules could be more explicit, but feels that updating and publishing the New Jersey and National Registers every two years would be more reasonable. Therefore, in proposed N.J.A.C. 7:4-2.6 the word "regularly" has been deleted and "every two years" has been added.

COMMENT: NJDOT suggested that proposed N.J.A.C. 7:4-2.7, which allows the State Historic Preservation Officer to not make available specific information on the location of properties proposed to be registered, would be unreasonably restrictive in certain instances.

RESPONSE: Proposed N.J.A.C. 7:4-2.7 would allow a State agency, such as NJDOT, access to specific information on the location of a nominated property. For clarification, the Department has added to the proposed rules that the State Historic Preservation Officer may not disclose information "if the State Historic Preservation Officer determines that the disclosure of specific information would create a risk of destruction or harm to such properties."

COMMENT: NJDOT suggested that the proposed rules include a procedure for establishing updated boundaries for earlier nominations with boundaries that were not explicit.

RESPONSE: The Department agrees. Therefore, in proposed N.J.A.C. 7:4-3.1(a) the Department has added that the boundary of a property listed in the New Jersey Register may be redelineated if the original delineation is inadequate to determine boundary limits. In proposed N.J.A.C. 7:4-3.1(b) and (c) the Department has added a simpler process for redelineating boundaries in these cases.

COMMENT: NJDOT made two related comments on proposed N.J.A.C. 7:4-3.2 regarding relocation of properties listed in the New Jersey Register. NJDOT noted that the wording of 7:4-3.2(a) might imply restrictions on relocations of registered properties by private owners and that the wording also suggested that when an encroachment will require the taking of a listed property then it must be moved to preserve it.

RESPONSE: In the interest of clarity the Department has made the wording of proposed N.J.A.C. 7:4-3.2(a) clearly advisory by deleting the word "shall" in two places and instead using the words "encourages" and "should." Also, proposed N.J.A.C. 7:4-7.2(e)2ii allows consideration of "whether or not feasible and prudent alternatives to the encroachment exist."

COMMENT: NJDOT suggested that proposed N.J.A.C. 7:4-3.2(e)3 require a reproduction of a United States Geological Survey Map, rather than the actual map, in the application for continued listing after relocation of a property, due to the cost to the applicant and storage problems at the Office of New Jersey Heritage.

RESPONSE: The Department disagrees. Requisite visual clarity is lost with reproductions of such maps and the cost of several dollars is relatively minimal. There is no storage problem for such maps in the National Register files at the Office of New Jersey Heritage.

COMMENT: NJDOT objected to proposed N.J.A.C. 7:4-4.1(c), which states that property listed in the New Jersey Register five years prior to the effective date of the proposed rules shall only be removed from the New Jersey Register on the grounds that the property has lost the qualities that caused it to meet the Criteria for Evaluation in proposed N.J.A.C. 7:4-2.3. NJDOT commented that it seemed unreasonable to not allow removal after five years for additional information, errors in professional judgment, or procedural error.

RESPONSE: The Department believes that five years is a reasonably long period of time for anyone to petition for removal on the less substantive grounds listed by NJDOT, as allowed by proposed N.J.A.C. 7:4-4.1(b), (c) and (d). After five years, anyone may still petition for removal on the basis of the actual property ceasing to meet the Criteria for Evaluation.

COMMENT: NJDOT commented that the requirement in proposed N.J.A.C. 7:4-4.1(d) that a National Register Nomination Form be used for the petition to remove a property from the New Jersey Register was unnecessary because the form is geared for nomination and because a property may or may not be also listed on the National Register.

RESPONSE: The Department agrees that the requirement for a nomination form to be used for a petition to remove a property from the New Jersey Register is unnecessary as the form is intended for nominating, and not removing, properties from the registers. Therefore, the Department has revised proposed N.J.A.C. 7:4-4.1(d) to eliminate the requirement that a petition for removal of a property from the New Jersey Register of Historic Places be made on a National Register Nomination Form.

COMMENT: NJDOT suggested that proposed N.J.A.C. 7:4-5.1 be amended to require that Certificates of Eligibility for listing in the New Jersey Register be submitted to the State Review Board for "ratification" within six months of their issuance or they would expire. NJDOT believed that a "second opinion" on the State Historic Preservation Officer's finding was needed. NJDOT also commented that to require a completed survey form for a property in a historic district seemed an unreasonable financial burden on a private property owner seeking "protection" of his or her property.

RESPONSE: The Department disagrees. Subchapter 5 has the very narrow purpose of providing Certifications of Eligibility only for applicants for grants under the New Jersey Green Acres, Cultural Centers and Historic Preservation Act of 1987. The State Historic Preservation Officer's determination of eligibility is sufficient for this purpose since it is based on application of the proposed rules' Criteria for Evaluation by professionals in the Office of New Jersey Heritage who meet the National Park Service's Professional Qualifications Standards. However, if the State Historic Preservation Officer determines that the property is not eligible for the New Jersey Register, the applicant has the right of appeal under proposed N.J.A.C. 7:4-5.3(c) to apply for nomination of the property for listing in the New Jersey and National Registers, thereby gaining review by the State Review Board. Regarding the comment on survey forms for district properties, proposed N.J.A.C. 7:4-5.3 would apply only to the public agencies and non-profits seeking grants, not to private property owners seeking the protection of registration.

COMMENT: NJDOT suggested that the New Jersey Register of Historic Places Act and proposed rules be waived in favor of Federal review when a public undertaking that requires prior authorization under the New Jersey Register of Historic Places Act also requires Federal "Section 106" review. Delays and duplicated work were feared.

RESPONSE: There is no statutory basis in the New Jersey Register of Historic Places Act to waive the requirement for State, county, or municipal agencies to gain prior authorization for undertakings which are encroachments. There is little likelihood of delay since the Department's Office of New Jersey Heritage can simultaneously review both encroachment applications and Section 106 applications. The 120 day period of review required under the New Jersey Register of Historic Places Act is actually less time than needed for many negotiated Section 106 reviews.

COMMENT: NJDOT suggested that proposed N.J.A.C. 7:4-7.1(a) be changed to clarify that it is the responsibility of the agency undertaking a project to define the area of potential impact. NJDOT argued that there was no need for consultation with the Department at this early stage.

RESPONSE: The Department believes that such a decision should not be unilateral on the part of the public agency and therefore requires consultation with the Department, particularly appropriate because the Office of New Jersey Heritage has considerable expertise and experience evaluating direct and indirect effects generated by an undertaking. The Department strongly believes that a public agency should consult with the Department in the early stages of a project to avoid unnecessary expenses and counterproductive confrontation later in the project schedule. Early consultation with the Department allows the Department an opportunity to notify the applicant of any issues and concerns.

COMMENT: NJDOT commented that the requirement in proposed N.J.A.C. 7:4-7.1(a)3 for agencies to contact the Department to determine if properties in a project's impact area have been nominated to the New Jersey Register since the most recently published list, goes beyond the New Jersey Register of Historic Places Act's authority.

RESPONSE: The intention of this section was to make sure an agency has full information of any properties actually registered since the most published list. Therefore in proposed N.J.A.C. 7:4-7.1(a)3 the words "nominated to" have been changed to "listed in."

COMMENT: Heritage Studies suggested that proposed N.J.A.C. 7:4-7.1(b), which states that an undertaking may commence if there is no property on the New Jersey Register in the project area, should reference the possible applicability of Executive Order No. 215.

RESPONSE: Executive Order No. 215 requires departments, agencies, and authorities of the State to prepare and submit to the Department an environmental assessment or environmental impact statement for major construction projects. The Department believes that the language of the rules makes it clear that the statement "without further review and approval" applies only to the New Jersey Register of Historic Places Act and these proposed rules, not other potentially required reviews such as Executive Order No. 215.

COMMENT: NJDOT commented that the plans and specifications specified in proposed N.J.A.C. 7:4-7.1(d) for the application for project authorization, might not be available in the early stages of the planning process and that therefore qualifying wording should be added to this section. NJDOT was also concerned that there would be no mechanism for a State agency to reimburse municipalities for the notarized list of property owners that is to be included in an application for project authorization.

RESPONSE: The Department believes that plans and specifications are especially crucial to evaluating construction projects and should be specified in the rules without any caveat. Rather than changing the wording of the rules, the Department believes that the necessary flexibility to review requests for "concept" authorization can be incorporated into the Department's application form. With regards to reimbursement for a notarized list of property owners, the Department believes that any cost for obtaining such a list would be minimal (if even required) and could be reimbursed through standard and routine State fiscal procedures.

COMMENT: The Hunterdon County Planning Board suggested that the requirement in proposed N.J.A.C. 7:4-7.1(d) for including a complete list of historical societies in the encroachment application should be met not by the applicant but by the County Cultural and Heritage Commission or the Office of New Jersey Heritage. NJDOT had a similar comment.

RESPONSE: The Department believes the applicant should be responsible for contacting organizations such as the County Cultural and Heritage Commission, municipal offices, or local historical societies to obtain the required list, which is then used for fullest possible public notice of the Historic Sites Council's review of an application. An applicant, especially if a municipal or county agency, will be most familiar with the project area and hence, the sometimes overlapping jurisdictions or interests of local historic preservation commissions or historical societies. The Office of New Jersey Heritage does not have a definitive list of historic preservation commissions (who enforce only local ordinances) or routinely deal with local historical societies.

COMMENT: NJDOT was concerned that under proposed N.J.A.C. 7:4-7.2(a) and (b) the 30 day review period for technical completeness would be separate from and in addition to the 120 day application review period, potentially resulting in a technically complete application being authorized 150 days after its submission.

RESPONSE: The Department believes this is a valid concern and therefore has revised proposed N.J.A.C. 7:4-7.2(b). The Department has 30 days to determine if any application is technically complete. If the Department determines that an application was technically complete on the day it was filed with the Department, then the Department must render its decision on the application within 120 days of the date the application was received by the Department.

COMMENT: The Pinelands Commission supported the procedure set forth in proposed N.J.A.C. 7:4-7.2(c) and (d) whereby the Department may determine that an undertaking does not constitute an encroachment and hence does not need formal authorization. The Commission commented that too much of the Historic Sites Council's time was previously taken up with reviewing inconsequential undertakings and that restricting formal review by the Council and Commissioner to projects actually encroaching, damaging, or destroying registered sites would expedite the review process for applicants.

RESPONSE: The Department agrees that the procedure set forth in proposed N.J.A.C. 7:4-7.2(c) and (d) will expedite the review process for applicants.

COMMENT: NJDOT objected to applying to the Department regardless of whether or not the undertaking constitutes an encroachment, stating that this procedure requires unnecessary paperwork, would result in project delays, and was an expansion of authority beyond that which is mandated by the New Jersey Register of Historic Places Act.

RESPONSE: The Department disagrees. Previous rules promulgated pursuant to the New Jersey Register of Historic Places Act have required submission of **all** undertakings for full Historic Sites Council review and final action by the Commissioner. The proposed rules will dramatically reduce the number of public projects requiring Historic Sites Council review and Commissioner authorization by limiting projects needing authorization to actual encroachments. The premise of this change is, in fact, a more literal interpretation of the New Jersey Register of Historic Places Act, which calls for prior authorization by the Commissioner only of any project that will "**encroach** upon, **damage or destroy**" a property listed in the New Jersey Register (emphasis added). For the sake of consistency, the Department believes that its professional preservation staff should review all potential encroachments by applying the nationally recognized criteria specified in proposed N.J.A.C. 7:4-7.4. The Department believes that the procedure for determining that certain projects do not constitute encroachments will actually reduce paperwork, eliminate unnecessary presentations before the Historic Sites Council, and considerably reduce project review time.

COMMENT: NJDOT suggested that the public entity undertaking a project should ultimately determine whether the undertaking constitutes an encroachment, and only consult the Department.

RESPONSE: The Department disagrees. To transfer the authority of determining whether a project is an encroachment from the Department to the public agency undertaking the project would contradict and undermine the intention of Section 13:1B-15.131 of the New Jersey Register of Historic Places Act, which **mandates** "prior written authorization or consent of the Commissioner." There would be no check and balance on the possibility of a State, county, or municipal agency making a determination that an undertaking was not an encroachment on the basis of factors other than objective criteria. Almost all State, county, or municipal agencies would not have qualified historic preservation professionals who could make fully informed judgments on such determinations.

COMMENT: Heritage Studies commented that the chief elected official of a municipality, owners, and other interested citizens should be afforded an opportunity to comment on whether or not an undertaking would constitute an encroachment.

RESPONSE: The Department does not believe that comment is necessary at that stage of the review process. A determination that an undertaking does not constitute an encroachment involves a straightforward professional decision that the project meets the very strict criteria specified in proposed N.J.A.C. 7:4-7.4. If even one aspect of an undertaking does not meet these criteria, it will be deemed an encroachment. Public comment on the merits of an undertaking are most appropriate once an undertaking is being reviewed as an encroachment, a stage of review where a full range of factors, such as public benefit, is considered.

COMMENT: The Montgomery Landmarks Commission and the Van Harlingen Historical Society of Montgomery suggested that the historic preservation commissions and local historical societies in the area of an undertaking's impact should be notified of every project that the Department determines will not constitute an encroachment.

RESPONSE: The Department agrees and has amended proposed N.J.A.C. 7:4-7.2(c)2 with the following sentence: "The Department shall send a copy of any notification that the undertaking does not constitute an encroachment or will not damage or destroy the historic property to local historical societies and historic preservation commissions, as listed by the applicant in the application for authorization, pursuant to N.J.A.C. 7:4-7.1(d)."

COMMENT: NJDOT commented that since the definition of undertaking includes examples of indirect effects such as changes in pattern of land use, population density, or growth rate, submissions on such matters would be outside the expertise of "historic preservation specialists." NJDOT suggested that the Office of New Jersey Heritage staff, the Historic Sites Council, and the Commissioner formally seek the advice of professional planners on such matters and transmit such opinions to the applicant during the application review process.

RESPONSE: The Department disagrees. Knowledge of land use planning is a major component of the historic preservation discipline and profession. Formal course work in planning is a routine requirement of

almost all graduate historic preservation programs. The Office of New Jersey Heritage currently employs several staff people with background and experience in planning. Professionals in planning, architecture and engineering are also members of the Historic Sites Council. In addition, requiring opinions of outside consultants would be costly and cause unnecessary delays in the application review schedule.

COMMENT: NJDOT commented that the Commissioner would be in the position of reviewing undertakings of the Department's Division of Parks and Forestry and therefore the rules should require the Department to seek a review by "qualified persons not employed by the Division," to avoid the appearance of a conflict of interest.

RESPONSE: The Department believes that the required review and recommendation of the Historic Sites Council provides appropriate and objective outside review by qualified professionals not in the employment of the Department. This outside review adequately avoids any conflict of interest.

COMMENT: NJDOT commented that the regulations do not specify how often the Council meets or how many members must be present to act upon an application.

RESPONSE: The Historic Sites Council was separately established under a statute other than the New Jersey Register of Historic Places Act. See N.J.S.A. 13:1B-15.108 et seq. Under the Historic Sites Council's by-laws, the Council must meet at least six times a year. By standard rules-of-order, a majority of appointed members constitutes a quorum.

COMMENT: NJDOT commented that the rules "allowed for the involvement of interested parties" but did not specify the degree of participation.

RESPONSE: The proposed rules require that notification of the Historic Sites Council meeting at which an application will be heard should be sent to "interested parties who have advised the Department in writing of their interest in the application" (proposed N.J.A.C. 7:4-7.2(e)1vi). Interested parties may attend the Council meeting, where the Council's procedure is to ask interested parties to state their views, consistent with the Open Public Meetings Act, N.J.S.A. 10:4-6 et seq. The statements of interested parties are included in the record of the application.

COMMENT: NJDOT commented that proposed N.J.A.C. 7:4-7.2(e)2 refers to criteria set forth in N.J.A.C. 7:4-5.4 and that no such section existed.

RESPONSE: The reference in proposed N.J.A.C. 7:4-7.2(e)2 to "7:4-5.4" was a typographical error and has been changed to "7:4-7.4."

COMMENT: NJDOT commented that the New Jersey Register of Historic Places Act does not give the Commissioner the explicit ability to impose conditions on an undertaking as specified in proposed N.J.A.C. 7:4-7.2(e)5ii. NJDOT also asked if there is any recourse if an encroachment application is denied.

RESPONSE: The Department believes that allowing the action of authorization with conditions gives the applicant more flexibility to meet Departmental concerns without being forced to receive a denial and then reapply with a revised application. Since the rules specify that the applicant must accept the conditions within 60 days or the Commissioner shall deny the application, the final action is in essence one of granting or denying authorization or consent. If an encroachment application is denied, an applicant has a right to an adjudicatory hearing to contest the denial pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

COMMENT: The Hunterdon County Planning Board suggested that rather than require the applicant to respond within 60 days to an authorization with conditions, the rules could state that if the applicant did not respond within 60 days the conditions of approval would be deemed acceptable.

RESPONSE: The Department believes that the procedure proposed in the rules gives both the applicant and the Department a clearer answer by the end of 60 days as to whether the project is authorized or denied.

COMMENT: NJDOT commented that in cases of temporary denial, the requirement that the applicant respond to the Department within 60 days might not allow enough time if the services of a consultant are needed. NJDOT suggested an option of a "temporary withdrawal of an application" in such cases.

RESPONSE: The Department believes that adding such an option could in effect indefinitely extend the review period, which would be unfair to the public and the applicant. The provision for temporary denial in proposed N.J.A.C. 7:4-7.2(e)5iii is meant to give the Commissioner and the applicant a chance to resolve specific outstanding issues within a reasonable period, rather than denying the application and forcing the applicant to again go through the entire application process. The Department has not encountered the problem mentioned by NJDOT when temporary denials have been issued in the past.

COMMENT: Hunterdon County suggested that the rules should specify a five year time period for which authorizations are valid, since most other Department permits are valid for that duration.

RESPONSE: The Department disagrees. As presently worded, the proposed rules do not limit the time for which authorizations are valid. To do so would constitute a substantive change in the proposed rules and would be inconsistent with Federal historic preservation reviews. The Department has not yet encountered a case where the length of time since an authorization has been an issue.

COMMENT: NJDOT expressed concern that the Department would have no liability for not immediately responding to an emergency. NJDOT was also concerned that proposed N.J.A.C. 7:4-7.3(b) could be interpreted as allowing 120 days for the Commissioner to make a decision on an emergency where this section refers back to proposed N.J.A.C. 7:4-7.2(e)5.

RESPONSE: The Department believes that proposed N.J.A.C. 7:4-7.3, the section on "emergency undertakings," provides for reasonable, prompt response to emergencies affecting properties on the New Jersey Register. The **maximum** time allowed for Commissioner authorization is seven days. The Commissioner could and would respond as swiftly as necessary to an emergency of great urgency. The most recent emergency of a transportation-related structure—a county-owned bridge damaged by an accident—received Department response within 24 hours. To allay NJDOT's concern about the Department's response possibly exceeding seven days, the following wording has been added to proposed N.J.A.C. 7:4-7.3(b), after the reference to proposed N.J.A.C. 7:4-7.2(e)5: "but within seven calendar days after receipt by the Department of the complete notification as described in (a) above."

COMMENT: The Burlington County Board of Chosen Freeholders and NJDOT commented that the rules do not clearly define the standards that would be used to evaluate which undertakings will be determined by the Department to be encroachments. NJDOT was also concerned that analogous wording found in the Federal Criteria of Effect and Adverse Effect (36 CFR Part 800.9)—about affecting a property without adversely affecting it and about an effect being determined only when the characteristics of a property which contribute to its significance are altered—were not in the criteria for determining encroachments (proposed N.J.A.C. 7:4-7.4).

RESPONSE: The Department disagrees. The criteria in proposed N.J.A.C. 7:4-7.4 clearly articulate a general standard for "adverse effect" and then provide a number of examples of negative changes that would be considered encroachments. Three important categorical exemptions to encroachment determinations are also listed. The criteria in proposed N.J.A.C. 7:4-7.4 are substantially similar to the Criteria of Adverse Effect used in the Federal Regulations of the Advisory Council on Historic Preservation Governing the Section 106 Review Process (36 CFR Part 800). Since the Office of New Jersey Heritage uses these same criteria for its Section 106 reviews, projects requiring review under both Federal and State laws will be given consistent evaluation. Wording substantially similar to the Federal Criteria of Effect is found in the proposed rules' definition of "undertaking," where NJDOT's two other concerns are addressed.

Summary of Agency-Initiated Changes:

1. In the definition "Historic Preservation Review Commission," the word "Review" was deleted from "Historic Preservation Review Commission" as the term is not in common usage.

2. In proposed N.J.A.C. 7:4-2.7, which allows the State Historic Preservation Officer to not make available specific information on the location of properties proposed to be registered, the following wording has been added to restrict information on properties already listed: "or already registered in the New Jersey or National Registers." The additional wording is based on Federal regulations for the National Register and was inadvertently omitted from the proposed rules. For clarification, the section heading has been changed to "Disclosure of nomination or registration of a historic property."

3. In proposed N.J.A.C. 7:4-3.1(b), the typographical error "N.J.A.C. 7:4-2.2(c)14" has been corrected to "N.J.A.C. 7:4-2.2(c)15."

4. In proposed N.J.A.C. 7:4-6.1(c), the year "1979" has been changed to "1970" to correct a typographical error, thereby according with an identical section in the previous, now expired rules.

5. In proposed N.J.A.C. 7:4-7.4(b)1, the typographical error, "archaeologica" has been corrected to "archaeological."

6. Throughout the rules references to the "Department of Environmental Protection" have been changed to the "Department of Environmental Protection and Energy" to accord with the change of the Department's name since the proposed rules were published.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

CHAPTER 4
PROCEDURES CONCERNING THE NEW JERSEY REGISTER OF HISTORIC PLACES

SUBCHAPTER 1. GENERAL PROVISIONS

7:4-1.1 Purpose

This chapter shall constitute the rules of the Department of Environmental Protection ***and Energy*** concerning the preservation of the State's historic, architectural, archaeological, engineering, and cultural heritage in accordance with the New Jersey Register of Historic Places Act, N.J.S.A. 13:1B-15.128 et seq.

7:4-1.2 Severability

If any section, subsection, provision, clause or portion of this chapter is adjudged unconstitutional or invalid by a court of competent jurisdiction, the remainder of this chapter shall not be affected thereby.

7:4-1.3 Definitions

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

"Acquisition" means the act or process of acquiring fee title or interest other than fee title of real property (including the acquisition of development rights or remainder interest).

"Act" means the "New Jersey Register of Historic Places Act", P.L. 1970, c.268, N.J.S.A. 13:1B-15.128, et seq., or subsequent amendments thereto.

"Area" means *[a building, a site, or]* a district as defined in this section.

"Area of undertaking's potential impact" means that geographical area within which direct and indirect effects generated by the undertaking as defined in this section, could reasonably be expected to occur.

"Building***(s)***" means ***a structure created to shelter any form of human activity. Examples include*** a single construction such as a house, barn, courthouse, city hall, social hall, commercial building, library, factory, mill, train depot, fort, residence, hotel, theater, school, store, or church, or a small group of buildings consisting of a main building and subsidiary buildings that are functionally and historically related such as a courthouse and jail, house and barn, mansion and carriage house, church and rectory, or farm house and related out buildings, created to shelter any form of human activity. *[If one or more of the buildings comprising a functionally and historically related group does not contribute to the significance of the property or has lost its historic integrity or if the group also includes any objects, sites or structures, the property must be classified as a district in order to distinguish between contributing and noncontributing resources.]*

"Certified Local Government" means a local government certified by the Department and the National Park Service to participate in Federal and State historic preservation programs pursuant to the National Historic Preservation Act of 1966 as amended.

"Chief elected local official" means the mayor, county executive or other titled chief elected administrative official who is the elected head of the local political jurisdiction in which the property is located.

"Commissioner" means the Commissioner of the Department of Environmental Protection ***and Energy***.

"Contributing property" means a building, site, structure, or object that adds to the historic architectural qualities, historic associations, or archaeological values for which a property is significant because:

1. It was present during the period of significance, and possesses historic integrity reflecting its character at that time or is capable of yielding important information about the period; or
2. It independently meets the New Jersey Register criteria set forth in N.J.A.C. 7:4-2.3.

"Cyclic maintenance" means that type of maintenance that is performed less frequently than annually and involves replacement or major mending of the fabric of a historic property, an example of which would be a complete re-roofing of a building.

"Damage" means partial physical harm or demolition of a historic property.

"Department" means the Department of Environmental Protection ***and Energy***, Division of Parks and Forestry, Office of New Jersey Heritage.

"District" means a significant concentration, linkage, or continuity of sites, buildings, structures, or objects united historically or aesthetically by plan or physical development. A district may also comprise individual elements that although linked by association or function were separated geographically during the period of significance, as a district of discontiguous archaeological sites or a canal system where manmade segments are interconnected by natural bodies of water. The concept of a discontiguous district applies only where visual continuity is not necessary to convey the historic interrelationship of a group of related resources. Examples include, but are not limited to, college campuses; central business districts; residential areas; commercial areas; industrial complexes; civic centers; rural villages; canal systems; collections of habitation and limited activity sites; irrigation systems; large estates, farms, ranches, or plantations; transportation networks; and large landscape parks.

"Emergency" means a situation in which the condition of a property is so damaged by an event such as, but not limited to, a natural disaster, major fire, serious accident or structural collapse, that it constitutes an immediate, direct, demonstrable, and severe hazard to the public safety. The poor condition of a property caused by long term deterioration shall not be considered an emergency.

"Encroachment" means the adverse effect upon any district, site, building, structure or object included in the New Jersey Register resulting from the undertaking of a project by the State, a county, municipality or an agency or instrumentality thereof, as determined by application of the Criteria for Determining Whether an Undertaking Constitutes an Encroachment set forth in N.J.A.C. 7:4-5.4 and the Standards for Historic Preservation Projects and Guidelines for Applying the Standards (36 C.F.R. 1207) or subsequent amendments thereto adopted by the Secretary of the United States Department of the Interior.

"Historic Preservation *[Review]* Commission" means the commission created by an ordinance adopted by the local governing body *[and approved by the Department and the National Park Service]* ***pursuant to the Municipal Land Use Law, N.J.S.A. 40:55D-107 through 112***.

"Historic property" means any district, site, building, structure or object significant in American history, architecture, archaeology, engineering and culture.

"Historic Sites Council" means the body within the Division of Parks and Forestry, Department of Environmental Protection ***and Energy*** established by P.L. 1967, c.124, N.J.S.A. 13:1B-15.108 et seq., and amended by P.L. 1984, c.562, N.J.S.A. 13:1B-15.111 et seq., for the purpose of recommending policies to the Commissioner for the following actions: the acquisition, development, use, improvement and extension of historic sites (including archaeological sites); the development of a broad historic sites preservation program on a Statewide and local basis; the identification, authentication, protection, preservation, conservation, restoration, and management of all historic sites within the State; and the provision of advice on encroachments by the undertakings of State, county or municipal governments or any agency or instrumentality thereof on properties listed in the New Jersey Register.

"Housekeeping" means light cleaning performed at short term intervals.

"Local government" means a city, borough, town, municipality, ***township, village,*** county or other general purpose political subdivision of the State.

"Maintenance" means treatment that includes housekeeping, routine, and cyclic work scheduled to mitigate wear and deterioration of a historic property.

"Major revisions" means alteration of the boundaries of a property or important substantive changes to the nomination which could be expected to change the ultimate determination as to whether or not the property is listed in the New Jersey or National Registers.

"National Park Service" means that agency of the United States Department of the Interior to which the Secretary of the Interior has delegated the authority and responsibility for administering the National Register of Historic Places program, under the National Historic Preservation Act of 1966, as amended, 16 U.S.C. 470 et seq.

"National Register" means the National Register of Historic Places, which consists of districts, sites, buildings, structures and objects significant in American history, architecture, archaeology, engineering and culture, and which the Secretary of the United States Department of the Interior is authorized to expand and maintain pursuant to The National Historic Preservation Act of 1966, 16 U.S.C. §470 et seq.

"National Register Nomination Form" means the legal document and reference for historical, architectural and archaeological data upon which the registration of properties is founded. Said document is the National Park *[Services]* ***Service's*** Form NPS 10-900, with accompanying continuation sheets (where necessary) or Form NPS 10-306 with continuation sheets (where necessary) now in use by the National Park Service and as may be subsequently modified, changed or amended.

"New Jersey and National Register Manual" means the document entitled "The New Jersey and National Register Process: A Manual for Completing the National Register of Historic Places Registration Form and the Multiple Property Documentation Form" published by the Office of New Jersey Heritage, Division of Parks and Forestry, Department of Environmental Protection."

"New Jersey Register" means the New Jersey Register of Historic Places, consisting of areas, sites, structures and objects within the State determined to have significant historical, archaeological, architectural, or cultural value, which the Commissioner is authorized to expand and maintain pursuant to the Act.

"Nominate" means to propose that a district, site, building, structure or object be listed in the New Jersey and National Registers by preparing a nomination application with accompanying maps and photographs, which clearly documents the significance of the property and is technically and professionally correct and sufficient in accordance with the procedure set forth in N.J.A.C. 7:4-2.2.

"Noncontributing property" means a building, site, structure, or object that does not add to the historic architectural qualities, historic associations, or archaeological values for which a property is significant because:

1. It was not present during the period of significance;
2. Due to alterations, disturbances, additions, or other changes, it not longer possesses historic integrity reflecting its character at that time or is incapable of yielding important information about the period; or
3. It does not independently meet the New Jersey Register criteria set forth in N.J.A.C. 7:4-2.3.

"Object(s)" means a construction that is primarily artistic in nature or is relatively small in scale and simply constructed, as distinguished from a building or a structure. Although it may be movable, by nature or design, an object is associated with a specific setting or environment, such as statuary in a designed landscape. Objects should be located in a setting appropriate to their significant historic use, roles, or character. Examples include, but are not limited to, sculpture, monuments, mileposts, boundary markers, statuary, and fountains. (Objects relocated in a museum setting are generally considered inappropriate for listing in the New Jersey Register.)

"Office of New Jersey Heritage" means that office of the Division of Parks and Forestry, Department of Environmental Protection and Energy, and any successors in right, with the responsibility for maintaining the New Jersey Register of Historic Places and administering the State Historic Preservation Program.

"Preservation" means the act or process of applying measures to sustain the existing form, integrity and material of a building or structure or the existing form and vegetative cover of a site. It may include initial stabilization work, where necessary, as well as ongoing maintenance of the historic building materials.

"Project" means a planned undertaking.

"Protection" means the act or process of applying measures designed to affect the physical condition of a property by defending or guarding it from deterioration, loss or attack, or to cover or shield the property from danger or injury. In the case of buildings and structures, such treatment is generally of a temporary nature and anticipates future historic preservation treatment. In the case of archaeological sites, the protective measure may be temporary or permanent.

"Reconstruction" means the act or process of reproducing by new construction the exact form and detail of a vanished building, structure, or object, or a part thereof, as it appeared at a specific period of time.

"Rehabilitation" means the act or process of returning a property to a state of utility through repair or alteration which makes possible an efficient contemporary use while preserving those portions or features of the property which are significant to its historical, architectural and cultural values.

"Restoration" means the act or process of accurately recovering the form and details of a property and its setting as it appeared at a particular period of time by means of the removal of later work or by the replacement of missing earlier work.

"Routine maintenance" means minor repairs such as in-kind replacement of a broken window pane or in-kind patching of a few roof shingles.

"Site(s)" means the location of a significant event, a prehistoric or historic occupation or activity, or a building or structure, whether standing, ruined or vanished, where the location itself maintains historic or archaeological value regardless of the value of any existing structure. Examples include, but are not limited to, habitation sites, funerary sites, rock shelters, village sites, hunting and fishing sites, ceremonial sites, petroglyphs, rock carvings, battlefields, ruins of historic buildings and structures, campsites, ruins of industrial works, sites of treaty signings, trails, shipwrecks, cemeteries, designed landscapes, and natural features, and such as springs, rock formations, and landscapes which have cultural significance.

"Stabilization" means the act or process of applying measures designed to reestablish a weather resistant enclosure and the structural stability of an unsafe or deteriorated property while maintaining the essential form as it exists at present.

"State Historic Preservation Officer" means the Commissioner of the Department of Environmental Protection ***and Energy***, who is designated by the Governor to administer the State Historic Preservation Program, including the identification and nomination of eligible properties to the National Register. The Commissioner is also authorized by the Act to establish criteria for receiving and processing nominations and approval of areas, sites, structures and objects, both publicly and privately owned, for inclusion in the New Jersey Register.

"State Historic Preservation Plan" means the document that sets forth long-range goals of the State Historic Preservation Program and describes specific ways that the Office of New Jersey Heritage will work to achieve those goals. The State Historic Preservation Plan organizes primary preservation activities—identification, evaluation, registration, and treatment of historic properties—in a logical sequence. The plan is based on 12 Statewide "historic contexts," which are thematic study units, such as "Initial Colonial Settlement, A.D. 1630-A.D. 1775." Goals and priorities are established for the historic properties associated with each historic context.

"State Historic Preservation Program" means the program established by the Department and approved by the Secretary of the United States Department of the Interior for the purposes of

carrying out the provisions of the National Historic Preservation of 1966, as amended, and related laws and regulations.

"State Review Board" means a body whose members represent the professional fields of American history, architectural history, prehistoric and historic archaeology, and other professional disciplines appointed by the State Historic Preservation Officer as part of the State Historic Preservation Program for the purpose of reviewing and recommending to the State Historic Preservation Officer whether to approve New Jersey and National Register nominations based on whether or not they meet the criteria for evaluation in N.J.A.C. 7:4-2.3.

"Structure(s)" ***means something that is arranged in a definite pattern of organization. (A building is a subset of a structure.) It*** is a term used to distinguish from buildings those functional constructions made usually for purposes other than creating shelter. Examples include, but are not limited to, gold dredges, firetowers, canals, turbines, dams, power plants, tunnels, corncribs, silos, highways, shot towers, windmills, grain elevators, kilns, mounds, cairns, palisade fortifications, earthworks, railroad grades, systems of roadways and paths, boats and ships, railroad locomotives and cars, telescopes, carousels, and aircrafts.

"Undertaking" means an action by the State, a county, municipality, or an agency or instrumentality thereof, which has the potential to result in direct or indirect effects on any district, site, building, structure or object listed in the New Jersey Register. An action shall be considered to have an effect whenever any condition of the action causes or may cause any change, beneficial or adverse, in the quality of the historical, architectural, archaeological, or cultural characteristics that qualified a historic property to meet the criteria for evaluation (N.J.A.C. 7:4-2.3) for the New Jersey Register. For the purpose of determining effect, alteration of features of the property's location, setting or use may be considered relevant depending on a property's significant characteristics. An effect may be direct or indirect. Direct effects are caused by the undertaking and occur at the same place and time. Indirect effects include those caused by the undertaking that are farther removed in distance or later in time, but are still reasonably foreseeable. Such indirect effects may include changes in the pattern of land use, population density or growth rate that may affect the quality of the historical, architectural, archaeological, or cultural characteristics that qualified a historic property to be listed in the New Jersey Register. Consistent with the above language, the following are examples of what shall be considered undertakings: acquisitions, sales, leases, transfers of deed, easements, an agreement or other form of permission allowing use of a registered property, cyclic maintenance, and alterations or relocation of a registered property. The following are examples of actions that shall not be considered as undertakings:

1. Changes in local zoning ordinances;
2. Issuance of building or demolition permits to private individuals or corporations;
3. Granting of zoning variances to private individuals or corporations; and
4. Housekeeping and routine maintenance.

SUBCHAPTER 2. REGISTRATION PROCEDURES AND CRITERIA

7:4-2.1 Integration of New Jersey and National Register of Historic Places Programs

(a) The procedures for registration in the New Jersey Register are integrated with the National Register of Historic Places Program administered by the Department and the National Park Service. The New Jersey and National Registers both use the same nomination criteria, nomination forms, State administrative agency (Office of New Jersey Heritage), and State Review Board. Both require that the Commissioner sign the nomination; in the case of the National Register, as the State Historic Preservation Officer. This integrated process is designed to avoid duplication of steps since the two programs parallel and complement each other. The dual process ends after the Commissioner signs a historic property's nomination form, which action lists the historic property in the New Jersey Register. The property is then registered and protected by the Act. Once signed by the State Historic Preservation Officer, the historic property's nomination form is then forwarded to the National Park Service in care of the Keeper of the National Register for consideration for inclusion in the National Register.

(b) The State Historic Preservation Officer is responsible for identifying and nominating eligible properties to the New Jersey and National Registers and establishing Statewide priorities for preparation and submittal of nominations to the New Jersey and National Registers in accordance with the State Historic Preservation Plan.

(c) The New Jersey Register is administered and maintained by the Department.

(d) The Commissioner, as the State Historic Preservation Officer, or the Commissioner's designee, shall make the final determination for New Jersey registration. If favorable, the Commissioner shall sign the nomination, thereby placing the historic property on the New Jersey Register and simultaneously recommending the historic property for National Register designation by the National Park Service.

7:4-2.2 Procedure for the nomination of properties for inclusion in the New Jersey and National Registers

(a) All applications for nomination to the New Jersey and National Registers shall be made under the supervision of the Department, on standard National Register Nomination Forms. Guidance in the completion of the forms is provided in the "New Jersey and National Register Manual," National Park Service publication "Guidelines for Completing National Register of Historic Places Forms" (National Register Bulletin Number 16) or subsequent amendments thereto and other guidelines issued by the Office of New Jersey Heritage or the National Park Service for nominations to the National Register. The forms, publication, and guidelines are available from the Department at the Office of New Jersey Heritage, CN 404, Trenton, New Jersey 08625.

(b) Applications for nomination to the New Jersey Register may be initiated by private individuals, any organization, or government agency.

(c) The procedure for the nomination of property for inclusion in the New Jersey and National Registers is as follows:

1. The applicant obtains a preliminary questionnaire and an individual building or district survey form from the Department.

2. The applicant submits the following to the Department for a preliminary determination by the Department whether the property is potentially eligible for listing in the New Jersey and National Registers under the criteria for evaluation set forth in N.J.A.C. 7:4-2.3:

i. The completed preliminary questionnaire and the individual or district survey form obtained under (c)1 above; and

ii. Clear photographs that show the property in complete exterior and interior views. In the case of a district, the photographs shall show representative views of the district;

3. Within 45 days of receiving a complete submittal for preliminary determination under (c)2 above, the Department shall:

i. Make a preliminary determination of the property's potential eligibility for the New Jersey and National Registers; and

ii. Notify the applicant in writing whether or not the Department determines that the property is potentially eligible for the New Jersey and National Registers.

(1) If the Department determines that the property potentially is eligible for the New Jersey and National Registers, the Department shall send a National Register Nomination Form to the applicant.

(2) If the Department determines that the property does not appear to be potentially eligible for the New Jersey and National Registers, the Department shall give the applicant a written explanation of the Department's preliminary determination that the property does not appear to meet the Criteria for Evaluation in N.J.A.C. 7:4-2.3. If the applicant intends to proceed with the application, the applicant shall notify the Department in writing of his intent to proceed within 90 days of the Department's issuance of a preliminary determination that the property does not appear to meet the Criteria for Evaluation. If a response from the applicant is not received within 90 days, the Department shall return the preliminary submittal to

the applicant. If a response from the applicant is received within 90 days, the Department shall forward a National Register Nomination Form to the applicant. If the applicant resubmits a request for a preliminary determination, it shall be treated as a new preliminary submittal.

4. The applicant shall, as part of an adequately documented and technically and professionally correct and sufficient National Register Nomination Form, submit to the Department a complete list of all owners of the nominated property as of the date of the National Register Nomination Form's submission. The list of property owners shall be the list of *[property owners]* ***private and public property owners (including right-of-way owners)*** named in official municipal tax records ***and maps*** and shall be notarized by the appropriate municipal official. If the property is not scheduled for consideration by the State Review Board under this subchapter within 90 days after the Department receives an adequately documented and technically and professionally correct and sufficient National Register Nomination Form, the Department may require that the applicant submit an updated list of property owners (notarized by the appropriate municipal official) which the applicant shall provide to the Department within 30 days of the issuance of the Department's written request.

5. Within 60 days of receiving a completed National Register Nomination Form, the Department shall notify the applicant in writing as to:

i. Whether or not the National Register Nomination Form is adequately documented and technically and professionally correct and sufficient;

ii. Whether or not the property appears to meet the criteria for evaluation in N.J.A.C. 7:4-2.3; and

iii. If the Department determines that the National Register Nomination Form is adequately documented and technically and professionally correct and sufficient and that the property appears to meet the criteria for evaluation in N.J.A.C. 7:4-2.3, the Department shall schedule the nomination for consideration at the earliest possible State Review Board meeting, consistent with the Department's established priorities for processing nominations. These priorities shall be consistent with implementation of the State Historic Preservation Plan and shall be established by the Department in consultation with the State Review Board. The Department shall notify the applicant in writing of the property's position in accordance with the Department's priorities for processing nominations under the State Historic Preservation Plan and of the approximate date the applicant can expect the nomination of the property to be considered by the State Review Board under this subchapter. If the nomination can be considered by the State Review Board at least 30 days but not more than 75 days after notification, the notice may specify a date when the nomination will be considered by the State Review Board; or

iv. If the Department determines that the National Register Nomination Form is not adequately documented and technically and professionally correct and sufficient or that the property does not appear to meet the criteria for evaluation in N.J.A.C. 7:4-2.3, the Department shall provide the applicant with a written explanation of the reasons for that determination.

6. If the Department determines that the National Register Nomination Form is not adequately documented and technically and professionally correct and sufficient, the applicant shall have 90 days from the date of issuance of the written notice under (c)4iv above to submit to the Department the additional documentation or information necessary to correct the deficiencies identified in the notice. If the Department does not receive the additional documentation or information necessary to correct the deficiencies identified in the notice within 90 days as above provided, the Department shall return the nomination to the applicant. If the Department determines that the additional documentation or information submitted by the applicant to correct the deficiencies identified on the notice substantially revises the original National Register Nomination Form, the Department may reprocess the nomination as a new submittal under this section.

7. If the Department determines that the National Register Nomination Form is adequately documented and technically and professionally correct and sufficient, but that the property does not appear to meet the criteria for evaluation in N.J.A.C. 7:4-2.3, the Department need not process the nomination further unless the Department receives a written request to do so from the Keeper of the National Register under 36 CFR Part 60, Section 60.12 referenced in N.J.A.C. *[(c)2]* ***7:4-2.2(c)21*** below, in which case the Department shall proceed with processing the nomination for the National Register but shall not be required to process the nomination for the New Jersey Register.

8. When a National Register Nomination Form for a property within the jurisdiction of a Certified Local Government is received by the Department, the Department shall:

i. Forward a copy of the nomination to the Certified Local Government's historic preservation commission for the commission's review and comment;

ii. Within 30 days of its receipt of the nomination, forward to the Certified Local Government's historic preservation commission a written determination on whether or not the nomination is adequately documented and technically and professionally correct and sufficient and whether the nominated property appears to meet the criteria for evaluation under N.J.A.C. 7:4-2.3;

iii. Allow the Certified Local Government 60 days from the date of issuance of the notice of adequate documentation and eligibility for the Chief Elected Local Official of the Certified Local Government to transmit to the Department a report by the historic preservation commission as to whether or not in its opinion the nominated property meets the criteria for evaluation in N.J.A.C. 7:4-2.3 and the recommendation of the chief elected local official;

iv. If the report by the Certified Local Government's historic preservation commission and the recommendations of its chief elected local official are not received by the Department within 60 days as provided in (c)8ii above, the Department shall proceed with processing the nomination pursuant to this chapter; and

v. If both the Certified Local Government's historic preservation commission and its chief elected local official recommend under (c)8ii above that a property not be listed in the National Register, the Department shall not proceed with processing the nomination for the National Register pursuant to this chapter unless, within 30 days of the receipt of the recommendation by the Department, the State Historic Preservation Officer receives a written request from any citizen or organization to proceed with the nomination. The report by the Certified Local Government's historic preservation commission and the recommendations of its chief elected local official shall be included by the Department with any nomination processed by the Department under this chapter and submitted by the State Historic Preservation Officer to the Keeper of the National Register.

9. As part of the nomination process, the Department shall notify the applicant and the owner(s) of the nominated property or the owner(s) of property within a nominated historic district in writing of the Department's intent to bring the nomination before the State Review Board on a specific date***, time and place***. The Department shall be responsible for notifying only those property owners named in the National Register Nomination Form in accordance with (c)4 above. Where more than one owner is named, each separate owner shall be notified. The Department shall send the written notification at least 30 but not more than 75 days before the State Review Board meeting during which the nomination is scheduled to be considered. In addition to informing the applicant and owner(s) that the property is being considered for nomination to the New Jersey Register, the notice shall solicit written comments on the significance of the property and whether or not it meets the criteria for evaluation set forth in N.J.A.C. 7:4-2.3, inform the owners what registration of the property will mean to the owner, and explain the benefits and responsibilities of property registration. The property owner(s) shall have at least 30 days but not more than 75 days from the date of issuance of written notification to submit written comments to the Department and to concur in or object to the nomination of such property. For a nomination with more than 50 property owners, the

Department may publish a public notice to property owners concerning the Department's intent to nominate instead of individually notifying all property owners. Such public notice shall be published at least 30 days but not more than 75 days before the State Review Board meeting during which the nomination is scheduled to be considered. ***Such public notice must be published in one or more local newspapers of general circulation in the area of the nomination.***

10. At least 30 but not more than 75 days before the State Review Board meeting during which the nomination is scheduled to be considered, the Department shall send the applicable chief elected local official of the county and municipality in which the property is located written notice of the Department's intent to bring the nomination before the State Review Board ***on a specific date, time and place***. ***Notifications of a proposed district shall include a map showing the district boundaries.*** In addition to informing the chief elected local official that the property is being considered for nomination to the New Jersey Register, the notice shall solicit written comments on the significance of the property and whether or not it meets the criteria for evaluation in N.J.A.C. 7:4-2.3. The chief elected local official shall have 30 but not more than 75 days from the date of issuance of written notification to submit written comments on the nomination to the Department.

11. The complete National Register Nomination Form shall be on file with the Department during the comment period in (c)9 and 10 above and a copy shall be made available by mail when requested by the public or made available at a location to which all affected property owners have reasonable access, such as a local library, municipal building, courthouse, or other public place so that written comments regarding the nomination can be prepared.

12. In the case of a nomination of an historic district including 50 or more property owners the Department shall conduct a public hearing in the municipality in which the property is located prior to consideration of the application by the State Review Board. In the event of an archaeological nomination, the public hearing may be waived by the Department. The Department shall send written notice of the hearing to property owners within the proposed historic district at least 30 days prior to the date of the hearing. The Department shall be responsible for notifying only those property owners within the proposed historic district named in the National Register Nomination Form in accordance with (c)4 above. The notification shall provide the following: a description of the proposed historic district, the benefits and responsibilities of historic district registration, the place that the nomination document can be examined prior to the hearing, and the date, time and place that the hearing will be held. Alternative methods of notification for the hearing, such as publication in the official newspaper of the municipality, or in a newspaper circulating in the municipality, may be used when the number of property owners in a proposed historic district exceeds 50.

13. Upon notification under (c)9 above, any owner or owners of a private property who objects to the nomination to the National Register shall submit to the Department a notarized statement certifying that the objector is the sole or partial owner of the private property and objects to the nomination. Upon receipt of notarized objections respecting a district or single private property with multiple owners, the Department shall ascertain how many owners have objected. If an owner whose name did not appear on the ownership list submits a written notarized statement from the municipality that the party is the sole or partial owner of a nominated private property, such owner shall be counted by the Department in determining how many owners have objected. Each owner of private property in a district shall be considered only once regardless of how many properties or what part of one property that party owns and regardless of whether the property contributes to the significance of district. Owner objections shall be considered by the State Historic Preservation Officer only with regard to submission of the nomination to the Keeper of the National Register of Historic Places.

14. Completed National Register Nomination Forms, Department recommendations, and public comments concerning the significance of a property and its eligibility for the New Jersey and National Registers shall be submitted by the Department to the State Review Board. The State Review Board shall review the nomination forms and comments concerning the property's significance and eligibility for the New Jersey Register. The State Review Board shall evaluate whether or not the property meets the criteria for evaluation set forth in N.J.A.C. 7:4-2.3 and make a recommendation to the State Historic Preservation Officer to approve or disapprove the nomination. The State Review Board may request that the applicant submit additional information before making a recommendation to the State Historic Preservation Officer. If a nomination is not recommended for approval by the State Review Board, the Board shall explain at the meeting the reasons for its determination that the property does not satisfy the criteria for evaluation set forth in N.J.A.C. 7:4-2.3. The Board's explanation shall be made a part of the minutes of the meeting.

15. Nominations approved by the State Review Board, along with any comments received, shall be reviewed by the State Historic Preservation Officer. If the State Historic Preservation Officer determines that a nomination is adequately documented and technically, professionally, and procedurally correct and sufficient and in conformance with the criteria for evaluation set forth in N.J.A.C. 7:4-2.3, the State Historic Preservation Officer shall, within 90 days of the State Review Board meeting, sign the National Register Nomination Form and thereby place the property on the New Jersey Register and simultaneously recommend the nomination to the Keeper of the National Register of Historic Places, National Park Service, United States Department of the Interior, Washington, D.C. 20240. All comments received by the Department and notarized statements of objection to listing received by the Department shall be submitted to the National Park Service along with the nomination. Historic properties placed on the New Jersey Register shall remain on the New Jersey Register regardless of the response of the National Park Service to the nomination to the National Register. The State Historic Preservation Officer's signature certifies that:

i. All procedural requirements set forth in this section have been met;

ii. The National Register Nomination Form is adequately documented;

iii. The National Register Nomination Form is technically and professionally correct and sufficient; and

iv. In the opinion of the State Historic Preservation Officer, the property meets the criteria for evaluation set forth in N.J.A.C. 7:4-2.3.

16. If the State Historic Preservation Officer determines that the nominated property does not meet the criteria for evaluation set forth in N.J.A.C. 7:4-2.3, the State Historic Preservation Officer shall, within 45 days of the State Review Board meeting, advise the applicant in writing of the reasons for the determination. In the event that the State Historic Preservation Officer determines that the nominated property does not meet the criteria for evaluation, the State Historic Preservation Officer need not sign the National Register Nomination Form.

17. If the State Historic Preservation Officer and the State Review Board disagree on whether a property meets the criteria for evaluation set forth in N.J.A.C. 7:4-2.3, the State Historic Preservation Officer, if he or she chooses, may submit the nomination, with an opinion concerning whether or not the property meets the criteria for evaluation and the opinion of the State Review Board, to the Keeper of the National Register for a final decision on the listing of the property in the National Register. The State Historic Preservation Officer shall submit such disputed nominations to the Keeper within 45 days after the recommendation by the State Review Board if so requested by the State Review Board, the chief elected official of the municipality in which the property is located, or by the Keeper of the National Register pursuant to federal rules for appeals under the National Register Program set forth in 36 CFR Part 60, Section 60.12 or subsequent amendments thereto.

18. If the owner of a nominated private property or the majority of such owners of a nominated historic district or single property with multiple owners has objected to the nomination to the National Register by notarized statements before the State Historic Preserva-

tion Officer submits the nomination to the Keeper, the State Historic Preservation Officer shall sign the National Register Nomination Form, but shall submit the nomination to the Keeper only for a determination of whether the property or historic district is eligible for the National Register pursuant to the federal rules for the National Register Program set forth in 36 CFR Part 60, section 60.6(n) and (s) or subsequent amendments thereto.

19. Nominations will be included in the National Register within 45 days of receipt by the Keeper of a completed National Register Nomination Form from the State Historic Preservation Officer unless:

i. The Keeper returns the nomination to the State Historic Preservation Officer because the National Register Nomination Form is not adequately documented and technically and professionally correct and sufficient;

ii. The Keeper returns the nomination to the State Historic Preservation Officer because the Keeper has determined that the nominated property or historic district does not meet the crtieria for listing in the National Register set forth in 36 CFR Part 60, section 60.4 or subsequent amendments thereto;

iii. An appeal is filed with the Keeper as provided in (c)22 below; or

iv. The owner of the nominated private property or the majority of the owners of property in a nominated historic district or single property with multiple owners objects by notarized statements received by the Keeper before the property or historic area is listed on the National Register.

20. When a nomination is returned to the State Historic Preservation Officer as provided in (c)19i and ii above, the State Historic Preservation Officer shall notify the applicant that the nomination has been returned. The notification shall include an explanation of the reasons for the return of the nomination. Upon receipt by the State Historic Preservation Officer of sufficient additional information from the applicant addressing the reasons for the return of the nomination, the State Historic Preservation Officer shall resubmit the nomination to the Keeper.

21. Any person or organization which supports or opposes the nomination of a property by the State Historic Preservation Officer for listing in the National Register may, during the review of the nomination by the National Park Service, petition the Keeper to accept or reject a nomination pursuant to the federal rules for appeals under the National Register Program, 36 CFR Part 60, Section 60.6(t) or subsequent amendments thereto. The petitioner must state the grounds of the petition and request in writing that the Keeper substantively review the nomination. Such petitions received by the Keeper prior to the listing of the property in the National Register or a determination of its eligibility where the private owners object to listing will be considered by the Keeper and the nomination will be substantively reviewed. Decisions by the Keeper on such petitions shall not affect a property's listing in the New Jersey Register.

22. If the Department determines to not nominate a property for inclusion in the National Register or the State Historic Preservation Officer does not nominate a property recommended by the State Review Board for inclusion in the National Register, any person or local government may appeal to the Keeper the failure or refusal of the State Historic Preservation Officer to nominate a property to the National Register that the person or local government considers to meet the criteria for listing in the National Register set forth in 36 CFR Part 60, Section 60.4 or subsequent amendments thereto. Such appeals shall be made in accordance with Federal rules for appeals under the National Register Program (36 CFR Part 60, section 60.12) or subsequent amendments thereto. Regardless of the decision by the Keeper, the State Historic Preservation Officer is not obligated to place the property on the New Jersey Register.

23. If subsequent to nomination of a property for listing in the New Jersey Register and National Registers, major revisions are made to the nomination or a property previously rejected by the Department or Keeper is renominated, the State Historic Preservation Officer shall notify the affected property owner(s) and the chief elected local official of the county and municipality in which the property is located of the revisions or renomination in the same manner as the original notification for the nomination under (c)9 and 10 above. In the case of major revisions, the Department may resubmit the nomination to the State Review Board or treat it as a new nomination to be processed in accordance with this section. Comments received and notarized statements of objection shall be forwarded to the Keeper along with the revisions or renomination. The State Historic Preservation Officer shall also certify by the resubmittal that the affected property owner(s) and the chief elected local officials have been renotified.

7:4-2.3 Criteria for evaluation of a property nominated for listing in the New Jersey Register

(a) The criteria for evaluation listed below shall be used by the Department, State Review Board, and State Historic Preservation Officer to determine the eligibility of a property for listing in the New Jersey Register. The Criteria for Evaluation are also used by the National Park Service for determining eligibility of properties for the National Register (36 CFR, Part 60, Section 60.4) or subsequent amendments thereto. These criteria are worded to apply to a wide diversity of properties. The criteria for evaluation are listed by letter as published in the Federal rules and as commonly utilized.

1. Criteria for Evaluation: The quality of significance in American history, architecture, archaeology, engineering and culture is present in districts, sites, buildings, structures and objects that possess integrity of location, design, setting, materials, workmanship, feeling and association and:

i. (Criterion A) That are associated with events that have made a significant contribution to the broad patterns of our history; or

ii. (Criterion B) That are associated with the lives of persons significant in our past; or

iii. (Criterion C) That embody the distinctive characteristics of a type, period, or method of construction, or that represent the work of a master, or that possess high artistic values, or that represent a significant and distinguishable entity whose components may lack individual distinction; or

iv. (Criterion D) That have yielded, or may be likely to yield, information important in prehistory or history.

2. Criteria considerations: Ordinarily cemeteries, birthplaces, graves of historical figures, properties owned by religious institutions or used for religious purposes, structures that have been moved from their original locations, reconstructed historic buildings, properties primarily commemorative in nature, and properties that have achieved significance within the past 50 years are generally not considered eligible for the New Jersey Register. However, such properties may qualify if they are integral parts of areas that do meet the criteria or if they fall within the following categories:

i. A religious property deriving primary significance from architectural or artistic distinction or historic importance;

ii. A building or structure removed from its original location but which is significant primarily for architectural value, or which is the surviving structure most importantly associated with an historic person or event;

iii. A cemetery which derives its primary significance from graves of persons of transcendant importance, from age, from distinctive design features, or from association with historic events;

iv. A reconstructed building when accurately executed in a suitable environment and presented in a dignified manner as part of a restoration master plan, and when no other building or structure with the same association has survived;

v. A property primarily commemorative in intent if design, age, tradition, or symbolic value has invested it with its own historical significance; or

vi. A property achieving significance within the past 50 years if it is of exceptional importance.

(b) The criteria for evaluation set forth in (a) above shall be applied in accordance with the "New Jersey and National Register Manual" published by the Department and guidelines issued by the National Park Service from time to time in the following or similar documents: "How to Apply the National Register Criteria for Evaluation", and "Guidelines for Completing National Register of Historic Places Forms" (National Register Bulletin Number 16) or

subsequent amendments thereto, incorporated herein by reference and available from the Office of New Jersey Heritage, CN 404, Trenton, New Jersey 08625.

7:4-2.4 Notification of registration and National Park Service determinations of eligibility

(a) Upon approval by the State Historic Preservation Officer of a property for listing in the New Jersey Register, all property owners named in the National Register Nomination Form in accordance with N.J.A.C. 7:4-2.2(c)4 shall receive from the Department written notification of the registration including the date of approval. Notification shall also be sent to the chief elected local official of the county and municipality in which the property is located and, if the property is located within the jurisdiction of a Certified Local Government, to the Historic Preservation Commission. Alternative methods of notification, such as publication in the official newspaper of the municipality, or in a newspaper circulating in the municipality, may be used when the number of property owners in a proposed historic area exceeds 50. ***Notification of all registrations in counties under the jurisdiction of the Pinelands Commission shall also be sent to the Pinelands Commission.***

(b) Upon approval by the Keeper of a property for listing in the National Register, the State Historic Preservation Officer shall send written notification of the registration to the property owners and the chief elected local official of the county and the municipality in which the property is located and, if the property is located within the jurisdiction of a Certified Local Government, to the Historic Preservation Commission. Alternative methods of notification, such as publication in the official newspaper of the municipality, or in a newspaper circulating in the municipality, may be used when the number of property owners in a proposed historic area exceeds 50.

(c) In the case of nominations where the owner of private property or the majority of such owners for an area or a single property with multiple owners has objected to listing in the National Register and the Keeper has determined the property or area to be eligible for the National Register, the State Historic Preservation Officer shall send written notification of the determination of eligibility to the property owners and the chief elected local official of the county and the municipality in which the property is located and, if the property is located within the jurisdiction of a Certified Local Government, to the Historic Preservation Commission. Alternative methods of notification, such as publication in the official newspaper of the municipality, or in a newspaper circulating in the municipality, may be used when the number of property owners in a proposed historic area exceeds 50.

7:4-2.5 Listed property file

Documentation of properties approved for listing in the New Jersey Register shall be on file and, subject to the provisions of N.J.A.C. 7:4-2.7, shall be available for public inspection at the Department.

7:4-2.6 Distribution of New Jersey Register and National Register

The Department shall *[regularly]* update and publish the New Jersey Register and National Register ***every two years***. After each publication, the Department shall send a copy of the New Jersey Register and National Register to the clerk of each county and municipality and to all New Jersey State Government departments.

7:4-2.7 Disclosure of nomination ***or registration of a historic property***

The State Historic Preservation Officer need not make available to any person or entity except a Federal or State agency planning a project, the property owner, the chief elected local official of the county or municipality in which the property or district is located and the local Historic Preservation Commission for Certified Local Governments of the municipality in which the property is located, specific information relating to the location of properties proposed to be registered***, or already registered in the New Jersey or National Registers, if the State Historic Preservation Officer determines that the disclosure of specific information would create a risk of destruction or harm to such properties***.

SUBCHAPTER 3. BOUNDARY REDELINEATION AND RELOCATION OF PROPERTIES LISTED IN THE NEW JERSEY REGISTER

7:4-3.1 Redelineation of the boundary of property listed in the New Jersey Register

(a) The boundary of a property listed in the New Jersey Register may be redelineated only if:

1. Property that meets the criteria for evaluation in N.J.A.C. 7:4-2.3 was not included in the registered property or property that does not meet the criteria for evaluation in N.J.A.C. 7:4-2.3 was included in the registered property as the result of professional error in the original nomination of the registered property for listing in the New Jersey Register;

2. Property comprising part of registered property no longer meets the criteria for evaluation in N.J.A.C. 7:4-2.3 because the integrity of the qualities that caused the property to be listed in the New Jersey Register has been lost;

3. The property possesses additional, previously unrecognized significance in American history, architecture, archaelogy, engineering or culture which causes the property to meet the criteria for evaluation in N.J.A.C. 7:4-2.3; *[or]*

4. Additional research documents that a larger or smaller area of the registered property should be listed*[.]**; or*

5. Original delineation is inadequate to determine boundary limits.

(b) ***Except for redelineations under (a)5 above,*** *[T]***t***he redelineation of the boundary of property listed in the New Jersey Register shall be considered a new nomination of a property to the New Jersey Register. A new National Register Nomination Form shall be prepared and submitted to the Department and processed by the Department in accordance with the procedure for the nomination of properties for inclusion in the New Jersey and National Registers set forth in N.J.A.C. 7:4-2.2. Any proposal to alter a boundary shall be documented in detail, including photographs of the historic resources located between the existing boundary and the proposed boundary. In the case of a proposed enlargement of the boundary of a registered property, only those property owners in the new area proposed to be included as part of a registered property shall be notified and counted in determining whether a majority of private property owners object to National Register listing as provided in N.J.A.C. 7:4-2.2(c)13. In the case of a proposed diminution of a boundary of a registered property, all owners of the registered property shall be notified and counted in determining whether a majority of private property owners object to the removal of part of a registered property from the National Register as provided in N.J.A.C. 7:4-2.2(c)13. If the State Historic Preservation Officer signs the National Register Nomination Form in accordance with N.J.A.C. 7:4-2.2(c)*[14]****15***, the revised boundaries of the registered property shall thereby be listed in the New Jersey Register and simultaneously recommended to the Keeper of the National Register. If the National Register Nomination Form is not signed by the State Historic Preservation Officer, the boundaries of the registered property shall not be changed.

(c) For redelineations under (a)5 above, an attachment to the National Register Nomination Form shall be prepared and submitted to the Department. The submission shall include a verbal boundary description, maps, and boundary justification. The Department shall process the redelineation in accordance with N.J.A.C. 7:4-2.2.

7:4-3.2 Relocation of properties listed in the New Jersey Register

(a) *[Properties listed in the New Jersey Register shall be relocated]* ***The Department encourages the relocation of properties on the New Jersey Register*** only when relocation is the only feasible means for preservation of the registered property. When a registered property is relocated every effort *[shall]* ***should*** be made to reestablish its historic orientation, immediate setting, and general environment.

(b) If the State, a county, municipality or any agency or instrumentality thereof proposes to relocate a property listed in the New Jersey Register, the State, county, municipality or agency or instrumentality

thereof shall submit an application to the Department for project authorization for projects encroaching upon property listed in the New Jersey Register. The application shall be prepared, submitted and reviewed in accordance with the review procedures for projects encroaching upon property listed in the New Jersey Register set forth in N.J.A.C. 7:4-7.

(c) In order for a property listed in the New Jersey Register to be relocated and remain listed in the New Jersey Register during and after the relocation, the applicant shall submit documentation to the Department and obtain the approval thereof by the State Historic Preservation Officer prior to the relocation. The documentation shall set forth in detail:

1. The reasons for the relocation;

2. The effect of the relocation on the registered property's historical integrity which causes the property to meet the criteria for evaluation in N.J.A.C. 7:4-2.3;

3. The description of the new setting and general environment of the proposed site, including evidence that:

i. The proposed site does not possess historical or archaeological significance that would be adversely affected by the proposed relocation; and

ii. The proposed site will, to the maximum extent possible, contribute to reestablishing the registered property's previous historic orientation, immediate setting, and general environment; and

4. Photographs showing the proposed location.

(d) Documentation submitted to the Department under (c) above shall be processed by the Department in accordance with the procedure for the nomination of properties for inclusion in the New Jersey and National Registers set forth in N.J.A.C. 7:4-2.2.

(e) If the State Historic Preservation Officer approves continued listing of the property despite its relocation, the property shall remain in the New Jersey Register during and after the relocation unless the historic integrity which causes the property to meet the criteria for evaluation in N.J.A.C. 7:4-2.3 is in some unforeseen manner destroyed during or as a result of the relocation. Within 90 days after the registered property has been relocated, an applicant shall submit to the Department:

1. A letter notifying the State Historic Preservation Officer of the date that the registered property was relocated;

2. Photographs of the registered property on its new site;

3. A revised map of the new site including a United States Geological Survey map; and

4. The acreage and a verbal boundary description of the new site.

(f) The State Historic Preservation Officer shall respond to a complete and properly documented submittal under (e) above within 45 days of receipt with a final determination on whether the relocation has destroyed the historic integrity of the registered property which caused the property to meet the criteria for evaluation in N.J.A.C. 7:4-2.3. If the State Historic Preservation Officer makes such a determination, the property shall be deleted from the New Jersey Register as of the date of the relocation of the property. In cases of properties removed from the New Jersey Register, if the applicant has neglected to obtain prior approval for the move or has evidence that previously unrecognized significance exists, or has accrued, the applicant may submit a new National Register Nomination Form for the property.

(g) If a registered property is relocated without first obtaining approval for continued listing from the State Historic Preservation Officer as provided in (e) above, the property shall, as of the date of relocation, be deleted from the New Jersey Register. However, a property which is subject to the encroachment review process set forth in N.J.A.C. 7:4-7 shall not be automatically deleted from the New Jersey Register until said review process is completed. If a registered property is relocated without first obtaining the approval required under (b) or (e) above, it is the responsibility of the property owner or applicant to notify the Department.

(h) If a property is deleted from the New Jersey Register under (g) above, in order for the property to be reentered in the New Jersey Register, a new National Register Nomination Form shall be prepared and submitted to the Department and processed by the Department in accordance with the procedure for nomination of properties for inclusion in the New Jersey and National Registers set forth in N.J.A.C. 7:4-2.2. In addition to the information required as part of a complete National Register Nomination Form under N.J.A.C. 7:4-2.2, the nomination form shall set forth in detail:

1. The reasons for the relocation;

2. The effect of the relocation on the property's historical integrity which caused the property to meet the criteria for evaluation in N.J.A.C. 7:4-2.3;

3. The new setting and general environment, including evidence that the new site does not possess historical or archaeological significance that would be affected by intrusion of the property;

4. Photographs showing the new site;

5. A United States Geological Survey Map showing the property at the new site; and

6. The acreage and a verbal boundary description of the new site.

7:4-3.3 Properties relocated in accordance with the recommendations of the Advisory Council on Historic Preservation

Properties relocated in accordance with the recommendations of the Advisory Council on Historic Preservation under 36 CFR, Part 800, are exempt from N.J.A.C. 7:4-3.2(c) through (h). An applicant shall notify the Department of the new site after the property has been relocated. The notice shall include the information and documentation required in N.J.A.C. 7:4-3.2(e).

7:4-3.4 Relocation by the State, a county or municipality of property listed in the New Jersey Register

(a) When the relocation by the State, a county, municipality or agency or instrumentality thereof of property listed in the New Jersey Register is authorized by the Commissioner in accordance with the procedures in N.J.A.C. 7:4-7 for project authorization of projects encroaching upon property listed in the New Jersey Register, the authorization exempts the registered property from N.J.A.C. 7:4-3.2(c) through (h).

(b) When the relocation by the State, a county, municipality or agency or instrumentality thereof of property listed in the New Jersey Register is authorized by the Commissioner in accordance with the provisions in N.J.A.C. 7:4-7 for project authorization for projects encroaching upon property listed in the New Jersey Register, the authorization does not exempt the registered property from N.J.A.C. 7:4-3.2(c) through (h) for the purpose of the property remaining in the National Register. In order for the property to remain in the National Register, an applicant shall comply with the procedures and obtain the determination required under N.J.A.C. 7:4-3.2(c) through (h).

(c) Under (a) and (b) above, an applicant shall notify the Department of the new site after the relocation. The notice shall include the information and documentation required under N.J.A.C. 7:4-3.2(e).

SUBCHAPTER 4. REMOVAL OF PROPERTY FROM THE NEW JERSEY REGISTER

7:4-4.1 Grounds for removal of property from the New Jersey Register

(a) A property listed in the New Jersey Register may be removed from the New Jersey Register only when the State Historic Preservation Officer determines that a petition for removal filed under (d) below establishes any of the following grounds:

1. The property has ceased to meet the criteria for evaluation in N.J.A.C. 7:4-2.3 because the qualities which caused the property to be listed in the New Jersey Register have been lost or destroyed, or such qualities were lost subsequent to nomination and prior to listing in the New Jersey Register;

2. Additional information establishes that the property does not meet the criteria for evaluation in N.J.A.C. 7:4-2.3;

3. Any error in professional judgment occurred in determining that the property meets the criteria for evaluation in N.J.A.C. 7:4-2.3; or

4. Prejudicial procedural error occurred in the nomination or listing process.

(b) Property removed from the New Jersey Register on the grounds set forth in (a)4 above shall be reconsidered for listing by the State Historic Preservation Officer after correction of the procedural error or errors by the applicant or Department, as appropriate. The reconsideration shall be conducted in accordance with N.J.A.C. 7:4-2.2, 2.3 and 2.5. Any property removed from the New Jersey Register for procedural deficiencies in the nomination and/or listing process shall automatically be considered eligible for inclusion in the New Jersey Register.

(c) Property listed in the New Jersey Register five years prior to *[the effective date of the proposed rule]* ***August 17, 1992*** shall only be removed from the New Jersey Register on the grounds set forth in (a)1 above.

(d) Any person, organization or governmental agency may petition the Department in writing for removal of a property from the New Jersey Register. *[The petition shall be made on a National Register Nomination Form with appendices, as appropriate.]* The petition shall fully ***document,*** describe and explain the reasons why the petitioner believes that the property should be removed from the New Jersey Register for any of the grounds set forth in (a) above. If the petition is based on the grounds set forth in (a)1 above, the petition shall include:

1. A copy of the original nomination indicating by number the significant elements that have lost integrity;

2. A narrative description and analysis clearly demonstrating loss of integrity and the reasons for that loss such as vandalism, demolition, destruction, relocation and alterations. In the case of a district, the description shall specifically identify properties affected by loss of integrity; and

3. Photographs showing existing conditions and keyed to a map and the nomination form.

(e) The State Historic Preservation Officer shall respond to the petitioner in writing within 45 days of receipt of the petition for removal of a property from the New Jersey Register. The response shall advise the petitioner of the State Historic Preservation Officer's views on the petition. A petitioner desiring to pursue his or her removal request shall notify the State Historic Preservation Officer in writing within 45 days of receipt of the written views on the petition. A property shall be considered *[from]* ***for*** removal according to the nomination application procedure in N.J.A.C. 7:4-2.2 except that:

1. The procedures in N.J.A.C. 4-2.2(c)4, 14, 15 and 16 shall be completed in 15 days; and

2. The State Historic Preservation Officer shall forward the removal petition to the Keeper of the National Register within 15 days of the date of the meeting at which the State Review Board considered the petition.

SUBCHAPTER 5. CERTIFICATION OF ELIGIBILITY FOR LISTING IN THE NEW JERSEY REGISTER

7:4-5.1 Certification of eligibility for listing in the New Jersey Register

(a) If the property for which a historic preservation grant is requested under the New Jersey Green Acres, Cultural Centers and Historic Preservation Bond Act of 1987, P.L. 1987, c.265, is not listed on the New Jersey Register, the applicant shall, prior to submission of a historic preservation grant application under N.J.A.C. 7:4A, obtain from the State Historic Preservation Officer a certification of eligibility stating that the property for which a grant is requested is eligible for listing in the New Jersey Register. An applicant for an historic preservation grant for property within a registered district which is not categorized on the National Register Nomination Form as either contributing or noncontributing to the character of the district shall apply to the Department for a certification of eligibility.

7:4-5.2 Criteria for issuance of a certification of eligibility

In determining whether to issue a certification of eligibility, the Department shall apply the criteria of evaluation set forth in N.J.A.C. 7:4-2.3.

7:4-5.3 Application for certification of eligibility

(a) To apply for a certification of eligibility for listing in the New Jersey Register, the applicant for an historic preservation grant shall:

1. Obtain a preliminary questionnaire and individual survey form from the Department;

2. Submit the folllowing to the Department for a determination by the State Historic Preservation Officer whether the property is eligible for listing in the New Jersey Register.

i. The completed preliminary questionnaire and individual survey form;

ii. Clear photographs that show the property in complete exterior and interior views; and

iii. A letter signed by the chief elected local official of the applying county or municipality, a letter signed by the chief executive officer of the applying nonprofit organization, or a letter signed by the head of the applying State agency confirming the intent of the State, county, municipality, or nonprofit organization to apply for a historic preservation grant for the property.

3. If a property within a district listed in the New Jersey Register is not described on the National Register Nomination Form as being contributing or noncontributing to the character of the district, the application shall describe on the individual survey form how the property contributes to the character of the district.

4. If, based on its review of the preliminary questionnaire, individual survey form and photographs submitted under (a)2 above, the Department determines that a property may be eligible for listing in the New Jersey Register as part of a district, the Department shall provide the applicant with a district survey form. The applicant shall complete the district survey form within 90 days of the Department's issuance of the form and submit it to the Department with photographs that show representative views of the district.

(b) Within 45 days after receipt by the Department of a complete application for a certification of eligibility under (a) above, the State Historic Preservation Officer shall:

1. Determine whether the property is eligible for listing in the New Jersey Register under the Criteria for Evaluation set forth in N.J.A.C. 7:4-2.3; and

2. Notify the applicant in writing whether or not the State Historic Preservation Officer has determined that the property is eligible for listing in the New Jersey Register.

i. If the State Historic Preservation Officer has determined that the property is eligible for listing in the New Jersey Register, the State Historic Preservation Officer shall send a certification of eligibility, which shall specify how the property meets the criteria for eligibility set forth in N.J.A.C. 7:4-2.3 to the applicant.

ii. If the State Historic Preservation Officer has determined that the property is not eligible for listing in the New Jersey State Register, the State Historic Preservation Officer shall give the applicant a written explanation of the State Historic Preservation Officer's determination that the property does not meet the criteria for evaluation in N.J.A.C. 7:4-2.3.

(c) If the State Historic Preservation Officer has determined that the property is not eligible for listing in the New Jersey Register, the applicant may apply for nomination of the property for listing in the New Jersey and National Registers under N.J.A.C. 7:4-2.2. The State Historic Preservation Officer's determination on the application for certification of eligibility shall be submitted with the National Register Nomination Form.

SUBCHAPTER 6. STATE FUNDS

7:4-6.1 Expenditure of State funds for historic preservation

(a) The Act requires that only properties on the New Jersey Register shall receive State funding for acquisition, preservation, restoration, and maintenance as historic properties.

(b) It is the responsibility of all State agencies considering funding a property for use as an historic place or site to apply for listing on the New Jersey Register as early as possible in their planning process. State agencies shall contact the Department for help and advice as to the eligibility of a property under their jurisdiction for listing in the New Jersey Register.

(c) Historic properties owned and maintained by the State of New Jersey, Department of Environmental Protection ***and Energy***, before November 30, *[1979]* ***1970***, are exempt from this subchapter.

SUBCHAPTER 7. REVIEW PROCEDURES FOR PROJECTS ENCROACHING UPON NEW JERSEY REGISTER PROPERTIES

7:4-7.1 Application procedure for encroachment authorization

(a) During the earliest stage of planning for any undertaking and before taking any action that could result in a physical effect on a property listed in the New Jersey Register, the State, a county, municipality or an agency or instrumentality thereof shall:

1. Consult with the Department for the purpose of defining the boundaries of the area of the undertaking's potential impact;

2. Consult the latest edition of the New Jersey Register to determine if there are any registered properties within the area of the undertaking's potential impact; and

3. Contact the Department and determine if other properties within the area of the undertaking's potential impact have been *[nominated to]* ***listed in*** the New Jersey Register since the most recently published list. Public projects or actions for which acquisition or construction contracts have been let prior to listing on the New Jersey Register shall not require review and approval.

(b) If there is no property on the New Jersey Register in the area of the undertaking's potential impact, the undertaking may commence without further review and approval by the Department pursuant to the Act and this chapter.

(c) If there is property on the New Jersey Register in the area of the undertaking's potential impact, the State, a county, municipality or an agency or instrumentality thereof shall submit an application to the Department for project authorization.

(d) The application shall be prepared by the State, county, municipality or agency or instrumentality thereof planning the undertaking or its authorized representative on forms available from the Department and shall include: maps, photographs, plans*****,* specifications, and proposed agreements sufficient to completely describe the planned undertaking. In addition, the application shall include a complete list of owners of registered properties that would be directly affected by the undertaking and a complete list of local historical societies and historic preservation commissions in the area of the undertaking's potential impact. The list of property owners shall be the list of *[property owners]* ***private and public property owners (including right-of-way owners)*** named in official municipal tax records ***and maps*** as of the date of the application's submission and shall be notarized by the appropriate municipal official. An application for relocating a property on the New Jersey Register shall also include the information and documentation required in N.J.A.C. 7:4-3.2(c).

7:4-7.2 Review of an application for project authorization

(a) Within 30 days of receipt of an application for project authorization, the Department shall review the application for technical and professional completeness and sufficiency and shall notify the applicant in writing as to whether or not the application is complete and sufficient. If the application or material is not complete and sufficient, the Department shall notify the applicant in writing of what information is needed.

(b) Pursuant to N.J.S.A. 13:1B-15.131, the Department shall have 120 days to review an application for project authorization. The 120 day review period shall commence on the date that the Department *[issues notice to the applicant that the application]* ***receives an application that*** is technically and professionally complete and sufficient. In the event that the Department does not authorize, consent to, conditionally authorize or consent to, deny, or temporarily deny an application within the 120 day period, the application shall be deemed to have been approved.

(c) Upon determination by the Department that an application for project authorization is technically and professionally complete and sufficient, the Department shall:

1. Conduct a review to determine if the undertaking for which the application is submitted constitutes an encroachment or will damage or destroy the historic property under the criteria set forth in N.J.A.C. 7:4-7.4 and the Standards for Historic Preservation Projects and Guidelines for Applying the Standards, 36 CFR Part 1207 or subsequent amendments thereto, adopted by the Secretary of the United States Department of the Interior, now in effect and as may subsequently be modified, changed or amended, incorporated herein by reference; and

2. Within 45 days after the Department's issuance of notice to the applicant that an application is technically and professionally complete and sufficient, notify the applicant in writing whether or not the undertaking constitutes an encroachment or will damage or destroy the historic property. The notification shall include an explanation of the reasons for the Department's determination. ***The Department shall send a copy of any notification that an undertaking does not constitute an encroachment or will not damage or destroy the historic property to local historical societies and historic preservation commissions, as listed by the applicant in the application for authorization, pursuant to N.J.A.C. 7:4-7.1(d).***

(d) If the Department determines that the undertaking does not constitute an encroachment or will not damage or destroy the historic property, the applicant may proceed with the project upon receipt of the Department's written notice under (c)2 above.

(e) If the Department determines that an undertaking constitutes an encroachment or will damage or destroy the historic property:

1. The application for project authorization shall be scheduled to be reviewed by the Historic Sites Council at a regularly scheduled meeting. At least 21 days before the scheduled meeting date, the Department shall determine the agenda for the Council meeting and consistent with the Open Public Meeting Act, N.J.S.A. 10:4-6 et seq. send written notification of the meeting to:

i. The applicant;

ii. The chief elected local official of the municipality in which the proposed undertaking would occur;

iii. A major circulation newspaper in the area of the municipality in which the proposed undertaking would occur;

iv. Local historical societies and historic preservation commissions, as listed by the applicant in the application for authorization pursuant to N.J.A.C. 7:4-7.1(d);

v. Owners of registered properties that would be directly affected by the undertaking, as listed by the applicant in the application for project authorization, pursuant to N.J.A.C. 7:4-7.1(d). For an application where more than 25 owners would be directly affected by the undertaking, the Department may publish a public notice to property owners concerning the Council's meeting instead of individually notifying all property owners. Such public notice shall be published 21 days before the scheduled meeting date; and

vi. Interested parties who have advised the Department in writing of their interest in the application.

2. The Historic Sites Council shall meet to review the application for project authorization and evaluate the encroachment using the criteria set forth in N.J.A.C. 7:4-*****[5.4]***7.4*** and the Standards for Historic Preservation Projects and Guidelines for Applying the Standards, 36 CFR Part 1207 or subsequent amendments thereto, adopted by the Secretary of the United States Department of the Interior, now in effect and as may subsequently be modified, changed or amended, incorporated herein by reference. The Council shall also consider the following:

i. The public benefit of the proposed undertaking;

ii. Whether or not feasible and prudent alternatives to the encroachment exist; and

iii. Whether or not sufficient measures could be taken to avoid, reduce or mitigate the encroachment.

3. The Historic Sites Council shall submit written recommendations to the Commissioner.

4. In addition to considering the recommendations of the Historic Sites Council, the Commissioner may direct the conduct of a public hearing on the application prior to granting or denying authorization of the encroachment.

5. Within the 120 day review period under (b) above, the Commissioner shall transmit to the applicant a written decision with specific reasons therefor which shall either:

i. Authorize or consent to the encroachment as described in the application;

ii. Authorize or consent to the encroachment with conditions. The conditions may include, but are not limited to placement of a preservation covenant in the deed for the property in the event of the conveyance of any interest in the property; marketing of the historic property over a reasonable period of time; recordation of the historic property to the standards and approval of the Historic American Buildings Survey or Historic American Engineering Record (HABS/HAER) through photographs, drawings and written narrative; archaeological survey or data recovery; salvage of significant architectural features; and revisions to the architectural plans or other conditions that would enable the project to meet the Standards for Historic Preservation Projects, 36 CFR Part 1207 or subsequent amendments thereto, or otherwise avoid, reduce or mitigate the encroachment.

(1) The applicant shall respond to the conditions within 60 days of the issuance of the Commissioner's decision. If the applicant agrees in writing that all the conditions are acceptable and will be met, the undertaking may proceed. If the applicant does not respond within 60 days or does not agree with all the conditions, the Commissioner shall deny the application for project authorization. Prior to the undertaking, the applicant shall submit to the Department written and photographic documentation or revised final architectural plans and specifications to show how the conditions of the approval have been or will be satisfied. Upon completion of the undertaking, the applicant shall document to the satisfaction of the Department that the applicant has complied with all the conditions;

iii. Deny the application for project authorization temporarily based on such factors as need for additional information, exploration of additional alternatives for avoidance or mitigation of the encrochment, damage, destruction or other adverse effects. The applicant shall respond to the Department within 60 days from the date of issuance of a temporary denial. In the event that no response is received by the Department within 60 days, the Commissioner shall deny the application. If the applicant submits a complete response including all information requested by the Department, the Department shall make a final determination within 60 days after receipt of the response; or

iv. Deny the application for project authorization with specific reasons therefor.

7:4-7.3 Emergency undertakings

(a) In the case of an emergency undertaking which needs to be implemented by the State, a county or municipality or an agency or instrumentality thereof, within 30 days of an emergency, the State, county or municipality or agency or instrumentality thereof, in lieu of the application procedure in N.J.A.C. 7:4-7.1, shall notify the Department by telephone and in writing as soon as possible. Said notification shall include: the name and address of the property listed in the New Jersey Register, a written description of the scope of the emergency undertaking, photographs documenting the condition of the registered property, a statement from an appropriate expert demonstrating how the condition of the property constitutes an immediate, direct, demonstrable and severe hazard to the safety of the public, and a statement as to how the undertaking will encroach upon the registered property. If demolition of all or a substantial portion of a property is proposed, the notification shall include a structural assessment and an evaluation of whether the property could be reasonably repaired, to be prepared by an architect or engineer with demonstrated experience with historic properties.

(b) The Department shall respond within seven calendar days after receipt by the Department of the complete notification as described in (a) above. If the Department determines that the condition of the property constitutes an immediate direct, demonstrable, and severe hazard to the safety of the public, Historic Sites Council review is not required and the Department shall respond in accordance with N.J.A.C. 7:4-7.2(e)5 ***but within seven calendar days after receipt by the Department of the complete notification as described in (a) above***. Until the Department authorizes the emergency undertaking, the State, county or municipality or agency or instrumentality thereof conducting the emergency undertaking shall only take measures necessary to stabilize or isolate the affected property to prevent danger to the public. The Department may determine that the situation does not constitute an emergency and require that the applicant follow the application procedure in N.J.A.C. 7:4-7.2.

7:4-7.4 Criteria for determining whether an undertaking constitutes an encroachment or will damage or destroy the historic property

(a) An undertaking will have an adverse effect and therefore constitute an encroachment when the effect of the undertaking on a property listed in the New Jersey Register may diminish the integrity of the property's location, design, setting, materials, workmanship, feeling, or association. Encroachments include, but are not limited to:

1. Physical destruction, damage, or alteration of all or part of the registered property;

2. Isolation of the registered property from or alteration of the character of the property's setting when that character contributes to the property's qualification for the New Jersey Register;

3. Introduction of visual, audible, or atmospheric elements that are out of character with the registered property or alter its setting; and

4. Acquisition, transfer, sale, lease, easement on, or an agreement or other permission allowing use of a registered property.

(b) An undertaking that would otherwise be found to constitute an encroachment pursuant to (a) above may be considered by the Department as not being an encroachment when:

1. The registered property is of value only for its potential contribution to archaeologica***l***, historical, or architectural research, and when such value can be substantially preserved through the conduct of appropriate research, and such research is conducted in accordance with applicable professional standards and guidelines;

2. The undertaking is limited to the rehabilitation, restoration, stabilization, or protection of buildings and structures and is conducted in a manner that preserves the historical and architectural value of affected historic property through conformance with the Standards for Historic Preservation Projects and Guidelines for Applying the Standards 36 CFR Part 1207 or subsequent amendments thereto, adopted by the Secretary of the United States Department of the Interior; or

3. The undertaking is limited to the acquisition, transfer, sale, lease, easement on, or an agreement or other permission allowing use of a registered property, and adequate restrictions or conditions are included to ensure preservation of the property's significant historic features.

HEALTH

(a)

DIVISION OF HEALTH FACILITIES EVALUATION

Standards for Licensure of Home Health Agencies Adopted Repeal and New Rules: N.J.A.C. 8:42

Proposed: June 1, 1992 at 24 N.J.R. 2031(a).

Adopted: July 21, 1992, by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Filed: July 21, 1992 as R.1992 d.322, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Effective Date: August 17, 1992.

Expiration Date: August 17, 1997.

Summary of Public Comments and Agency Responses:

On June 1, 1992, the Department proposed the repeal of the current licensing standards for home health agencies at N.J.A.C. 8:42, due to expire on August 17, 1992, and proposed new and revised rules, Standards for Licensure of Home Health Agencies, also at N.J.A.C. 8:42, as the basis for licensure of home health agencies in New Jersey.

The Department received 16 letters of comment regarding the proposed new and revised rules. Letters were submitted by the Home Health Assembly of New Jersey, Inc., the New Jersey State Board of Nursing, the New Jersey State Board of Social Work Examiners, the Division of Mental Health Advocacy of the Department of the Public Advocate, the New Jersey Pharmaceutical Association, and the following providers: Community Nursing Service of the City of Vineland, Shore Care, Holy Name Hospital Home Care/Hospice, Mercer Street Friends Center, Long Branch Public Health Nursing Association, Inc., Visiting Nurse and Health Services of Elizabeth, Moorestown Visiting Nurse Association, Somerset Valley Visiting Nurse Association, Inc., Prime Care in Home Health Services, and Visiting Nurse Association of Southern New Jersey. A form letter was submitted by the following members of the staff at Somerset Valley Visiting Nurse Association, Inc.: Cynthia Robotti, RN, MS; Lois Grudinsky, RN, BSN; Parisol Kulick, BS, RN; Alice McIntyre, RN; Lillian Elizabeth Gasper, RN; Kathleen Murray Bayda, RN, BSN; Maureen Bassinger, RN; Judith Schwartz, RN; Donna Gaykill, RN; Anita Ciano, RN; Sherry Kuhne, RN; Joanne Lane, RN; Karen Garren, RN; Roberta Hausman, RN; Carol Cooke, RN; and an individual whose signature is illegible. All of the letters of comment are on file at the Standards and Quality Assurance Program of the Department and may be reviewed by contacting that office. As discussed below, consideration of the comments and further review of the proposed rules have resulted in changes being made to the rules. The Department maintains that these changes will not jeopardize patient health or safety, nor are they so substantive as to require additional public notice and comment. A summary of the comments and the Department's responses follows.

COMMENT: Several agencies, including Long Branch Public Health Nursing Association, Visiting Nurse and Health Services of Elizabeth, Visiting Nurse Association of Southern New Jersey, Moorestown Visiting Nurse Association, and the Home Health Assembly of New Jersey, commended the revised standards as more readable and relevant, as addressing needed and significant improvements, as clarifying ambiguities, and as a cooperative effort between the Department and the provider community.

RESPONSE: The Department appreciates these comments, as well as the valuable contributions made by the home health industry.

N.J.A.C. 8:42-1.2 Definitions

"Director of Nursing" and "nursing supervisor"

COMMENT: Comments were submitted by five entities in regard to the revised qualifications for the Director of Nursing position in home health agencies. The New Jersey State Board of Nursing stated that the Director of Nursing is responsible for the overall provision of all care to patients, and cited professional standards recommending a master's prepared professional nurse to provide direction to home health services. The Board expressed concern about a lower standard of care for New Jersey residents, and noted that "the removal of the requirement for a bachelor of science in nursing degree does not seem in keeping with the Department's intent ensuring quality care."

Community Nursing Service of the City of Vineland commented that "a lowering of educational standards in order to procure a body to direct an agency should not be allowed." This provider stated that a master's degree is an extension of the baseline nursing knowledge provided by a BSN, and that the previous requirement for a master's degree should stand. Mercer Street Friends Center agreed that the standards should not be permanently lowered, and that the current practice of requesting temporary waivers for exceptional candidates should continue. This agency wrote that eliminating the master's degree requirement would result in further erosion of the stature of home health in the health care industry and would pose a threat to the quality of care; the agency further noted that deleting the BSN requirement for Nursing Supervisor would diminish the value of the public health and administrative theory that higher education provides. Long Branch Public Health Nursing Association commented that "the Profession of Nursing is continually trying to establish itself as a recognized Profession, and that lowering the educational requirement for leadership/administrative positions is a significant step backward." This agency continued by writing that high qualifications in home care management positions are still necessary "since there is no end in sight for the projected significant growth and complexity in this area of health care." Visiting Nurse and Health Services of Elizabeth noted that New Jersey is recognized for its high standards and requested that the standards not be changed.

RESPONSE: The Department is steadfast in its support of the highest quality of care possible in the provision of health services. It is important to remember that the standards of care which are proposed are minimum standards, and that, in all cases, the agency or facility has the option of holding to higher standards. The definition of qualifications for the Director of Nursing position, for example, includes the master's degree as the first option, and the definition for nursing supervisor includes the bachelor of science degree as the option of choice. Agencies may hold to these options in their own personnel policies. The Department has elected to expand the options and offer more flexibility to those agencies which have been unable to recruit candidates with these qualifications. The Department has received a significant number of waiver requests for these positions which indicates a greater need for flexibility in setting a minimum standard. In limited cases, imposition of the higher standards without flexibility could cause financial hardship to smaller agencies. Finally, the Department recognizes that credentials alone do not necessarily ensure that the highest quality of patient care will be rendered in all circumstances. Consequently, the standards as proposed remain unchanged.

"Clinical note"

COMMENT: Community Nursing Service of Vineland objected to "the forced use of a narrative note on every visit," citing increased record size, nurse's documentation time, and visit cost." Mercer Street Friends Center commented that the requirement of a daily narrative does not necessarily assure quality, and that a detailed flow sheet with multiple codes can document both parameters and patient responses. Long Branch PHN Association suggested that the flow sheet format be used to document signs and symptoms, treatment and/or medications administered, patient response, and any changes in physical or emotional condition, and that nurses "document a narrative clinical note to identify all changes or care provided that cannot be clearly documented on the flow sheet, and document a narrative clinical note at least weekly." Somerset Valley Visiting Nurse Association, Inc., commented that the expanded definition requiring a written narrative progress note for each visit, even in the presence of an entry on a flow sheet, constitutes "over-regulation" and is too prescriptive. The Home Health Assembly of New Jersey, Inc. wrote that the requirement for narrative notes creates a duplicative paperwork burden which does not ultimately protect the public or improve care; in fact, it would take time away from direct patient care. The Home Health Assembly asserted that agencies have the right and responsibility to determine their own best medical record methods and systems and suggested a revised definition which would permit flow sheet, narrative, or a combination of documentation methods. Visiting Nurse Association of Southern New Jersey commented that flow sheets were designed to increase the nurse's "hands-on" time with a patient by decreasing the time needed for documentation, and that requiring nurses to return to narrative is going backwards. This agency also commented that the format should be left up to the agency.

RESPONSE: The Department acknowledges the concerns that have been expressed, and concurs that the proposed definition can be modified to reduce the paperwork burden. However, the use of flow sheets without periodic narrative notes may, in many instances, result in incomplete documentation and may not accurately portray changes in the patient's condition or care. Consequently, the definition of "clinical note" has been amended to permit documentation in a flow sheet format, with supplementary narrative notes required at least once a week, and whenever there is a change in the patient's condition or care which cannot be clearly documented on the flow sheet.

"Restraint"

COMMENT: The Division of Mental Health Advocacy of the Department of the Public Advocate commented that the definition of restraint is all inclusive, so that a home health agency may be authorized under these standards to utilize not only loose and soft restraining devices, including bed rails, but also the most restrictive and most medically dangerous form of restraint, namely leather limb restraints. The Public Advocate cited cases in which institutionalized patients have died as a result of circulatory obstruction from the use of leather limb restraints over prolonged periods. The Advocate also cited rules that this Depart-

ment has recently adopted regarding the use of restraints in acute care hospitals, noting that the restrictions on their use should be at least as severe in the home health setting. The Advocate finally noted concerns for patient rights under the New Jersey Patients' Bill of Rights.

RESPONSE: The Department shares the concerns of the Public Advocate regarding the safety and rights of patients with the use of restraints. The Department would point out, however, that the home health care patient population has significant differences from the institutionalized population, a major one being the fact that home care patients are under the care of home health agency personnel for only short periods of time, and are under the care of family members or other caretakers for the remainder of the time. The previous rule for home health agencies permitted no use of restraints by home health agency personnel, but has been modified in the current proposal to reflect the fact that many patients are under physician orders for some type of restraint and that home health care personnel must realistically be permitted to adjust, loosen, modify, or apply restraints at least occasionally. The guiding factor is that the type and use of restraints must be ordered by the physician (home health personnel do not select the type, such as leather limb restraints, nor do they have control over how long the restraints are used, as they are not present for long periods of time). However, at N.J.A.C. 8:42-13.1(a)13, the patient's right "to freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the patient or others from injury" is spelled out, and a component for teaching the patient's family or caregiver the appropriate use of restraints is included at N.J.A.C. 8:42-6.2(a)8v. The agency is further required to have policies and procedures indicating the need for physician orders, indications and contraindications for use, alternatives to physical restraints, and the designation of staff who are authorized to use restraints according to scope of practice. These safeguards, although minimal, are believed to be adequate, and no change in the rule is made at this time.

"Social worker"

COMMENT: The New Jersey State Board of Social Work Examiners wrote in reference to the Social Workers Licensing Act (P.L. 1991, c.134), which sets forth the requirements for licensure or certification of various levels of social work practice. The Board requested that the definition of "social worker" at N.J.A.C. 8:42-1.2 be amended to include the specifics of the requirements for licensure both prior to and after the actual granting of licenses by that Board.

RESPONSE: The Department acknowledges the impact of the Social Workers Licensing Act upon the practice of social work in all licensed health care facilities in New Jersey. However, the commenter is referred to the rule at N.J.A.C. 8:42-3.4(b), which mandates that all personnel who require licensure, certification, or authorization to provide patient care shall be licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey, so that social workers will be required to be licensed or certified according to level of practice when the Act is fully in effect. The definition of social worker in the proposed rules is generic and will not be changed at this time.

N.J.A.C. 8:42-3.4

COMMENT: Moorestown Visiting Nurse Association wrote that the new employee health standards requiring Mantoux testing and rubeola screening "are excessive and place an unfair burden on the employer." The agency noted that non-clinical employees should not be required to have Mantoux testing and questioned the frequency of the proposed testing schedule, especially for those agencies that do not serve high risk areas. Finally, it noted that new rules requiring rubeola screening will be costly and unnecessary.

RESPONSE: The rules are considered important public health measures and are designed to protect both agency personnel and home care patients, especially in view of the documented spread of infectious disease in New Jersey. For example, there have been recent fatal outbreaks of measles (rubeola) among patients in compromised health status, and tuberculosis is one of the diseases known to be associated with AIDS. The target population and the frequency of testing are recommended by the Division of Epidemiology and Communicable Disease Control of the Department, and the public health benefit is considered to outweigh the moderate cost. Therefore, the rule has not been amended.

N.J.A.C. 8:42-3.5

COMMENT: Community Nursing Service of Vineland commented that requiring annual education for all staff and subcontracted personnel in child abuse, sexual abuse, domestic violence, and abuse of the elderly or disabled adult "leaves little time for other possible more pertinent educational programs." The agency noted that policies are available, there is a person designated for reporting, and costs will rise because clinicians are attending another program instead of out making visits.

RESPONSE: The Department disagrees that the training in these issues of great social importance is superfluous or replaces more valuable training or tasks. In many instances, home health care workers may be primary case finders who must know how to respond even before delegating responsibility to another person. The standard remains unchanged.

N.J.A.C. 8:42-3.8

COMMENT: A comment was made by Shore Care of Shore Memorial Hospital noting that the standard at N.J.A.C. 8:42-3.8(a)1 makes reference to "public health nurse director," when in fact that title has been changed in the definitions section to "Director of Nursing."

RESPONSE: The commenter is correct, and the standard has been amended to reflect the new title.

N.J.A.C. 8:42-6.1

COMMENT: The New Jersey Pharmaceutical Association, representing 3,500 pharmacist/members, commented that "the Advisory Group should have a consultant pharmacist as a member, since many of these home care patients are undergoing drug therapy and the addition of a consultant pharmacist would be beneficial to patients." This Association also suggested that, in addition to one member of the Advisory Group being neither an owner nor an employee of the facility, the Department should add the language "nor a person representing anyone under contract to the facility."

RESPONSE: The Department believes that the addition of a consultant pharmacist to the roster of the Advisory Group would constitute a substantive change to the rule, requiring additional publication and opportunity for public comment. A fiscal impact to agencies would result from the suggested change. Consequently, the suggested change has not been made at this time, but will be taken under consideration at a later date. At such time, the comment regarding contractual personnel will also be considered.

COMMENT: Somerset Valley Visiting Nurse Association, Inc., commented upon the revised requirement that "the full advisory group shall meet at least annually." The agency noted that its advisory group meets three times per calendar year, and, in a possible misinterpretation of the standard, wrote that individual members could attend one or two meetings per year without the agency having the full complement at any one meeting.

RESPONSE: As noted, the agency appears to have misinterpreted the revised standard. The rule requiring at least one meeting per year is a minimum standard; agencies are free to set higher standards for this or any other rule in the manual. Further, the rule applies to the advisory committee in its entirety, not to individual members; consequently, the full complement of committee members must meet at least once a year. There is no change in the rule.

N.J.A.C. 8:42-6.2

COMMENT: The New Jersey Pharmaceutical Association wrote that this section should include a requirement for the services of a consultant pharmacist "based on the fact that these patients suffer from conditions very similar to nursing home patients, but have chosen to be at home rather than institutionalized." According to the Association, the addition of this service would ensure the same high level of professional service to home health as to institutionalized patients.

RESPONSE: Again, this suggestion appears to be a substantive change and cannot be considered at this time. It will, however, be given consideration at a later date, if amendments to the home health care standards are proposed.

COMMENT: Moorestown Visiting Nurse Association commented that the requirement at N.J.A.C. 8:42-6.2(a) for annual review of policies and procedures governing patient care is excessive, and requested that agencies continue to be allowed to set their own frequencies for policy review.

RESPONSE: The proposed language is consistent with that in updated standards for all licensed health facilities in New Jersey. These updated rules require that policies and procedures are reviewed at least annually, revised as needed, and implemented. There is no change to the rule, since the Department believes this minimum standard to be both reasonable and necessary for the protection of the public's health.

N.J.A.C. 8:42-6.3

COMMENT: Shore Care wrote that this section calls for community education programs for the distribution of information concerning advanced directives. The commenter wished to know whether this requirement could be met through a centralized education program emanating from an agency's parent organization, for example, a hospital education department.

RESPONSE: N.J.A.C. 8:42-6.3(c) mandates that the agency shall provide community education programs "individually or in coordination with other area agencies or organizations." The Department believes that the intent of the rule would be met if community education programs were organized and provided by the parent organization (hospital); however, the home health agency should participate in the organization and provision of these programs in order to reach its specific target population of home health consumers.

COMMENT: An additional comment was submitted by Shore Care regarding the requirement at N.J.A.C. 8:42-6.3(d)4 that agencies evaluate the validity of advance directives. The commenter noted that this appears to be a legal issue and should therefore be omitted, since agency personnel cannot give legal advice.

RESPONSE: A similar comment was made and responded to at the time that the amendments regarding advance directives for home health agencies were adopted. At that time, it was noted that the New Jersey Advance Directives for Health Care Act requires a health care facility "to assist patients interested in discussing and executing an advance directive." The standard cited above requires that the agency have the capability of evaluating the validity of the advance directive where a question of validity is indicated. The Department does not believe that specific legal expertise is required; the intent is that the advance directive be reviewed for such items as a valid form and witnessed signature. Should questions of validity arise, the agency must have a means to evaluate the validity, such as consultation with in-house counsel, or an institutional or other ethics committee.

N.J.A.C. 8:42-7.3

COMMENT: Both the Home Health Assembly and Long Branch PHNA commented on the requirement at N.J.A.C. 8:42-7.3(c) that a nursing supervisor or an alternate RN be available on the premises during facility hours of operation. Long Branch noted that this requirement could impose a hardship on a small agency with only one nursing supervisor who might be called away on an emergency or to a meeting; further, the alternate RN might be busy with clinical work in the field. Long Branch proposed the use of beepers. The Home Health Assembly asked: "Since agencies are open 24 hours a day, 7 days a week, does this mean that a nursing supervisor must be on the premises during all of those hours?" The Assembly also noted that "in this era of beepers and cellular phones, agency nursing supervisors are routinely available round-the-clock via these communication devices."

RESPONSE: The Department would point out that the standard as proposed is a relaxation of the previous rule which required simply that a nursing supervisor be available on the premises, with no provision in the rule for alternate coverage. The Department does not agree that beepers and cellular phones are reliable or adequate substitute for the presence of a supervisor or alternate who is immediately available to perform such functions as resolving emergencies, getting critical information from the medical/health record, answering inquiries from staff, and taking verbal orders from physicians. In response to the query of the Home Health Assembly regarding hours of operation, the Department would point out that agencies are not required to be "open" 24 hours a day, seven days a week, although N.J.A.C. 8:42-3.1(a) does require that nursing services be available at all times. In order to clarify agency hours of operation, during which a nursing supervisor or alternate would need to be present under the proposed rule, a definition of "Hours of operation" has been added at N.J.A.C. 8:42-1.2 to indicate "normal business hours."

N.J.A.C. 8:42-7.8

COMMENT: Shore Care wrote that this subsection and the definitions combine homemaker and home health titles, and that although the two have been used interchangeably, the duties assigned to each are different as dictated by training. The agency urged that the opportunity be taken with the adoption of these standards to more accurately reflect the difference.

RESPONSE: The Department acknowledges the difference in scope of responsibility and training of these two classifications. For example, only home health aides are certified. However, the Department at this time does not plan to make a differentiation between the titles in its rules, although agencies may develop separate job descriptions for each category of employee.

COMMENT: Moorestown Visiting Nurse Association requested clarification of N.J.A.C. 8:42-7.8(a)1, and stated that homemaker-home health aides who have successfully completed a certification course should not have to wait several weeks to receive their certification card from the New Jersey State Board of Nursing before being permitted to work as certified home health aides. The commenter wrote that these workers cannot afford to wait to start working until their card is received.

RESPONSE: The rule does not preclude what the Department understands to be current practice in the industry, which is that homemaker-home health aides begin work after completing the training course. The Department, however, would anticipate that certification take place in a timely manner and in accordance with New Jersey State Board of Nursing guidelines, and requires that the agency maintain adequate documentation of training in accordance with Federal guidelines. No change is made to the standard.

N.J.A.C. 8:42-11.2

COMMENT: Twelve comments, nine of which were from provider agencies, were submitted in regards to the proposed standard at N.J.A.C. 8:42-11.2(g) requiring that original medical/health records or original components thereof not be removed from agency premises. Community Nursing Service of Vineland wrote that while protection of the record may be the motivating factor behind the standard, adherence could have adverse effects on patient care as the nurse must have access to the chart during a patient visit. Shore Care noted that the physical size of storage areas may force agencies to transfer records to a secure storage facility after a patient's discharge, and that this should be included in the rules. Home Care/Hospice of Holy Name Hospital noted that although the financial ramifications of copying records are nominal, the following issues are of concern: 1) negative impact on nursing productivity; 2) increased costs relative to development of new documentation format; 3) potential for negative impact on nursing quality; 4) increase in potential for inconsistent/non-flowing documentation; and 5) nearly non-existent potential for destruction or loss of record.

Mercer Street Friends Center acknowledged that the proposed rule would facilitate record retrieval and filing, but would ultimately drive up costs without any corresponding positive impact on patient outcome. Long Branch PHNA cited the duplication of documentation which the proposed rule would impose, increasing the cost of provision of services. Visiting Nurse and Health Services of Elizabeth noted that in no health care facility is a nurse required to provide services without immediate access to the patient record, and that making a copy of the record does not safeguard it. Somerset Valley Visiting Nurse Association, Inc. commented that the proposed rule would "wreak havoc with a nurse's ability to render safe, quality care to the patient." This agency stated that it is irrational to expect the nurse to make a home visit without the clinical record in hand, and for the agency to set up a dual record system with copies going with the nurse. Every copy provides less and less protection of confidentiality, and agencies must use professional nursing time wisely, not require the rewriting of clinical notes. A form letter signed by members of the professional nursing staff of Somerset Valley VNA emphasized the importance of having the record for reference and documentation during the home visit, and expressed the opinion that, greater than increased record-keeping costs, would be the cost to patient safety and quality care. Prime Care commented that the rule "which appears facility-inspired will increase time, dollars, and margin for error in documentation for agency professionals."

The Home Health Assembly wrote in opposition to the proposed rule, and submitted a copy of a 1987 HCFA letter which acknowledges that there may be a risk in removing patient records from an agency, but notes that HHA regulations do not prohibit their removal. The Assembly cited increased potential for spread and loss of confidential information if portions of the record are photocopied and noted that current practices have stood the test of time. The Assembly supported requirements that agencies have adequate policies and procedures to assure confidentiality and same day access to records. VNA of Southern New Jersey noted that the proposed rule in effect mandates "travel charts" which increase costs but do not safeguard the patient's rights to confidentiality or the likelihood of record loss. Finally, the State Board of Nursing commented that delayed charting is dangerous, leading to mistakes and inaccuracies; the Board recommended proper and immediate documentation.

RESPONSE: The Department has carefully considered the various comments received regarding the proposed rule. It is the Department's understanding that current practice in New Jersey home health agencies in regard to this issue falls into three categories: some agencies prohibit the removal of any portion of the medical/health record and have developed systems for adequate and timely documentation; some agencies permit the removal of the entire record; and the large majority of agencies (approximately 80 percent) have developed systems in which some components of the record remain in the agency and some components may be removed by clinical staff. Therefore, many of the issues which were of concern to the commenters, such as increased cost, timeliness and accuracy of documentation, and access to clinical information, would seem to have been satisfactorily resolved by a number of agencies. This would appear to be corroborated by the low percentage (approximately 15 percent) of licensed provider agencies that chose to comment about this proposed standard.

The rationale for the rule at the time of proposal, corroborated by the Home Health Advisory Group, was that it is basic, sound administrative and clinical practice to ensure patient records against the possibility of loss, destruction, and infringement of confidentiality. This is counterbalanced by the legitimate need of clinical staff working in the field to have access to clinical records for immediate reference and timely documentation. Consequently, the Department has modified its proposed rule upon adoption to permit the removal of the medical/health record or parts thereof only for purposes of providing clinical patient care and treatment and under controlled conditions, including a system to safeguard security and confidentiality and to assure the timely return of the record.

In response to the query about storage of closed records, the commenter is referred to N.J.A.C. 8:42-11.2(h), which mandates that medical records shall be retained and preserved in accordance with N.J.S.A. 26:8-5 et seq.

N.J.A.C. 8:42-12.1

COMMENT: Long Branch PHNA wrote with concerns about the requirement to designate "a person who shall have education, training, completed course work, or experience in infection control or epidemiology," since the commenter, who has recruited, interviewed, and staffed the agency for 11 years, has seen very few individuals with such training. The commenter was also unaware of accessible training programs, seminars, or course work in infection control which would meet the intent of the requirement.

RESPONSE: The New Jersey Department of Health co-sponsors, with the Association of Practitioners in Infection Control (APIC), a basic training course entitled "Principles of Infection Control." This five-day program, based on Centers for Disease Control material, is offered twice a year at the Center for Health Affairs in Princeton, New Jersey and costs under $300.00, including meals. The next offering is in October, 1992. For information contact: Anthony Monaco, Program Manager, Public Health Safety and Sanitation, CN 369, Trenton, New Jersey 08625, or telephone (609) 588-3124.

Agency-Initiated Change:

A technical error was noted in the definitions subsection for the title of "speech-language pathologist." A correction has been made.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 42
MANUAL OF STANDARDS FOR LICENSURE OF HOME HEALTH AGENCIES

SUBCHAPTER 1. DEFINITIONS

8:42-1.1 Scope: purpose

(a) The rules in this chapter pertain to all home health agencies in the State of New Jersey.

(b) The purpose of this chapter is to assure the provision of high quality home health care services to the residents of New Jersey in a coordinated and cost-effective manner.

8:42-1.2 Definitions

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

"Activities of daily living (ADL)" means the functions or tasks for self-care which are performed either independently or with supervision or assistance. Activities of daily living include at least mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting.

"Administrator" means a person who is administratively responsible and available for all aspects of facility operations, and:

1. Has a master's degree in administration or a health related field, and at least two years of supervisory or administrative experience in home health care or in a health care setting; or

2. Has a baccalaureate degree in administration or a health related field and four years of supervisory or administrative experience in home health care or in a health care setting.

"Advance directive" means a written statement of the patient's instructions and directions for health care in the event of future decisionmaking incapacity in accordance with the New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201. It may include a proxy directive, an instruction directive, or both.

"Audiologist" means a person who is so licensed by the Audiology and Speech-Language Pathology Advisory Committee of the Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety.

"Available" means ready for immediate use (pertaining to equipment); capable of being reached (pertaining to personnel).

"Branch office" means a facility site from which services are provided to patients in their homes or place of residence; which is physically separate from the home health agency but shares administrative oversight and services; which meets all requirements for licensure; and which has a nursing supervisor or alternate coverage by a registered professional nurse on the premises during its hours of operation.

"Bylaws" means a set of rules adopted by the facility for governing its operation. (A charter, articles of incorporation, and/or a statement of policies and objectives is an acceptable equivalent.)

"Cleaning" means the removal by scrubbing and washing, as with hot water, soap or detergent, and vacuuming, of infectious agents and/or organic matter from surfaces on which and in which infectious agents may find conditions for surviving or multiplying.

"Clinical note" means a signed and dated notation made at each patient visit by each health care professional who renders a service to the patient. The clinical note *[may include, but shall not be limited to, a flow sheet, and]* shall include a written description of signs and symptoms, treatment and/or medication(s) administered, the patient's response, and any changes in physical or emotional condition***, and may be documented in a flow sheet format. The flow sheet shall be supplemented by a narrative clinical note at least once a week and whenever there is a change in the patient's condition or care which cannot be clearly documented on a flow sheet.*** The clinical note shall be written or dictated on the day service is rendered and shall be incorporated into the patient's medical/health record according to the facility's policies and procedures.

"Commissioner" means the New Jersey State Commissioner of Health.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products, which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

"Conspicuously posted" means placed at a location within the facility accessible to and seen by patients and the public.

"Contamination" means the presence of an infectious or toxic agent in the air, on a body surface, or on or in clothes, bedding, instruments, dressings, or other inanimate articles or substances, including water, milk, and food.

"Current" means up-to-date, extending to the present time.

"Department" means the New Jersey State Department of Health.

"Dietitian or dietary consultant" means a person who:

1. Is registered or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association; or

2. Has a bachelor's degree from a college or university with a major in foods, nutrition, food service or institution management, or the equivalent course work for a major in the subject area; and has completed a dietetic internship accredited by the American

Dietetic Association or a dietetic traineeship approved by the American Dietetic Association or has one year of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting; or

3. Has a master's degree plus six months of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting.

"Director of Nursing" means a registered professional nurse who has at least one of the following qualifications:

1. A master's degree in nursing or a health related field and two years combined public health nursing and progressive management experience in public health nursing; or

2. A bachelor of science degree in nursing or a health related field and three years combined public health nursing and progressive management experience in public health nursing.

"Disinfection" means the killing of infectious agents outside the body, or organisms transmitting such agents, by chemical and physical means, directly applied.

1. "Concurrent disinfection" means the application of measures of disinfection as soon as possible after the discharge of infectious material from the body of an infected person, or after the soiling of articles with such infectious discharges, all personal contact with such discharges or articles being minimized prior to such disinfection.

2. "Terminal disinfection" means the application of measures of disinfection after the patient has ceased to be a source of infection, or after the facility's isolation practices have been discontinued. (Terminal disinfection is rarely practiced; terminal cleaning generally suffices (see definition of "cleaning"), along with airing and sunning of rooms, furniture, and bedding. Terminal disinfection is necessary only for diseases spread by indirect contact.)

"Documented" means written, signed and dated.

"Drug administration" means a procedure in which a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and rules governing such procedures. The complete procedure of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the prescriber's orders, giving the individual dose to the patient, seeing that the patient takes it (if oral), and recording the required information, including the method of administration.

"Full-time" means a time period established by the facility as a full working week, as defined and specified in the facility's policies and procedures.

"Governing authority" means the organization, person, or persons designated to assume legal responsibility for the determination and implementation of policy and for the management, operation, and financial viability of the facility.

"Home health agency" means a facility which is licensed by the New Jersey State Department of Health to provide preventive, rehabilitative, and therapeutic services to patients in the patient's home or place of residence. All home health agencies shall provide nursing, homemaker-home health aide, and physical therapy services.

"Homemaker-home health aide" means a person who has completed a training program approved by the New Jersey Board of Nursing and who is so certified by that Board.

"Hours of operation" means normal business hours, during which the agency is open for business.

"Job description" means written specifications developed for each position in the facility, containing the qualifications, duties, competencies, responsibilities, and accountability required of employees in that position.

"Licensed nursing personnel" (licensed nurse) means registered professional nurses and practical (vocational) nurses licensed by the New Jersey State Board of Nursing.

"Licensed practical nurse" means a person who is so licensed by the New Jersey State Board of Nursing.

"Medication" means a drug or medicine as defined by the New Jersey State Board of Pharmacy.

"Monitor" means to observe, watch, or check.

"Nursing supervisor" means a registered professional nurse who has at least one of the following qualifications:

1. A bachelor of science degree in nursing and two years combined public health nursing and progressive professional responsibilities in public health nursing; or

2. Three years combined public health nursing and progressive professional responsibilities in public health nursing.

"Occupational therapist" means a person who is certified or eligible for certification as an occupational therapist, registered (OTR) by the American Occupational Therapy Association, and has at least one year of experience as an occupational therapist.

"Physical therapist" means a person who is so licensed by the New Jersey State Board of Physical Therapy.

"Physician" means a person who is licensed or authorized by the New Jersey State Board of Medical Examiners to practice medicine in the State of New Jersey.

"Plan of care" (nursing, rehabilitation, social work, dietary counseling) means a written plan based on an assessment of the patient and the care and treatment to be provided by each discipline. Each discipline that provides service shall initiate the development and implementation of its own service plan, including measurable goals with timeframes, at the time of the patient's admission to that service. If the patient does not need a specific service, a plan is not needed for that service.

"Plan of treatment" means a written plan established and authorized in writing by the physician based on an evaluation of the patient's immediate and long-term needs. This plan shall be:

1. Initiated and implemented when the patient is admitted;

2. Coordinated and maintained by the nursing service or the physical therapy service, if physical therapy is the sole service;

3. Inclusive of, but not limited to, the patient's diagnosis, patient goals, means of achieving goals, and care and treatment to be provided;

4. Current and available to all personnel providing patient care; and

5. Included in the patient's medical/health record.

"Progress note" means a written, signed, and dated notation by the practitioner providing care, periodically summarizing information about the care provided and the patient's response to it.

"Public health nursing" means a branch of nursing practice which has as its goals health promotion, health maintenance, primary prevention, health education and management, coordination of health care services, and continuity of care through the provision of health care to individuals, families, and groups in the community. These goals may be accomplished through activities which include, but are not limited to, making home visits to assess, plan for, and provide nursing services; providing instruction and direct nursing services in community health agencies; teaching subjects related to individual and community welfare; and coordinating services with other community agencies.

"Registered professional nurse" means a person who is so licensed by the New Jersey State Board of Nursing.

"Restraint" means devices, materials, or equipment that are attached or adjacent to a person and that prevent free bodily movement to a position of choice.

"Signature" means at least the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D.) of a person, legibly written either with his or her own hand, generated by computer with authorization safeguards, or communicated by a facsimile communications system (FAX) followed by the original.

"Social worker" means a person who has a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education, and at least one year of post-master's social work experience in a health care setting.

["Speed-language] ***"Speech-language*** pathologist" means a person who is so licensed by the Audiology and Speech-Language Pathology Advisory Committee of the Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety.

"Staff education plan" means a written plan developed at least annually and implemented throughout the year which describes a coordinated program for staff education for each service, including in-service programs and on-the-job training.

"Staff orientation plan" means a written plan for the orientation of each new employee to the duties and responsibilities of the service to which he or she has been assigned, as well as to the personnel policies of the facility.

"Sterilization" means a process of destroying all microorganisms, including those bearing spores, in, on, and around an object.

"Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his or her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity.

SUBCHAPTER 2. LICENSURE PROCEDURE

8:42-2.1 Certificate of Need

(a) According to N.J.S.A. 26:2H-1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, licensed to operate, or closed except upon application for and receipt of a Certificate of Need issued by the Commissioner.

(b) Applications shall provide the information required by N.J.A.C. 8:33 and N.J.A.C. 8:33L. Application forms for a Certificate of Need and instructions for completion may be obtained from:

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
CN 360
Trenton, NJ 08625

(c) The facility shall implement all conditions imposed by the Commissioner as specified in the Certificate of Need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with N.J.S.A. 26:2H-1 et seq., and amendments thereto.

8:42-2.2 Application for licensure

(a) Following acquisition of a Certificate of Need, any person, organization, or corporation desiring to operate a facility shall make application to the Commissioner for a license on forms prescribed by the Department in accordance with the requirements of this chapter. Such forms may be obtained from:

Director
Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
CN 367
Trenton, NJ 08625

(b) The applicant shall submit to the Department a nonrefundable fee of $500.00 for the filing of an application for licensure of a home health agency and $500.00 for the annual renewal of the license. An additional $150.00 shall be submitted for the filing of an application for each branch office of the facility, and $150.00 for its annual renewal.

(c) Any person, organization, or corporation considering application for license to operate a facility shall make an appointment for a preliminary conference at the Department with the Licensing, Certification and Standards Program.

8:42-2.3 Surveys and temporary license

(a) When the written application for licensure is approved and the building is ready for occupancy, a survey of the facility by representatives of the Health Facilities Inspection Program of the Department shall be conducted to determine if the facility adheres to the rules in this Chapter.

1. The facility shall be notified in writing of the findings of the survey, including any deficiencies found.

2. The facility shall notify the Health Facilities Inspection Program of the Department when the deficiencies, if any, have been corrected, and the Health Facilities Inspection Program will schedule one or more resurveys of the facility prior to issue of license.

(b) A temporary license may be issued to a facility when the following conditions are met:

1. An office conference for review of the conditions for licensure and operation has taken place between the Licensing, Certification and Standards Program and representatives of the facility, who will be advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance with N.J.S.A. 26:2H-1 et seq., and amendments thereto, and the rules pursuant thereto;

2. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities;

3. Survey(s) by representatives of the Department indicate that the facility adheres to these rules; and

4. Professional personnel are employed in accordance with the staffing requirements in these rules.

(c) No health care facility shall accept patients until the facility has the written approval and/or license issued by the Licensing, Certification and Standards Program of the Department.

(d) Survey visits may be made to a facility at any time, or to a patient's home, by authorized staff of the Department. Such visits may include, but not be limited to, a review of all facility documents and patient records, and conferences with patients and/or their families.

(e) A temporary license may be issued to a facility for a period of six months and may be renewed as determined by the Department.

(f) The temporary license shall be conspicuously posted in the facility.

(g) The temporary license is not assignable or transferable and shall be immediately void if the facility ceases to operate or if its ownership changes.

8:42-2.4 Full license

(a) A full license shall be issued on expiration of the temporary license, if surveys by the Department have determined that the health care facility is being operated as required by N.J.S.A. 26:2H-1 et seq., and amendments thereto, and by the rules in this chapter.

(b) A license shall be granted for a period of one year or less as determined by the Department. (See N.J.S.A. 26:2H-12.)

(c) The license shall be conspicuously posted in the facility.

(d) The license is not assignable or transferable and it shall be immediately void if the facility ceases to operate or if its ownership changes.

(e) The license, unless sooner suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date. The facility will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

(f) The license may not be renewed if local rules, regulations, and/or requirements are not met.

8:42-2.5 Surrender of license

The facility shall directly notify each patient, the patient's physician, and any guarantors of payment concerned at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of license. In such cases, the license shall be returned to the Licensing, Certification and Standards Program of the Department within seven working days after the revocation, non-renewal, or suspension of license.

8:42-2.6 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of this chapter, waive sections of the rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of patients or the public.

(b) A facility seeking a waiver of these rules shall apply in writing to the Director of the Licensing, Certification and Standards Program of the Department.

(c) A written request for waiver shall include the following:

1. The specific rule(s) or part(s) of the rule(s) for which waiver is requested;

2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon full compliance;

3. An alternative proposal which would ensure patient safety; and

4. Documentation to support the application for waiver.

(d) The Department reserves the right to request additional information before processing a request for waiver.

8:42-2.7 Action against a license

(a) If the Department determines that operational or safety deficiencies exist, it may require that all new admissions to the facility cease. This may be done simultaneously with, or in lieu of, action to revoke licensure and/or impose a fine. The Commissioner or his or her designee shall notify the facility in writing of such determination.

(b) The Commissioner may order the immediate cessation of services by a facility whenever he or she determines imminent danger to any person's health or safety.

(c) The provisions of (a) and (b) above shall apply to facilities with a temporary license and facilities with a full license.

8:42-2.8 Hearings

(a) If the Department proposes to suspend, revoke, deny or refuse to renew a license, the licensee or applicant may request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) Prior to transmittal of any hearing request to the Office of Administrative Law, the Department may schedule a conference to attempt to settle the matter.

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:42-3.1 Compliance with rules and laws

(a) The facility shall provide preventive, rehabilitative, and therapeutic services to patients. This shall include, but not be limited to, nursing, homemaker-home health aide, and physical therapy services. Nursing services shall be available 24 hours a day, seven days a week.

(b) The facility shall routinely provide nursing services through its own staff. Nursing services provided under contract shall be rendered only if the following conditions pertain:

1. During temporary periods when all available full and part-time employees have achieved maximum caseloads, or in order to provide specialized care which is unavailable through existing staff;

2. Contracted nursing personnel are oriented to the policies and procedures of the facility and receive supervision from supervisory staff employed by the facility; and

3. Provisions are made for continuity of patient care by the same contracted nursing personnel whenever possible.

(c) Other services such as physical therapy, occupational therapy, speech-language pathology, audiology, dietary counseling, and social work services shall be available directly or through written agreement.

(d) The facility shall adhere to applicable Federal, State, and local rules, regulations, and requirements.

(e) The facility shall adhere to all applicable provisions of N.J.S.A. 26:2H-1 et seq., and amendments thereto.

8:42-3.2 Ownership

(a) The ownership of the facility and the property on which it is located shall be disclosed to the Department. Proof of this ownership shall be available in the facility. Any proposed change in ownership shall be reported to the Director of the Licensing, Certification and Standards Program of the Department in writing at least 30 days prior to the change and in conformance with the requirements for Certificate of Need applications.

(b) No health care facility shall be owned or operated by any person convicted of a crime relating adversely to the person's capability of owning or operating the facility.

8:42-3.3 Submission of documents

The facility shall, upon request, submit any documents which are required by these rules to the Director of the Licensing, Certification and Standards Program of the Department.

8:42-3.4 Personnel

(a) The facility shall ensure that the duties and responsibilities of all personnel are described in job descriptions and in the policy and procedure manual for each service.

(b) All personnel who require licensure, certification, or authorization to provide patients care shall be licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey.

(c) All personnel, both directly employed and under contract to provide direct care to patients, shall at all times wear or produce upon request employee identification.

(d) The facility shall have policies and procedures for the maintenance of confidential personnel records for each employee, including at least his or her name, previous employment, educational background, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials and references, health evaluation records, job description, and evaluations of job performance.

(e) All new personnel, both directly employed and under contract to provide direct patient care, shall receive an initial health evaluation which includes at least a documented history.

(f) Employee health records shall be maintained for each employee. Employee health records shall be confidential, and kept separate from personnel records.

(g) The employee health record shall include documentation of all medical screening tests performed and the results.

(h) All personnel, both directly employed and under contract to provide direct care to patients, shall receive a Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions are personnel with documented negative Mantoux skin test results (zero to nine millimeters of induration) within the last year, personnel with documented positive Mantoux skin test results (10 or more millimeters of induration), personnel who received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests shall be acted upon as follows:

1. If the Mantoux tuberculin skin test result is between zero and nine millimeters of induration, the test shall be repeated one to three weeks later.

2. If the Mantoux test result is 10 millimeters or more of induration, a chest x-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy.

(i) The Mantoux tuberculin skin test shall be administered by December 1, 1992 to all agency personnel, both directly employed and under contract, and thereafter to all new personnel at the time of employment. The tuberculin skin test shall be repeated on an annual basis for all persons who provide direct patient care and every two years for all other employees.

(j) The agency shall report annually on forms provided by the Department of Health the results of tuberculin testing for all agency personnel.

(k) All personnel, both directly employed and under contract to provide direct care to patients, shall be given a rubella screening test using the rubella hemagglutination inhibition test or other rubella screening test. The only exceptions are personnel who can document seropositivity from a previous rubella screening test or who can document inoculation with rubella vaccine, or when medically contraindicated.

(l) The facility shall inform each person in writing of the results of his or her rubella screening test.

(m) The facility shall maintain a list identifying the name of each person who is seronegative and unvaccinated.

(n) All personnel, both directly employed and under contract to provide direct care to patients, who were born in 1957 or later shall be given a (measles) rubeola screening test using the hemagglutination inhibition test or other rubeola screening test. The only exceptions are personnel who can document receipt of live measles vaccine on or after their first birthday, physician-diagnosed measles, or serologic evidence of immunity.

(o) The facility shall ensure that all personnel, both directly employed and under contract to provide direct care to patients, who cannot provide serologic evidence of immunity are offered rubella and rubeola vaccination.

8:42-3.5 Policy and procedure manual

(a) A policy and procedure manual(s) for the organization and operation of the facility shall be established, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility at all times. The manual(s) shall include at least the following:

1. A written narrative of the program describing its philosophy and objectives, and the services provided by the facility;

2. An organizational chart delineating the lines of authority, responsibility, and accountability, so as to ensure continuity of care to patients;

3. A description of the quality assurance program for patient care and staff performance;

4. Definition and specification of full-time employment;

5. Policies and procedures for complying with applicable statutes and protocols to report child abuse and/or neglect, sexual abuse, and abuse of elderly or disabled adults, specified communicable disease, rabies, poisonings, and unattended or suspicious deaths. These policies and procedures shall include, but not be limited to, the following:

i. The development of written protocols for the identification and reporting of children and elderly or disabled adults who are abused and/or neglected;

ii. The designation of a staff member(s) to be responsible for coordinating the reporting child abuse and/or neglect in compliance with N.J.S.A. 9:6-1 et seq., recording notification of the Division of Youth and Family Services on the medical/health record, and serving as a liaison between the facility and the Division of Youth and Family Services; and

iii. The provision at least annually of education and/or training programs for all staff and subcontracted personnel who provide direct patient care regarding the identification and reporting of child abuse and/or neglect; sexual abuse; domestic violence; and abuse of the elderly or disabled adult.

NOTE: Copies of the law may be obtained from the local district office of the Division of Youth and Family Services (DYFS) or from the Office of Program Support, Division of Youth and Family Services, New Jersey State Department of Human Services, CN 717, Trenton, NJ 08625.

(b) The policy and procedure manual(s) shall be available and accessible to all patients, staff, and the public.

8:42-3.6 Staffing

(a) Provision shall be made for staff with equivalent qualifications to provide services for absent staff members. Staffing schedules shall be implemented to facilitate continuity of care to patients. The facility shall maintain staff attendance records.

(b) The facility shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of the person(s) responsible for training.

8:42-3.7 Written agreements

(a) The facility shall have a written agreement, or its equivalent, for services provided by contract or subcontract. The written agreement or its equivalent shall:

1. Be dated and signed by a representative of the facility and by the person or agency providing the service;

2. Specify each party's responsibilities, functions, and objectives, the time during which services are to be provided, the financial arrangements and charges, and the duration of the written agreement or its equivalent;

3. Specify that the facility retain administrative responsibility for services rendered, including subcontracted services;

4. Require that services are provided in accordance with these rules and that personnel providing services meet training and experience requirements and are supervised in accordance with these rules; and

5. Require the provision of written documentation to the facility, including, but not limited to, documentation of services rendered by the person or agency providing the service.

8:42-3.8 Reportable events

(a) The facility shall notify the Department immediately by telephone (609-588-7725), followed within 72 hours by written confirmation, of the following:

1. Termination of employment of the administrator and/or the *[public health nurse director]* ***Director of Nursing***, and the name and qualifications of his or her replacement;

2. Expected or actual interruption or cessation of operations and services listed in these rules; and

3. Any deaths resulting from accidents or incidents related to the facility's services.

(b) The facility shall provide statistical data as required by the Department.

8:42-3.9 Notices

(a) The facility shall conspicuously post a notice that the following information is available in the facility to patients and the public:

1. All waivers granted by the Department;

2. All documents required by these rules;

3. A list of deficiencies from the last annual licensure inspection and certification survey report (if applicable), and the list of deficiencies from any valid complaint investigation during the past 12 months;

4. A list of the facility's committees, or their equivalents, and the membership and reports of each;

5. The names and addresses of members of the governing authority;

6. Any changes of membership of the governing authority, within 30 days after the change; and

7. Policies and procedures regarding patient rights.

8:42-3.10 Reporting information to the State Board of Medical Examiners

(a) In accordance with the Professional Medical Conduct Reform Act, P.L. 1989, c.300, the facility shall notify the Medical Practitioner Review Panel established by the New Jersey State Board of Medical Practitioners if a practitioner who is employed by or who is under contract to render professional services of all actions which result in reduction or restriction of staff privileges. The information to be reported shall include, but not be limited to, the following:

1. A disciplinary proceeding or action taken by the governing body against any practitioner licensed by the Board when the proceeding or action results in a practitioner's reduction or suspension of privileges or removal or resignation from the medical staff; and

2. A medical malpractice liability insurance claim settlement, judgment or arbitration award in which the facility is involved.

(b) For purposes of (a) above, "practitioner" means physician, medical resident or intern, or podiatrist.

(c) Notifications shall be provided within seven days of the date of the action, settlement, judgment or award and shall be submitted on forms provided for that purpose. Forms shall be submitted to the New Jersey State Board of Medical Examiners, 28 West State Street, Trenton, New Jersey 08608. (Questions may be directed to the Board office at (609) 292-4843.)

8:42-3.11 Reporting to professional licensing boards

The facility shall comply with all requirements of the professional licensing boards for reporting termination, suspension, revocation, or reduction of privileges of any health professional licensed in the State of New Jersey.

SUBCHAPTER 4. GOVERNING AUTHORITY

8:42-4.1 Responsibility

(a) The governing authority shall assume legal responsibility for the management, operation, and financial viability of the facility. The governing authority shall be responsible for, but not limited to, the following:

1. Services provided and the quality of care rendered to patients;

2. Adoption and documented review of written bylaws or their equivalent at least every two years;

3. Development and documented review of all policies and procedures;

4. Establishment and implementation of a system to identify and resolve patient and staff grievances and/or recommendations, including those relating to patient rights. This system shall include a feedback mechanism through management to the governing authority, indicating what action was taken;

5. Determination of the frequency of meetings, which shall be at least annually, of the governing authority, holding such meetings, and documenting them through minutes, including a record of attendance;

6. Delineation of the powers and duties of the officers and committees, or their equivalent, of the governing authority; and

7. Establishment of the qualifications of members and officers of the governing authority, the procedures for electing, appointing, or employing officers, and the terms of service for members, officers, and committee chairpersons or their equivalents.

SUBCHAPTER 5. ADMINISTRATION

8:42-5.1 Administrator

(a) The governing authority shall appoint an administrator who is administratively responsible and available for all aspects of facility operations. If the facility has only one office, and if the qualifications for both positions are met, the director of nursing may function as the administrator.

(b) An alternate or alternates shall be designed in writing to act in the absence of the administrator.

8:42-5.2 Administrator's responsibilities

(a) The administrator shall be responsible for, but not limited to, the following:

1. Ensuring the development, implementation, and enforcement of all policies and procedures, including patient rights;

2. Planning for and administering the managerial, operational, fiscal, and reporting components of the facility;

3. Participating in the quality assurance program for patient care;

4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions;

5. Ensuring the provision of staff orientation and staff education; and

6. Establishing and maintaining liaison relationships, communication, and integration with facility staff and services and with patients and their families, in accordance with the philosophy and objectives of the facility.

8:42-5.3 Director's of Nursing responsibilities

The director of nursing shall be responsible for the direction of patient care services provided to patients.

SUBCHAPTER 6. PATIENT CARE SERVICES

8:42-6.1 Advisory group

(a) The governing authority shall appoint an advisory group which ensures participation by at least one physician, the director of nursing and/or nursing supervisor, a consumer, and a representative of physical therapy services, and, if offered by the agency, occupational therapy, speech-language therapy, audiology, social work, and dietary counseling.

(b) At least one member of the advisory group shall be neither an owner nor an employee of the facility.

(c) The full advisory group shall meet at least annually.

8:42-6.2 Policies and procedures

(a) The facility shall establish written policies and procedures governing patient care that are reviewed at least annually by the agencywide advisory group, revised as needed, and implemented. They shall include at least the following:

1. Criteria for admission, discharge, and readmission of patients. Admissions criteria shall be based solely upon the patient's needs and the ability of the facility to meet safely the medical, nursing, and social needs of the patient. Discharge policies shall preclude punitive discharge.

2. Criteria for physicians orders for home health services, including timeframes and other requirements for written, verbal, and renewal orders. Physician orders for physical therapy, occupational therapy, and speech therapy shall include the modality, frequency, and duration of treatment.

3. Protocols for initiation, implementation, review, and revision of plans of care and of the service plan;

4. Protocols for reassessment of patients, in accordance with timeframes documented by each health care practitioner in the service plan;

5. Protocols for providing continuity of care by the same health care practitioner whenever possible;

6. Provision of care in accordance with the plan of care;

7. Provision of emergency care;

8. Policies and procedures for the use of restraints, including at least:

i. The need for written physicians orders;

ii. Indications and contraindications for use, including emergency use or use during medical procedures;

iii. Alternatives to physical restraints, such as environmental interventions or behavior management;

iv. The designation of staff who are authorized to use restraints according to scope of practice; and

v. Teaching the patient's family or primary caregiver the use of a progressive range of restraining procedures from the least restrictive to the most restrictive, the appropriate application and release of restraints, and observation of the patient;

9. Requirements for a discharge plan for each patient developed prior to the patient's discharge, and methods for including the patient and/or the patient's family in planning and implementing the discharge plan; and

10. A system for referral of patients to other sources of care.

8:42-6.3 Advance directives

(a) In accordance with the New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, the agency shall establish procedures for the resolution of conflict concerning the patient's decision-making capacity or the appropriate interpretation and application of the terms of an advance directive to the patient's course of treatment. The procedures may include consultation with an institutional ethics committee, a regional ethics committee, or another type of affiliated ethics committee, or with any individual or individuals who are qualified by training or experience to make clinical and ethical judgments.

(b) The agency shall establish a process for patients, families, and staff to address concerns relating to advance directives.

(c) The agency shall provide community education programs at least annually, individually or in coordination with other area agencies or organizations. These programs shall be provided within the agency's service area as recognized by the Certificate of Need process and shall provide information to consumers regarding advance directives and their rights under New Jersey law to executive advance directives.

(d) The agency shall establish written policies and procedures governing the services provided to implement the New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201. These policies and procedures shall be reviewed annually, revised as needed, and shall include at least:

1. Providing to each patient prior to the provision of care, or to family member or other representative if the patient is unable to respond, a written statement of the patient's rights under New Jersey law to make decisions including the right to refuse medical care and to formulate an advance directive, as well as the agency's written policies and procedures regarding implementation of such rights. This statement shall be issued by the Commissioner and shall be made available in any language which is spoken as the primary language by more than 10 percent of the population in the agency's service area;

2. Routinely inquiring of each adult patient, in advance of coming under the care of the agency and at other appropriate times, about the existence and location of an advance directive. If the patient is incapable of responding to this inquiry, the agency shall request the information from the patient's family or other representative. The response to this inquiry shall be documented in the patient's medical record;

3. Requesting and taking reasonable steps to obtain for all patients copies of currently executed advance directives, which shall be entered into the medical record;

4. Evaluating the validity of the advance directive, where a question of validity is indicated, and establishing procedures for assisting in the execution of a currently valid advance directive;

5. Providing appropriate written informational materials concerning advance directives to all interested patients, families, and health care representatives, and assistance or referral to staff or community resource persons for patients interested in discussing and executing an advance directive.

6. Delineation of the responsibilities of attending physicians, administration, nursing, social service, and other staff in regards to (d)1 through 5 above; and

7. Policies for transfer of the responsibility for care of patients with advance directives when a health care professional declines as a matter of professional conscience to participate in withholding or withdrawing life-sustaining treatment. Such transfer shall assure that the advance directive is implemented by the agency in accordance with the patient's wishes.

(e) A patient shall be transferred in another agency only for the following reasons:

1. A valid medical reason, including the agency's inability to care for the patient;

2. In order to comply with clearly expressed and documented patient choice in accordance with applicable laws or regulations; or

3. In conformance with the New Jersey Advance Directives for Health Care Act in the instance of a private, religiously affiliated home health agency which establishes written policies defining circumstances in which it will decline to participate in the withholding or withdrawal of life-sustaining treatment. Such agencies shall:

i. Provide written notice of the policy to patients, families, or health care representatives prior to or at the time of admission to services; and

ii. Implement a timely and respectful transfer of the patient to an agency which will implement the advance directive.

(f) The sending agency shall receive approval from the receiving agency before transferring the patient.

(g) The agency shall provide staff training and education programs regarding the New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, and the Federal Patient Self Determination Act, Pub.L. 101-508. This education and training shall address at least the following:

1. The rights and responsibilities of staff; and

2. Internal policies and procedures to implement these laws.

(h) The agency shall establish policies and procedure for the declaration of death of patients in accordance with N.J.S.A. 26:6 and the New Jersey Declaration of Death Act, P.L. 1991, c.90. Such policies shall also be in conformance with regulations and policies promulgated by the New Jersey Board of Medical Examiners which address declaration of death based on neurological criteria and the acceptable medical criteria, tests, and procedures that may be used. The policies and procedures must accommodate the patient's religious beliefs with respect to declaration of death.

8:42-6.4 Pharmacy and supplies

(a) The facility shall establish written policies and procedures governing pharmacy and supplies that are reviewed annually, revised as needed, and implemented. They shall include at least the following:

1. Provision for emergency supplies, including the contents, locations, and frequency of checking (including checking of expiration dates) of emergency supplies;

2. Requirements for the purchase, storage, handling, safeguarding, accountability, use, and disposition of medications in accordance with the New Jersey State Board of Pharmacy Rules (N.J.A.C. 13:39), the Controlled Dangerous Substances Act of 1970 (Title II, Pub.L. 91-153), and the New Jersey Controlled Dangerous Substances Act of 1970 (N.J.S.A. 24:21-1 et seq.) and amendments thereto;

3. Procedures for documenting all drug administration; and

4. Reporting and documenting medication errors and adverse drug reactions.

(b) The facility shall provide current pharmaceutical reference materials and sources of information to staff.

SUBCHAPTER 7. NURSING SERVICES

8:42-7.1 Provision of nursing services

The facility shall provide nursing services to patients who need these services.

8:42-7.2 Nursing organization, policies, and procedures

(a) A written organizational chart and written plan that delineates lines of authority, accountability, and communication shall be available to all nursing personnel in the agency at all times.

(b) The agency shall have written policies and procedures for the provision of nursing services that guide nursing practices in the agency. These policies shall be reviewed annually, revised as needed, and implemented. These policies and procedures shall conform with the Nurse Practice Act at N.J.S.A. 45:11-23 and N.J.A.C. 13:37-1.4, 6.1, 6.2, 13.1, and 13.2.

(c) The agency's current clinical and administrative nursing policies and procedures shall be available to all nursing personnel at all times.

8:42-7.3 Nursing staff qualifications and responsibilities

(a) The governing authority shall appoint a full-time director of nursing who shall be available in the facility. An alternate or alternates shall be designated in writing to act in the absence of the director.

(b) The director of nursing shall be responsible for the direction, provision, and quality of nursing services. He or she shall be responsible for, but not limited to, the following:

1. Overall planning, supervision, and administration of nursing services;

2. The coordination and integration of nursing services with other home health services to provide a continuum of care for the patient;

3. Development of protocols for regular verbal communication, including case conferencing, between the nursing service and other disciplines based on the needs of each patient;

4. Development of written job descriptions and performance criteria for nursing personnel, and assigning duties based upon education, training, competencies, and job descriptions;

5. Ensuring that nursing services are provided to the patient as specified in the nursing plan of care; and

6. Ensuring public health nursing supervision to nursing personnel.

(c) A full-time nursing supervisor or alternate coverage by a registered professional nurse shall be available on the premises of each facility branch office during its hours of operation to provide clinical supervision.

(d) Registered professional nurses and licensed practical nurses shall provide nursing care to patients commensurate with their scope of practice, as delineated in the Nurse Practice Act. Nursing care shall include, but not be limited to, the following:

1. The promotion, maintenance, and restoration of health;

2. Ensuring the prevention of infection, accident, and injury;

3. Performing an initial assessment and identifying problems for each patient upon admission to the nursing service. The initial assessment shall be performed by a registered professional nurse;

4. Reassessing the patient's nursing care needs an ongoing, patient-specific basis and providing care which is consistent with the medical plan of treatment;

5. Monitoring the patient's response to nursing care; and

6. Teaching, supervising, and counseling the patient, family members, and staff regarding nursing care and the patient's needs, including other related problems of the patient at home. Only a registered professional nurse shall initiate these functions, which may be reinforced by licensed nursing personnel.

(e) Nursing staff shall administer medications in accordance with all Federal and State laws and rules.

8:42-7.4 Nursing entries in the medical/health record

(a) In accordance with written job descriptions and with these rules, nursing personnel shall document in the patient's medical/health record:

1. The nursing plan of care in accordance with the facility's policies and procedures;

2. Clinical notes and progress notes; and

3. A record of medications administered. After each administration of medication, the following shall be documented by the nurse who administered the drug: name and strength of the drug, data and time of administration, dosage administered, method of administration, and signatures of the licensed nurse who administered the drug.

8:42-7.5 Homemaker-home health aide services

(a) The facility shall provide homemaker-home health aide services in accordance with the following:

1. The homemaker-home health aide shall have completed a training program approved by the New Jersey Board of Nursing, shall be certified by the Board of Nursing, and shall provide verification of current certification for inclusion in the agency personnel record;

2. The homemaker-home health aide shall provide personal care and/or homemaking services under the direction and supervision of a registered professional nurse;

i. The registered professional nurse shall assign the homemaker-home health aide to a patient and shall give written instructions to the homemaker-home health aide regarding the home health services to be provided. The homemaker-home health aide shall document the home health services provided. Copies of the written instructions shall be kept in the patient's home and documentation of services provided shall be kept in the patient's medical/health record;

ii. If the registered professional nurse delegates selected tasks to the homemaker-home health aide, the registered professional nurse shall determine the degree of supervision to provide, based upon an evaluation of the patient's condition, the education, skill, and training of the homemaker-home health aide to whom the tasks are delegated, and the nature of the tasks and activities being delegated. The registered professional nurse shall delegate a task only to a homemaker-home health aide who meets the requirements specified in (a)1 above and who has demonstrated the knowledge, skill, and competency to perform the delegated tasks; and

iii. The registered professional nurse shall make supervisory visits to the patient's home and document these visits in the patient's medical record, in accordance with the facility's policies and procedures; and

3. The homemaker-home health aide shall be responsible for, but not limited to, providing personal care and homemaking services essential to the patient's health care and comfort at home, including shopping, errands, laundry, meal planning and preparation (including therapeutic diets), serving of meals, child care, assisting the patient with activities of daily living, and assisting with prescribed exercises and the use of special equipment.

SUBCHAPTER 8. REHABILITATION SERVICES (PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH-LANGUAGE PATHOLOGY, AND AUDIOLOGY)

8:42-8.1 Services

(a) The facility shall provide physical therapy and may provide occupational therapy, speech-language pathology, and audiology services, directly or through written agreement, to patients who need these services.

(b) The facility shall develop and implement written objectives, policies, a procedural manual, and a quality assurance program for rehabilitation services.

8:42-8.2 Responsibilities of rehabilitation personnel

(a) In accordance with written job descriptions (and for physical therapy personnel, in accordance also with the State of New Jersey Physical Therapy Practice Act, N.J.S.A. 45:9-37.11 et seq.; and for speech-language pathology and audiology personnel, in accordance also with the State of New Jersey Audiology and Speech-Language Pathology Practice Act, N.J.S.A. 45:3B-1 et seq.), each physical therapist, occupational therapist, speech-language pathologist, and audiologist shall be responsible for, but not limited to, the following:

1. Assessing the physical therapy, occupational therapy, speech-language pathology, or audiology needs of the patient, preparing the rehabilitation plan of care based on the assessment, providing rehabilitation services to the patient as specified in the rehabilitation plan of care, reassessing the patient's response to services provided, and revising the rehabilitation plan of care as needed. Each of these activities shall be documented in the patient's medical/health record;

2. Participating in the quality assurance program for rehabilitation services and patient care;

3. Participating in staff education activities and providing consultation to facility personnel; and

4. Communicating and documenting the communication with other disciplines and services to provide continuity and coordination of patient care.

8:42-8.3 Rehabilitation entries in the medical/health record

(a) Each physical therapist, occupational therapist, speech-language pathologist, or audiologist shall document in the patient's medical/health record:

1. The rehabilitation plan of care, which may be the rehabilitation portion of the patient's plan of care. The plan of care shall be reviewed and revised by the therapist, speech-language pathologist, or audiologist; and

2. Clinical notes and progress notes.

SUBCHAPTER 9. SOCIAL WORK SERVICES

8:42-9.1 Services

(a) Social work services may be provided directly or through written agreement to patients who need these services.

(b) Written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for social work services shall be developed and implemented.

8:42-9.2 Social worker's responsibilities

(a) Each social worker shall be responsible for, but not limited to, the following:

1. Performing a psychosocial assessment of the patient; preparing the social work plan of care based on the assessment; providing social work services to the patient as specified in the social work plan of care; reassessing the patient's response to services provided; and revising the social work plan of care as needed. Each of these activities shall be documented in the patient's medical/health record;

2. Contacting social service and other community resources for information, referrals, and services;

3. Providing social work counseling to the patient and his or her family;

4. Participating in the quality assurance program for social work services and patient care; and

5. Participating in staff education activities and providing consultation to facility personnel.

8:42-9.3 Social work entries in the medical/health record

(a) The social worker shall document in the patient's medical/health record:

1. The social work plan of care, which may be the social work portion of the patient treatment plan. The plan of care shall be reviewed and revised by the social worker; and

2. Clinical notes and progress notes.

SUBCHAPTER 10. DIETARY COUNSELING SERVICES

8:42-10.1 Services

(a) Dietary counseling services may be provided directly or through written agreement to patients who need these services.

(b) The facility shall develop and implement written objectives, policies, a procedure manual, and a quality assurance program for dietary counseling services.

8:42-10.2 Responsibilities of dietitian or dietary consultant

(a) Each dietitian or dietary consultant shall be responsible for, but not limited to, the following:

1. Assessing the dietary needs of the patient, preparing the dietary plan of care based on the assessment, providing dietary counseling services to the patient as specified in the dietary plan of care, reassessing the patient's response to services provided, and revising the dietary plan of care as needed. Each of these activities shall be documented in the patient's medical/health record;

2. Communicating and documenting the communication with other disciplines and services to provide continuity and coordination of patient care;

3. Participating in the quality assurance program for dietary counseling services and patient care; and

4. Participating in staff education activities and providing consultation to facility personnel.

8:42-10.3 Dietary entries in the medical/health record

(a) The dietitian or dietary consultant shall document in the patient's medical/health record:

1. The dietary plan of care, which may be the dietary counseling portion of the patient's plan of care. The plan of care shall be reviewed and revised by the dietitian or dietary consultant; and

2. Clinical notes and progress notes.

SUBCHAPTER 11. MEDICAL/HEALTH RECORDS

8:42-11.1 Medical/health records organization

(a) The facility shall develop written objectives, policies and procedures, an organizational plan, and a quality assurance program for medical/health records services. The quality assurance program shall include monitoring medical/health records for accuracy, completeness, legibility, and accessibility.

(b) At least 14 days before a facility plans to cease operations, it shall notify the New Jersey Department of Health in writing of the location and method for retrieval of medical/health records.

(c) There shall be a system for identifying medical/health records to facilitate their retrieval by patient identifier.

(d) Medical/health records shall be organized with a uniform format for all records.

(e) The patient's medical/health record shall be available to the health care practitioners involved in the patient's care.

8:42-11.2 Medical/health records policies and procedures

(a) The facility shall have written policies and procedures for medical/health records that are reviewed annually, revised as needed and implemented. They shall include at least:

1. Entries for clinical treatment, which shall be included in the medical/health record within 14 days;

2. Procedures for record completion, including review for accuracy and completion, which shall occur within 45 days;

3. Procedures for the protection of medical record information against loss, tampering, alteration, destruction, or unauthorized removal or use;

4. Conditions, procedures, and fees for releasing medical information; and

5. Release and/or provision of copies of the patient's medical/health record to the patient and/or the patient's authorized representative, including, but not be limited to, the following:

i. Establishment of a fee schedule for obtaining copies of the patient's medical/health record;

ii. Availability of the patient's medical/health record to the patient's authorized representative if it is medically contraindicated (as documented by a physician in the patient's medical/health record) for the patient to have access to or obtain copies of the record; and

iii. Procedures to ensure that a copy of the patient's medical/health record is provided within 30 calendar days of a written request.

(b) All entries in the patient's medical/health record shall be typewritten or written legibly in ink, and shall include date, signature, title, or authentication if an electronic system is used.

(c) A medical/health record shall be initiated for each patient upon admission and shall include at least the following:

1. Patient identification data, including name, date of admission, address, date of birth, sex, race and religion (optional), next of kin, and person to notify in an emergency;

2. Name, address, and telephone number of the patient's physician, an alternate physician, and other primary health care providers if any;

3. A plan of treatment as defined at N.J.A.C. 8:42-1.1. This plan shall be:

i. Initiated and implemented when the patient is admitted;

ii. Coordinated and maintained by the nursing service or the physical therapy service, if physical therapy is the sole service;

iii. Inclusive of, but not limited to, the patient's diagnosis, patient goals, means of achieving goals, and care and treatment to be provided;

iv. Current and available to all personnel providing patient care; and

v. Included in the patient's medical/health record.

4. A plan of care as defined at N.J.A.C. 8:42-1.1, including an assessment and plan by each discipline involved in the patient's care;

5. All physician orders;

6. All telephone orders, which must be countersigned by a physician within 14 days;

7. Clinical notes;

8. Progress notes;

9. A record of medications if administered, including the name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the person who administered the drug. This record shall include action, side effects and contraindications of medications where clinically indicated;

10. Documentation of allergies in the medical/health record and on its outside front cover;

11. An immunization record, in accordance with the facility's policies and procedures;

12. Written informed consents if indicated;

13. A copy of the patient's advance directive, if available, or documentation of the existence or nonexistence of an advance directive; and documentation of the agency's inquiry to the patient, family, or health care representative regarding this;

14. Copies of written instructions given to the patient and/or the patient's family;

15. A record of any treatment, medication, or service in the service plan that is not provided and the reason, including patient refusal; and

16. A comprehensive discharge summary with narrative information from each service within 30 days of discharge unless the patient is readmitted during that 30 day period.

(d) If the patient is transferred to another health care facility, the agency shall maintain a transfer record reflecting the patient's immediate needs and send a copy of this record to the receiving agency at the time of transfer. The transfer record shall contain at least the following information:

1. Diagnosis, including history of any serious condition unrelated to the proposed treatment which might require special attention to keep the patient safe;

2. Physician orders in effect at the time of transfer and the last time each medication was administered;

3. The patient's nursing needs;

4. Hazardous behavioral problems;

5. Drug and other allergies;

6. Reason for transfer; and

7. A copy of the patient's advance directive if available or notice of the existence of an advance directive.

(e) All consent forms for treatment shall be printed in an understandable format and the text written in clear, legible, nontechnical language. If a family member or other patient representative signs the form, the reason for the patient's not signing it and the signer's relationship to the patient shall be indicated on the form.

(f) Medical records shall be completed within 45 days of discharge.

[(g) Original medical/health records or original components thereof shall not be removed from facility premises unless they are under court order or subpoena or in order to safeguard the record in case of a physical plant emergency or natural disaster.]

***(g) The agency shall develop policies and procedures for the removal of the medical/health record, which shall occur only under the following conditions:**

1. No medical/health record or parts thereof shall be removed from the agency except for purposes of providing clinical patient care and treatment;

i. Any such record or part thereof which is removed from the agency shall be returned to the agency during the next business day;

2. If there is a court order or subpoena for its release; or

3. To safeguard the record in case of a physical plant emergency or natural disaster; and

4. There shall be a system to protect the security and confidentiality of all components of the medical/health record at all times.*

(h) Medical records shall be retained and preserved in accordance with N.J.S.A. 26:8-5 et seq.

SUBCHAPTER 12. INFECTION PREVENTION AND CONTROL

8:42-12.1 Infection prevention and control program

(a) The administrator shall ensure the development and implementation of an infection prevention and control program.

(b) The administrator shall designate a person who shall have education, training, completed course work, or experience in infection control or epidemiology, and who shall be responsible for the direction, provision, and quality of infection prevention and control services. The designated person shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, a system for data collection, and a quality assurance program for the infection prevention and control service.

8:42-12.2 Infection control policies and procedures

(a) The facility shall have a multidisciplinary committee which establishes and implements an infection prevention and control program.

(b) The designated committee shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following:

1. Infection control and isolation, including Universal Precautions, in accordance with the Centers for Disease Control and Occupational Safety and Health Administration publication, "Enforcement Procedures for Occupational Exposure to Hepatitis B Virus (HVB) and Human Immunodeficiency Virus (HIV)," OSHA Instruction CPL 2-2.44A, August 15, 1988 or revised or later editions, if in effect incorporated herein by reference;

2. In accordance with N.J.A.C. 8:57, a system for investigating, reporting, and evaluating the occurrence of all infections or diseases which are reportable or conditions which may be related to activities and procedures of the facility, and maintaining records for all patients or personnel having these infections, diseases, or conditions;

3. Aseptic technique, employee health, and staff training, the prevention of infection, and general improvement of patient care as it relates to infection control and prevention;

4. Exclusion from work, and authorization to return to work, for personnel with communicable diseases;

5. Surveillance techniques to minimize sources and transmission of infection;

6. The prevention of decubitus ulcers;

7. Sterilization, disinfection, and cleaning practices and techniques including, but not limited to, the following:

i. Care of utensils, instruments, solutions, dressings, articles, and surfaces;

ii. Selection, storage, use, and disposition of single use and nondisposable patient care items;

iii. Methods to ensure that sterilized materials are packaged, labeled, processed, transported, and stored to maintain sterility and to permit identification of expiration dates; and

iv. Care of urinary catheters, intravenous catheters, respiratory therapy equipment, and other devices and equipment that provide a portal of entry for pathogenic microorganisms; and

8. Collection, handling, storage, decontamination, disinfection, sterilization, and disposal of regulated medical waste and all other solid or liquid waste.

NOTE: Centers for Disease Control publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
or
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

8:42-12.3 Infection control measures

(a) The facility shall follow all Category I recommendations in the current editions of the following Centers for Disease Control publications, and any amendments or supplements thereto, incorporated herein by reference:

1. Guideline for Prevention of Catheter-Associated Urinary Tract Infections;

2. Guideline for Prevention of Intravascular Infections;

3. Guideline for Prevention of Surgical Wound Infections; and

4. Guideline for Handwashing and Hospital Environmental Control.

8:42-12.4 Use and sterilization of patient care items

(a) The facility shall develop protocols for decontamination and sterile activities, including receiving, decontamination, storage, cleaning, packaging, labeling, disinfection, sterilization, transporting, and distribution of reusable items. These protocols shall ensure that:

1. Single use patient care items shall not be reused. Other patient care items which are reused shall be reprocessed and reused in accordance with manufacturers' recommendations;

2. Sterilized materials shall be marked with an expiration date and shall not be used subsequent to the expiration date;

3. Sterilized materials shall be packaged and labeled so as to maintain sterility and so as to permit identification of expiration dates; and

4. Expiration dates shall be assigned to sterilized materials in accordance with the following:

i. Double-wrapped muslin/paper wrappers shall be marked with an expiration date not to exceed one month following sterilization;

ii. Heat-sealed paper/plastic wrappers shall be marked with an expiration date not to exceed one year following sterilization; and

iii. Self-sealed packaging shall be marked with an expiration date not to exceed the manufacturer's recommendation.

8:42-12.5 Care and use of sterilizers

(a) Sterilizers shall be kept clean.

(b) Sterilizer drains shall be flushed at least weekly, unless otherwise specified by the manufacturer, and a record shall be maintained.

(c) At the completion of each sterilization load, the time, temperature, and pressure readings shall be checked and recorded.

(d) A record of each sterilization load, including the date, the load number, the contents of the load, and the expiration dates of the contents, shall be maintained for at least one year.

8:42-12.6 Regulated medical waste

(a) Regulated medical waste shall be collected, stored, handled, and disposed of in accordance with applicable Federal and State laws and regulations.

(b) The facility shall comply with the provisions of the Medical Waste Tracking Act of 1988, and N.J.S.A. 13:1E-48.1 et seq., the

Comprehensive Regulated Medical Waste Management Act, and all rules and regulations promulgated pursuant to the aforementioned Acts.

8:42-12.7 Communicable diseases alert

The facility shall develop protocols for identifying and handling high-risk bodies, in accordance with centers for Disease Control guidelines and in compliance with N.J.S.A. 26:6-8. In accordance with the provisions of P.L. 1988, c.125 (Assembly bill 1457), the facility shall complete the New Jersey State Department of Health form HFE-4, "Communicable Diseases Alert," in applicable cases.

8:42-12.8 Orientation and in-service education

(a) Orientation for all new employees and staff under contract to provide direct patient care shall include infection control practices for the employee's specific discipline and the rationale for the practices.

(b) The designated committee shall coordinate educational programs to address specific problems at least annually for staff in all disciplines and patient care services.

SUBCHAPTER 13. PATIENT RIGHTS

8:42-13.1 Policies and procedures

(a) The facility shall establish and implement written policies and procedures regarding the rights of patients and the implementation of these rights. A complete statement of these rights, including the right to file a complaint with the New Jersey Department of Health, shall be conspicuously posted in the facility and shall be distributed to all staff and contracted personnel. These patient rights shall be made available in any language which is spoken as the primary language by more than 10 percent of the population in the agency's service area.

(b) Each patient shall be entitled to the following rights, none of which shall be abridged or violated by the facility or any of its staff:

1. To treatment and services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment;

2. To be given a written notice, prior to the initiation of care, of these patient rights and any additional policies and procedures established by the agency involving patient rights and responsibilities. If the patient is unable to respond, the notice shall be given to family member or other responsible individual;

3. To be informed in writing of the following:

i. Services available from the facility;

ii. The names and professional status of personnel providing and/or responsible for care;

iii. The frequency of home visits to be provided;

iv. The agency's daytime and emergency telephone numbers; and

v. Notification regarding the filing of complaints with the New Jersey Department of Health 24-hour Complaint Hotline at 1-800-792-9770, or in writing to:

Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625

4. To receive, in terms that the patient understands, an explanation of his or her plan of care, expected results, and reasonable alternatives. If this information would be detrimental to the patient's health, or if the patient is not able to understand the information, the explanation shall be provided to a family member or guardian and documented in the patient's medical record;

5. To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and health care personnel;

6. To receive the care and health services that have been ordered;

7. To participate in the planning of his or her home health care and treatment;

8. To refuse services, including medication and treatment, provided by the facility and to be informed of available home health treatment options, including the option of no treatment, and of the possible benefits and risks of each option;

9. To refuse to participate in experimental research. If he or she chooses to participate, his or her written informed consent shall be obtained;

10. To receive full information about financial arrangements, including, but not limited to:

i. Fees and charges, including any fees and charges for services not covered by sources of third-party payment;

ii. Copies of written records of financial arrangements;

iii. Notification of any additional charges, expenses, or other financial liabilities in excess of the predetermined fee; and

iv. Description of agreements with third-party payors and/or other payors and referral systems for patients' financial assistance.

11. To express grievances regarding care and services to the facility's staff and governing authority without fear of reprisal, and to receive an answer to those grievances within a reasonable period of time. The facility is required to provide each patient or guardian with the names, addresses, and telephone numbers of the government agencies to which the patient can complain and ask questions, including the New Jersey Department of Health Complaint Hotline at 1-800-792-9770;

12. To freedom from mental and physical abuse and from exploitation;

13. To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the patient or others from injury;

14. To be assured of confidential treatment of his or her medical/health record, and to approve or refuse in writing its release to any individual outside the facility, except as required by law or third-party payment contract;

15. To be treated with courtesy, consideration, respect, and recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy and confidentiality concerning patient treatment and disclosures;

16. To be assured of respect for the patient's personal property;

17. To join with other patients or individuals to work for improvements in patient care;

18. To retain and exercise to the fullest extent possible all the constitutional, civil, and legal rights to which the patient is entitled by law, including religious liberties, the right to independent personal decisions, and the right to provide instructions and directions for health care in the event of future decisionmaking incapacity in accordance with the New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, and with N.J.A.C. 8:42-6.3;

19. To be transferred to another facility only for one of the reasons delineated at N.J.A.C. 8:42-6.3(c); and

20. To discharge himself or herself from treatment by the facility.

SUBCHAPTER 14. QUALITY ASSURANCE

8:42-14.1 Quality assurance organization

(a) The governing authority of the facility shall have ultimate responsibility for the quality assurance program.

(b) The facility shall establish and implement a written plan for a quality assurance program for patient care. The plan shall include a mechanism to ensure participation of all disciplines in quality assurance activities and monitoring, and shall specify staff responsibilities for the quality assurance program.

8:42-14.2 Quality assurance policies and procedures

(a) The quality assurance plan shall be reviewed at least annually and revised as necessary. Responsibility for reviewing and revising the plan shall be designated in the plan itself.

(b) The quality assurance program shall include regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing and monitoring corrective actions on the basis of these data.

(c) The quality assurance plan shall designate the frequency of data collection to ensure regular monitoring of patient care activities.

(d) The ongoing quality assurance activities shall include, but not be limited to:

1. Incident review;

2. Evaluation of patient care services and statistics;

3. Monitoring of infection prevention and control;
4. Evaluation of staffing patterns and staff qualifications and credentials;
5. Evaluation of clinical competence of all clinical practitioners;
6. Evaluation of staff orientation and staff education;
7. Evaluation by patients and their families of care and services provided by the facility; and
8. Audit, at least quarterly, of patient medical/health records (including those of both active and discharged patients) to determine if care has conformed to criteria established by each patient care service for the maintenance of quality of care.

(e) Reports of the activities of all facility committees or their equivalents shall be made available to the advisory group specified in N.J.A.C. 8:42-6.1(a).

(f) The results of the quality assurance program shall be submitted to the governing authority at least annually, and shall include at least deficiencies found and recommendations for corrections or improvements. The administrator shall, with the approval of the governing authority, implement measures to ensure that corrections or improvements are made.

PUBLIC NOTICES

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

FISH, GAME AND WILDLIFE
MARINE FISHERIES ADMINISTRATION
Notice of Receipt of and Action on Petition for Rulemaking
N.J.A.C. 7:25-18.1
Winter Flounder Size Limits

Petitioner: Atlantic Star Fishing & Cruises, Inc.
Authority: N.J.S.A. 23:2B-6.

Take notice that on May 20, 1992, the Department of Environmental Protection and Energy (Department) received a petition for rulemaking concerning the amendment of the Department's regulations governing size limits for winter flounder.

N.J.A.C. 7:25-18.1 currently provides that a person may not take from the marine waters in the State, or have in his or her possession, any winter flounder under 10 inches in length. The petitioner requests that the Department reduce the limit to nine inches. The petitioner owns and operates a party boat, and fishes the Navesink River, the Shrewsbury River, and Sandy Hook Bay.

The Department adopted the 10 inch size limit for winter flounder on July 1, 1991 (see 23 N.J.R. 2011(a)). The size limit was originally instituted to allow the maximum number of winter flounder to spawn prior to capture. Research conducted in New Jersey indicates that 100 percent of males and 99 percent of females are able to spawn at 10 inches. Allowing a maximum number of fish to spawn each year results in larger year classes when environmental conditions are conducive to survival of eggs and larvae.

Recent management recommendations contained in the Atlantic States Marine Fisheries Commission's Winter Flounder Management Plan reinforce the need for a 10 inch size limit. Current estimates of fishing mortality indicate that winter flounder stocks may be overfished. In order to reduce fishing mortality to a level that protects the spawning stock, a 10 inch size limit is recommended. This management strategy is the first step in achieving a three step management regime recommended in the management plan. If fishing mortality is not sufficiently reduced, then additional restrictions on catches of winter flounder will be instituted in 1995 and 1998. The Department has therefore determined that it is in the best interest of the winter flounder resource and the fishery to maintain the existing minimum size limit of 10 inches.

(b)

OFFICE OF REGULATORY POLICY
Amendment to the Upper Raritan Water Quality Management Plan
Public Notice

Take notice that on July 20, 1992, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Upper Raritan Water Quality Management Plan was adopted by the Department. This amendment, proposed by the Township of Bedminster, allows for conversion of the Bedminster Village Wastewater Treatment Plant to a pumping station with all wastewater flows being conveyed to the Environmental Disposal Corporation (EDC) sewage treatment plant. The amendment also reduces the amount of flow to be received by EDC from the Township of Bernards. The amendment modifies the Bedminster Township, Borough of Far Hills, and Township of Bernards Sewerage Authority Wastewater Management Plans.

(c)

OFFICE OF REGULATORY POLICY
Amendment to the Monmouth County Water Quality Management Plan
Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Monmouth County Water Quality Management (WQM) Plan. This amendment would adopt a Wastewater Management Plan (WMP) for the Borough of Tinton Falls. The WMP addresses wastewater management planning for the Borough. The Borough will retain WMP responsibility for the municipality.

The WMP delineates all of the Borough as existing and future sewer service area. The northern portion of the Borough is served by the Northeast Monmouth Regional Sewerage Authority, a future (2010) wastewater flow from the northern portion of the Borough of 800,000 gallons per day (GPD), exclusive of infiltration and inflow (I/I), is projected. This includes 3248 GPD from a small portion of Ocean Township in the vicinity of Pine Lane which is shown as part of the service area but does not become part of the WMP area of Tinton Falls. An ultimate flow of 2.617 million gallons per day (MGD), exclusive of I/I, is projected. The southern portion of the Borough in the Shark River drainage basin is served by the Township of Neptune Sewerage Authority, a future wastewater flow (2010) from the southern portion of the Borough of 1.632 MGD, exclusive of I/I, is projected. An ultimate flow, exclusive of I/I, of 2.345 MGD is projected.

This notice is being given to inform the public that a plan amendment has been proposed for the Monmouth County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Regulatory Policy, CN-029, 401 East State Street, Third Floor, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Regulatory Policy at (609) 633-7021.

Interested persons should submit written comments on the amendment to Mr. Ed Frankel, Office of Regulatory Policy, at the NJDEPE address cited above. A copy of the comments should be sent to Gregory Blash, Leon S. Avakian, Inc., 788 Wayside Road, Neptune, New Jersey 07753. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested person may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of the date of this public notice to Mr. Ed Frankel at the NJDEPE address cited above. If a public hearing is held, the public comment period in this notice shall be extended 15 days after the date of the public hearing.

(d)

OFFICE OF REGULATORY POLICY
Amendment to the Tri-County Water Quality Management Plan
Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comments on a proposed amendment to the Tri-County Water Quality Management (WQM) Plan. This amendment was proposed by the Crown/Vista Energy Project (CVEP). The amendment would identify new industrial treatment works to serve the proposed CVEP facility. The new treatment works consist of an on-site lagoon for recycled water, an on-site lagoon for industrial runoff and wastewater pretreatment facilities. The CVEP will be located at Block 328, Lot 1-B of West Deptford Township, Gloucester County.

This notice is being given to inform the public that a plan amendment has been proposed for the Tri-County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Regulatory Policy, CN-029, 401 East State Street, 3rd Floor, Trenton, N.J. 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Regulatory Policy at (609) 633-7021.

Interested persons should submit written comments on the proposed amendment to Mr. Edward Frankel, at the NJDEPE address cited above with a copy sent to Mr. Frederick B. Pope, Frank Moolin & Associates, One Oxford Valley, Suite 200, Langhorne, PA 19047. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment (or extend the public comment period in this notice up to 30 additional days). These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of the date of this public notice to Mr. Frankel at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF REGULATORY POLICY

Amendment to the Lower Delaware Water Quality Management Plan

Public Notice

Take notice that on July 20, 1992, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Lower Delaware Water Quality Management Plan was adopted by the Department. This amendment was proposed by the Landis Sewerage Authority (LSA) on behalf of Cumberland County College (CCC). The amendment expands the sewer service area of the LSA to include those portions of the CCC campus located within the City of Millville. Those portions of the CCC campus located within the City of Vineland are already within the sewer service area of the LSA but are not presently receiving sewer service. The entire college site has a projected wastewater flow of 11,500 gallons per day.

(b)

OFFICE OF REGULATORY POLICY

Amendment to the Cape May County Water Quality Management Plan

Public Notice

Take notice that on July 10, 1992, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Cape May County Water Quality Management Plan was adopted by the Department. This amendment adopts a Wastewater Management Plan (WMP) for Lower Township, Cape May County. The WMP allows for the expansion, as delineated, of the service area to the Lower Township Municipal Utilities Authority sewage treatment plant (STP). The WMP also allows for a new on-site groundwater disposal system to serve the Cape May National Golf Club. The projected wastewater flow to this facility is 23,725 gallons per day (gpd). The WMP delineates the service areas for on-site groundwater disposal systems with design capacities of less than 20,000 gpd and the sewer service area of the Wildwood/Lower STP.

HEALTH

(c)

DIVISION OF FAMILY HEALTH SERVICES

Notice of Availability of Grants

Cardiovascular Disease Program

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq. (P.L. 1987, c.7), the Department of Health hereby publishes notice of the availability of the following grant:

Name of grant program: Cardiovascular Disease Program, Grant Program No. 93-81-HYP.

Purpose for which the grant program funds will be used: To provide cardiovascular health promotion, disease prevention services to large communities located in areas of highest need throughout the State, addressing the modifiable risk factors; high cholesterol; high blood pressure; smoking; obesity; sedentary lifestyle; and diabetes.

Amount of money in the grant program: The availability of funds for this program is contingent on appropriation of funds to the Department. Contact the person identified in this notice to determine whether the funds have been awarded and to receive further information.

Group or entities which may apply for the grant program: Currently funded New Jersey State Healthy Heart Programs.

Qualifications needed by an applicant to be considered for the grant: Demonstrated ability to organize and work through a coalition in the provision of services.

Procedures for eligible entities to apply for grant funds: Submit a completed New Jersey State Department of Health application for Health Service Grant.

For information contact:

Ms. Phyllis F. Dower, MPH
Coordinator
Cardiovascular Disease Program
Division of Family Health Services
CN 364
Trenton, NJ 08625-0364
Telephone: 609-292-4961

Deadline by which application must be submitted: October 1, 1992.

Date by which applicant shall be notified whether they will receive funds: January 21, 1993.

HUMAN SERVICES

(d)

NEW JERSEY COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

Notice of Availability of Grant Funds

Vending Machine Service Contract Management

Take notice that, in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the New Jersey Commission for the Blind and Visually Impaired, Department of Human Services hereby announces the availability of the following grant program funds.

A. Name of Program: Vending Machine Service Contract Management.

B. Purpose: To obtain a managing agent that will be responsible for enforcing the provisions of the State of New Jersey's vending machine service contract at State sites. The goals are to assure quality of services and accurate and correct fiscal collections and distributions. Responsibilities include: On-site surveys; procuring and placing of vending services; monitoring of vending services including review of receipts, meter readings, assuring quality of products and services; responding to complaints or questions by using agencies, and to requests by the Commission for the Blind and Visually Impaired (CBVI); working cooperatively with CBVI and being part of a Vending Machine Advisory Board; and maintaining files, records and documentations on vending service contractors.

Priority counties for services are: Mercer, Burlington, Essex, Camden and Ocean. Other areas may be included as needed.

C. Amount of available funding for the program: Up to $130,000 is available. This contract may be renewable conditional upon performance and upon availability of funds.

D. Organizations which may apply for this funding: Individuals, profit or not-for-profit agencies and organizations or business firms which have knowledge of the vending machine service industry.

E. Qualifications needed by an applicant to be considered for funding: Thorough knowledge of all aspects of vending machine services; knowledge of general sound fiscal practices; familiarity with or ability to learn State purchasing system, State and Federal health, safety and building codes; ability to survey and monitor sites; ability to keep records and files in a retrievable, accurate and complete manner; ability and experience dealing with the public; food service, retail or marketing experience helpful.

F. Procedure for eligible organizations to apply: RFP available as of August 12, 1992 from the address indicated below or by telephone.

G. Address to which applications must be submitted:

Program Development/Contract Unit
New Jersey Commission for the Blind and Visually Impaired
153 Halsey Street
P.O. Box 47017
Newark, NJ 07101
(201) 648-4799 or (201) 648-2899

H. Deadline by which applications must be submitted: September 18, 1992.

I. Date the applicant is to be notified of acceptance or rejection: October 2, 1992.

LAW AND PUBLIC SAFETY

(a)

DIVISION OF MOTOR VEHICLES

Notice of Application for Contract and Common Carrier Permit

Take notice that Director Stratton C. Lee, Jr., Division of Motor Vehicles, pursuant to the authority of N.J.S.A. 39:5E-11, hereby lists the name and address of an applicant who has filed an application for a Contract and Common Carrier Permit:

CONTRACT AND COMMON (NON-GRANDFATHER)
Miller Transporters, Inc.
5500 Hwy, 80 W.
Jackson, MS 39209

Protests in writing and verified under oath may be presented to the Director, Division of Motor Vehicles, 25 South Montgomery Street, Trenton, N.J. 08666, within 20 days (September 6, 1992) following the publication of an application.

REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

The research supplement to the New Jersey Administrative Code

A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the July 6, 1992 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of adoption of the rule and its chronological ranking in the Registry. As an example, R.1992 d.1 means the first rule adopted in 1992.

Adoption Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

Transmittal. A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code: Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

N.J.R. Citation Locator. An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT JUNE 15, 1992

NEXT UPDATE: SUPPLEMENT JULY 20, 1992

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register	If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
23 N.J.R. 2447 and 2560	August 19, 1991	24 N.J.R. 673 and 888	March 2, 1992
23 N.J.R. 2561 and 2806	September 3, 1991	24 N.J.R. 889 and 1138	March 16, 1992
23 N.J.R. 2807 and 2898	September 16, 1991	24 N.J.R. 1139 and 1416	April 6, 1992
23 N.J.R. 2899 and 3060	October 7, 1991	24 N.J.R. 1417 and 1658	April 20, 1992
23 N.J.R. 3061 and 3192	October 21, 1991	24 N.J.R. 1659 and 1840	May 4, 1992
23 N.J.R. 3193 and 3402	November 4, 1991	24 N.J.R. 1841 and 1932	May 18, 1992
23 N.J.R. 3403 and 3548	November 18, 1991	24 N.J.R. 1933 and 2102	June 1, 1992
23 N.J.R. 3549 and 3678	December 2, 1991	24 N.J.R. 2103 and 2314	June 15, 1992
23 N.J.R. 3679 and 3840	December 16, 1991	24 N.J.R. 2315 and 2486	July 6, 1992
24 N.J.R. 1 and 164	January 6, 1992	24 N.J.R. 2487 and 2650	July 20, 1992
24 N.J.R. 165 and 318	January 21, 1992	24 N.J.R. 2651 and 2752	August 3, 1992
24 N.J.R. 319 and 508	February 3, 1992	24 N.J.R. 2753 and 2970	August 17, 1992
24 N.J.R. 509 and 672	February 18, 1992		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:6A-9.2, 14.1, 14.4, 18.1, 18.3, 18.5	Special Education Program	24 N.J.R. 1936(a)		
1:13A-1.2, 18.1, 18.2	Lemon Law hearings: exceptions to initial decision	24 N.J.R. 1843(a)		
	Most recent update to Title 1: TRANSMITTAL 1992-3 (supplement May 18, 1992)			
AGRICULTURE—TITLE 2				
2:5-1	Equine entry restriction	Emergency (expires 9-18-92)	R.1992 d.321	24 N.J.R. 2737(a)
2:22	Insect control	24 N.J.R. 1662(a)	R.1992 d.294	24 N.J.R. 2556(a)
2:24-4	Volunteer Inspector Program: noncommercial apiaries and bees	24 N.J.R. 1141(a)	R.1992 d.278	24 N.J.R. 2421(a)
2:69-1.11	Commercial values of primary plant nutrients	24 N.J.R. 2318(a)		
2:71-2.2, 2.4, 2.5, 2.6	Jersey Fresh Quality Grading Program	24 N.J.R. 2318(b)		
2:71-2.28, 2.29	Inspection and grading charges for fruits and vegetables	24 N.J.R. 2321(a)		
2:76-3.12, 4.11	Farmland Preservation Program: pre-existing nonagricultural uses of enrolled lands	24 N.J.R. 893(b)	R.1992 d.325	24 N.J.R. 2831(a)
2:76-6.15	Farmland Preservation Program: pre-existing nonagricultural uses on lands permanently deed restricted	24 N.J.R. 896(a)	R.1992 d.324	24 N.J.R. 2833(a)
	Most recent update to Title 2: TRANSMITTAL 1992-2 (supplement June 15, 1992)			
BANKING—TITLE 3				
3:1-19	Consumer checking accounts	24 N.J.R. 1662(b)	R.1992 d.305	24 N.J.R. 2710(a)
3:4-1	Capital requirements for depository institutions	24 N.J.R. 1665(a)	R.1992 d.326	24 N.J.R. 2834(a)
3:23	Department license fees	24 N.J.R. 1667(a)	R.1992 d.303	24 N.J.R. 2712(a)
3:25	Debt adjustment and credit counseling	24 N.J.R. 2106(a)	R.1992 d.323	24 N.J.R. 2836(a)
3:38	Mortgage bankers and brokers	24 N.J.R. 2653(a)		
3:38-1.9, 5.2, 5.3	Branch offices; mortgage services licensure exemption; solicitor registration	24 N.J.R. 1937(a)		
	Most recent update to Title 3: TRANSMITTAL 1992-5 (supplement June 15, 1992)			
CIVIL SERVICE—TITLE 4				
	Most recent update to Title 4: TRANSMITTAL 1990-3 (supplement July 16, 1990)			
PERSONNEL—TITLE 4A				
4A:1	General rules and Department organization	24 N.J.R. 2490(a)		
4A:2	Appeals, discipline, separations	24 N.J.R. 2491(a)		
4A:2-2.13	Expungement from personnel files of references to disciplinary action	23 N.J.R. 2906(a)		
4A:4-3.7, 7.10, 7.12	Reinstatement of permanent employee following disability retirement	24 N.J.R. 2107(a)		
4A:4-7.11	Transfers and retention of employee rights in a consolidation	24 N.J.R. 2494(a)		
4A:5	Veterans and disabled veterans preference	24 N.J.R. 2495(a)		
4A:6-1, 2, 3, 4, 5	Leaves, hours of work, and employee development: preproposed readoption	24 N.J.R. 2496(b)		
4A:6-6	Awards program: preproposed readoption	24 N.J.R. 2496(a)		
4A:6-16	Sick leave injury (SLI) benefits: carpal tunnel syndrome and asbestosis	24 N.J.R. 2108(a)		

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4A:7	Equal employment opportunity and affirmative action	24 N.J.R. 2496(c)		
4A:9-1	Political subdivision	24 N.J.R. 2498(a)		
4A:10	Violations and penalties	24 N.J.R. 2499(a)		
	Most recent update to Title 4A: TRANSMITTAL 1992-1 (supplement January 21, 1992)			
COMMUNITY AFFAIRS—TITLE 5				
5:4-2	Debarment and suspension from Department contracting	24 N.J.R. 2322(a)		
5:10-25	Indirect apportionment of heating costs in multiple dwellings: methods, devices, and systems	24 N.J.R. 1844(a)		
5:12-2.1	Homelessness Prevention Program: eligibility	23 N.J.R. 3439(a)		
5:13	Limited dividend and nonprofit housing corporations and associations	24 N.J.R. 1668(a)	R.1992 d.290	24 N.J.R. 2556(b)
5:14-1.6, 2.2, 3.1, 4.1, 4.5, 4.6, 4.7	Neighborhood Preservation Balanced Housing Program: per unit developer fees and costs; other revisions	24 N.J.R. 1144(a)		
5:18-1.5, 2.4A, 2.4B, 2.7, 2.8	Uniform Fire Code: life hazard uses and permits	24 N.J.R. 2654(a)		
5:18-1.5, 4.7	Uniform Fire Code: eating and drinking establishments; exemption from fire suppression system requirement	24 N.J.R. 1938(a)		
5:18-2.4A, 2.4B, 2.7	Uniform Fire Code: life hazard uses; permits	23 N.J.R. 2999(a)		
5:18A-2.9, 4.6	Fire Code enforcement: conflict of interest	24 N.J.R. 678(a)	R.1992 d.243	24 N.J.R. 2422(a)
5:18C-4.2	Firefighter I certification	23 N.J.R. 2084(a)	Expired	
5:19	Continuing care retirement communities	24 N.J.R. 1146(a)		
5:22-1, 2	Rehabilitation of one and two-unit residences and multiple dwellings: exemptions from taxation	24 N.J.R. 1669(a)	R.1992 d.291	24 N.J.R. 2556(c)
5:23	Uniform Construction Code	24 N.J.R. 1420(b)		
5:23-2.1, 2.15	Uniform Construction Code: licensing disputes	24 N.J.R. 4(a)		
5:23-2.5	UCC: increase in building size	24 N.J.R. 1421(a)		
5:23-2.17, 8	Asbestos Hazard Abatement Subcode	24 N.J.R. 1422(a)		
5:23-3.7, 3.8, 4.20	Indirect apportionment of heating costs in multiple dwellings: methods, devices, and systems	24 N.J.R. 1844(a)		
5:23-3.10, 5	UCC: enforcing agency classification; licensing of enforcement officials	24 N.J.R. 1446(a)	R.1992 d.272	24 N.J.R. 2424(a)
5:23-3.14	Uniform Construction Code: tent permits	24 N.J.R. 2656(a)		
5:23-3.21	UCC: one and two family dwelling subcode	23 N.J.R. 3444(b)		
5:23-4.5, 4.11, 4.14	UCC enforcement: conflict of interest	24 N.J.R. 678(a)	R.1992 d.243	24 N.J.R. 2422(a)
5:23-4.5, 4.19–4.22, 4A.12, 5.21, 5.22, 8.6, 8.10, 8.18, 8.19, 12.5, 12.6	UCC: State Training Fee Report; fees	24 N.J.R. 2657(a)		
5:23-4.18, 4.20	UCC enforcing agencies: minimum fees	24 N.J.R. 169(b)		
5:23-4.18, 4.20	Uniform Construction Code: gas service entrances	24 N.J.R. 1846(a)	R.1992 d.313	24 N.J.R. 2712(b)
5:23-5.4	Uniform Construction Code: enforcement interns	24 N.J.R. 1669(b)	R.1992 d.292	24 N.J.R. 2557(a)
5:23-5.7	UCC: subcode official requirements	24 N.J.R. 2661(a)		
5:23-5.19	UCC: elevator inspector H.H.S. requirements	24 N.J.R. 2662(a)		
5:24-3	Protected housing tenancy in qualified counties and in planned real estate developments	24 N.J.R. 1453(a)	R.1992 d.287	24 N.J.R. 2429(a)
5:25-5.4	State new home warranty plan contributions	24 N.J.R. 2663(a)		
5:26-2.3, 2.4	Planned real estate development full disclosure: fees	24 N.J.R. 2657(a)		
5:26-9.1, 9.2	Protected housing tenancy in qualified counties and in planned real estate developments	24 N.J.R. 1453(a)	R.1992 d.287	24 N.J.R. 2429(a)
5:33-4	Property tax and mortgage escrow account transactions	24 N.J.R. 2664(a)		
5:34-7	Cooperative purchasing by local contracting units	24 N.J.R. 2667(a)		
5:80-32	Housing and Mortgage Finance Agency: project cost certification	24 N.J.R. 2208(a)		
5:91	Council on Affordable Housing: procedural rules	24 N.J.R. 2671(a)		
5:100-2.3, 2.4, 2.5	Ombudsman for Institutionalized Elderly: resident advance directives	24 N.J.R. 1455(a)	R.1992 d.284	24 N.J.R. 2431(a)
5:100-2.3, 2.4, 2.5	Ombudsman for Institutionalized Elderly: extension of comment period on resident advance directives	24 N.J.R. 1847(a)		
	Most recent update to Title 5: TRANSMITTAL 1992-6 (supplement June 15, 1992)			
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5A:5	State veterans' facilities: admission criteria, care maintenance fee, transfer or discharge	24 N.J.R. 2499(b)		
	Most recent update to Title 5A: TRANSMITTAL 1992-1 (supplement February 18, 1992)			
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6:5-2.4, 2.5	Organization of Department: reporting responsibilities; public information requests	Exempt	R.1992 d.279	24 N.J.R. 2431(b)
6:8-9	Educational improvement plans in special needs districts	24 N.J.R. 2323(a)		
6:11-6.2	Early childhood instructional certificate	23 N.J.R. 2210(b)	Expired	

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6:20-9.2	Policy and agreement for School Nutrition Programs: administrative correction	————	————	24 N.J.R. 2712(c)
6:21-5, 6, 6A, 6B, 6C, 8, 9	Pupil transportation: school bus and small vehicle standards	24 N.J.R. 2109(a)		
6:21-6A.6	Pupil transportation: administrative correction to N.J.A.C. 6:21-6A.6 regarding school bus color	24 N.J.R. 2325(a)		
6:26	Establishment of pupil assistance committees	24 N.J.R. 1670(a)	R.1992 d.307	24 N.J.R. 2713(a)
6:28	Special education	24 N.J.R. 1150(a)	R.1992 d.280	24 N.J.R. 2434(a)
6:29-2.4	Attendance at school by pupils or adults infected by HIV	24 N.J.R. 2124(a)		
6:29-8	Nonpublic school nursing services	24 N.J.R. 2325(b)		
6:64	Public, school, and college libraries	24 N.J.R. 2126(a)		
	Most recent update to Title 6: TRANSMITTAL 1992-2 (supplement May 18, 1992)			
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7:1-1.3, 1.4	Delegations of authority within the Department	23 N.J.R. 3276(a)		
7:1-2	Third-party appeals of permit decisions	23 N.J.R. 3278(a)		
7:1J	Spill Compensation and Control Act: processing of damage claims (repeal 17:26)	24 N.J.R. 1255(a)		
7:1K	Pollution prevention program requirements: preproposed new rules	24 N.J.R. 1968(a)		
7:4	New Jersey Register of Historic Places: procedures for listing of historic places	23 N.J.R. 2103(b)	R.1992 d.318	24 N.J.R. 2926(a)
7:6-1.24, 9.2	Boating rules: rotating lights; "personal watercraft"	24 N.J.R. 1694(a)		
7:7-4.5, 4.6	Coastal Permit Program: public hearings; final review of applications	23 N.J.R. 3280(a)		
7:7A-1.4, 2.7, 8.10	Freshwater wetlands protection: project permit exemptions; hearings on contested letters of interpretation	24 N.J.R. 912(b)		
7:7E-7.5	Alternative traffic reduction programs in Atlantic City	24 N.J.R. 1986(a)		
7:9-6	Ground water quality standards	24 N.J.R. 181(a)		
7:9A-1.1, 1.2, 1.6, 1.7, 2.1, 3.3, 3.4, 3.5, 3.7, 3.9, 3.10, 3.12, 3.14, 3.15, 5.8, 6.1, 8.2, 9.2, 9.3, 9.5, 9.6, 9.7, 10.2, 12.2–12.6, App. A, B	Individual subsurface sewage disposal systems	24 N.J.R. 1987(a)		
7:14-8.3	Water Pollution Control Act: administrative correction regarding affirmative defense by violator	————	————	24 N.J.R. 2448(a)
7:14A-1, 2, 3, 5–14, App. F	NJPDES program and Clean Water Enforcement Act requirements	24 N.J.R. 344(b)		
7:14A-1.2, 1.7–1.10, 2.1, 2.4, 2.5, 2.12, 2.13, 3.8, 3.9, 3.11, 3.12, 3.13, 3.17, App. A, B, 7.8, 9.1, 10.3, 14.8, App. H	Statewide Stormwater Permitting Program	24 N.J.R. 2352(a)		
7:15-1.5, 3.4, 3.6, 4.1, 5.22	Statewide water quality management planning	24 N.J.R. 344(b)		
7:19-6.8	Water supply interconnections: administrative correction	————	————	24 N.J.R. 2715(a)
7:25-5	1992-93 Game Code	24 N.J.R. 1847(b)	R.1992 d.315	24 N.J.R. 2715(b)
7:25-6	1993-94 Fish Code	24 N.J.R. 2539(a)		
7:25-16.1	Defining freshwater fishing lines	24 N.J.R. 204(a)		
7:25-18.1	Filleting of flatfish at sea	24 N.J.R. 1456(a)		
7:25-18.1, 18.5	Atlantic sturgeon management	24 N.J.R. 205(a)		
7:25-18.5	Haul seining and fyke netting regulation	24 N.J.R. 207(a)		
7:26-1.4, 2.13, 6.3, 6.8	Solid waste management: scrap metal shredding residue, animal manure, interdistrict and intradistrict flow	24 N.J.R. 1995(a)		
7:26-2.4	Small scale solid waste facility permits: request for comment on draft revisions	23 N.J.R. 2458(a)		
7:26-4.3	Thermal destruction facilities: compliance monitoring fees and postponed operative date	24 N.J.R. 1999(a)		
7:26-4.3	Thermal destruction facilities: extension of comment period regarding compliance monitoring fees	24 N.J.R. 2687(a)		
7:26-4.6	Solid waste program fees	23 N.J.R. 3690(a)	R.1992 d.311	24 N.J.R. 2726(a)
7:26-4.6	Solid waste program fees: extension of comment period	24 N.J.R. 1458(a)		
7:26-4A.6	Hazardous waste program fees: annual adjustment	24 N.J.R. 2001(a)		
7:26-5.4, 7.4, 7.6, 9.4, 12.4	Hazardous waste manifest discrepancies	23 N.J.R. 3607(a)		

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7:26-5.4, 7.4, 7.6, 9.4, 12.4	Hazardous waste manifest discrepancies: reopening of comment period	24 N.J.R. 2002(a)		
7:26-8.2	Hazardous waste exclusions: household waste	23 N.J.R. 3410(a)		
7:26-8.2	Hazardous waste exclusions: used chlorofluorocarbon refrigerants	23 N.J.R. 3692(a)		
7:26-8.16	Hazardous constituents in waste streams	23 N.J.R. 3093(b)		
7:26-8.16	Hazardous constituents in waste streams: reopening of comment period	24 N.J.R. 2003(a)		
7:26-8.20	Used motor oil recycling	24 N.J.R. 2383(a)		
7:26A-6	Used motor oil recycling	24 N.J.R. 2383(a)		
7:26B	Environmental Cleanup Responsibility Act rules: extension of comment period	24 N.J.R. 1281(a)		
7:26B-1.3, 1.5, 1.6, 1.8, 1.9, 1.10, 1.13, 5.4, 13.1, App. A	Environmental Cleanup Responsibility Act rules	24 N.J.R. 720(a)		
7:26B-7, 9.3	Remediation of contaminated sites: Department oversight	24 N.J.R. 1281(b)		
7:26C	Remediation of contaminated sites: Department oversight	24 N.J.R. 1281(b)		
7:26D	Cleanup standards for contaminated sites	24 N.J.R. 373(a)		
7:26D	Cleanup standards for contaminated sites: additional public hearing and extension of comment period	24 N.J.R. 1458(b)		
7:26D	Cleanup standards for contaminated sites: additional public hearing and extension of comment period	24 N.J.R. 2003(b)		
7:26E	Technical requirements for contaminated site remediation	24 N.J.R. 1695(a)		
7:27-25	Control and prohibition of air pollution by vehicular fuels: public meeting and hearing on oxygenated fuels program	24 N.J.R. 2128(a)		
7:27-25.1–25.4, 25.7–25.12	Control and prohibition of air pollution by vehicular fuels	24 N.J.R. 2386(a)		
7:27-26	Low Emissions Vehicle Program	24 N.J.R. 1315(a)		
7:27-26	Low Emissions Vehicle Program: correction to proposal	24 N.J.R. 1458(c)		
7:27A-3.10	Civil administrative penalties for violations of Air Pollution Control Act	24 N.J.R. 2386(a)		
7:36-9	Green Acres Program: nonprofit land acquisition	24 N.J.R. 2405(a)		
	Most recent update to Title 7: TRANSMITTAL 1992-6 (supplement June 15, 1992)			
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8:13	Shellfish handling and shipping; hard and soft shell clam depuration	24 N.J.R. 2504(a)		
8:21-3.13	Repeal (see 8:21-3A)	24 N.J.R. 2410(b)		
8:21-3A	Registration of wholesale drug distributors and device manufacturers and wholesale distributors	24 N.J.R. 2410(b)		
8:21A	Good drug manufacturing practices; tamper-resistant packaging for over-the-counter products	24 N.J.R. 2003(c)	R.1992 d.316	24 N.J.R. 2729(a)
8:24-1.3, 2.5, 3.3, 13.2	Retail food establishments: "community residence"; eggs and egg dishes	24 N.J.R. 915(a)	R.1992 d.281	24 N.J.R. 2448(b)
8:31B-4.40	Uncompensated care collection procedures	24 N.J.R. 1124(c)		
8:31C-1.5, 1.6	Residential alcoholism treatment facilities: target occupancy penalty	24 N.J.R. 1463(a)	R.1992 d.312	24 N.J.R. 2730(a)
8:33	Health care facilities and services: Certificate of Need application and review process	24 N.J.R. 2222(a)		
8:33C	Regionalized perinatal services: Certificate of Need criteria and standards	24 N.J.R. 2005(a)		
8:33H	Long-term care services: Certificate of Need policy manual	24 N.J.R. 2014(a)		
8:34-1.7	Licensure examination fee for nursing home administrator	24 N.J.R. 2414(a)		
8:35A	Maternal and child health consortia: licensing standards	24 N.J.R. 2027(a)		
8:42	Home health agencies: standards for licensure	24 N.J.R. 2031(a)	R.1992 d.322	24 N.J.R. 2941(a)
8:43	Residential health care facilities: standards for licensure	24 N.J.R. 2506(a)		
8:43G-19	Hospital licensing standards: obstetrics	24 N.J.R. 2045(a)		
8:45-1.3, 2.1	Blook bank licensure fees and Department laboratory services charges	24 N.J.R. 2508(a)		
8:65-2.5	Controlled Dangerous Substances: physical security controls	24 N.J.R. 174(a)		
8:65-10.1	Controlled dangerous substances: addition of methcathinone to Schedule I	———	———	24 N.J.R. 2451(a)
8:71	Interchangeable drug products (see 23 N.J.R. 3334(b); 24 N.J.R. 144(b), 948(a))	23 N.J.R. 2610(a)	R.1992 d.295	24 N.J.R. 2558(a)
8:71	Interchangeable drug products (see 24 N.J.R. 145(b))	23 N.J.R. 3258(a)	R.1992 d.136	24 N.J.R. 948(b)
8:71	Interchangeable drug products	24 N.J.R. 59(b)	R.1992 d.137	24 N.J.R. 949(a)
8:71	Interchangeable drug products (see 24 N.J.R. 947(b), 1897(a))	24 N.J.R. 61(a)	R.1992 d.297	24 N.J.R. 2560(a)

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8:71	Interchangeable drug products (see 24 N.J.R. 1896(a))	24 N.J.R. 735(a)	R.1992 d.298	24 N.J.R. 2560(b)
8:71	Interchangeable drug products	24 N.J.R. 1673(a)	R.1992 d.296	24 N.J.R. 2559(a)
8:71	Interchangeable drug products	24 N.J.R. 1674(a)	R.1992 d.300	24 N.J.R. 2557(b)
8:71	Interchangeable drug products	24 N.J.R. 2414(b)		
8:100	State Health Plan	24 N.J.R. 1164(a)	R.1992 d.299	24 N.J.R. 2561(a)
8:100-14.8, 14.13	State Health Plan: hospital inpatient services	24 N.J.R. 2704(a)		
8:100-16	State Health Plan: correction to Economic Impact statement regarding Long-Term Care Services	24 N.J.R. 1675(a)		
	Most recent update to Title 8: TRANSMITTAL 1992-6 (supplement June 15, 1992)			
HIGHER EDUCATION—TITLE 9				
9:1-1.2, 3.1, 3.2, 3.4, 3.5	Teaching university	24 N.J.R. 1464(a)		
9:7	Student Assistance Programs	24 N.J.R. 2510(a)		
9:7-2.3, 2.11	Student Assistance Programs: administrative corrections	———	———	24 N.J.R. 2451(b)
9:9-7.2, 7.3, 7.8	NJCLASS program: family income limit, maximum loan amount, repayment	24 N.J.R. 1675(b)	R.1992 d.293	24 N.J.R. 2626(a)
9:9-7.6	NJCLASS Program: loan interest rate	24 N.J.R. 2687(b)		
9:11-1.5	Educational Opportunity Fund Program: financial eligibility for undergraduate grants	24 N.J.R. 1859(a)		
9:16-1	Primary Care Physician and Dentist Loan Redemption Program	24 N.J.R. 1192(a)		
	Most recent update to Title 9: TRANSMITTAL 1992-2 (supplement May 18, 1992)			
HUMAN SERVICES—TITLE 10				
10:8	Administration of State-provided Personal Needs Allowance	24 N.J.R. 681(a)		
10:16	Child Death and Critical Incident Review Board concerning children under DYFS supervision	23 N.J.R. 3417(a)		
10:35	County psychiatric facilities	24 N.J.R. 208(a)		
10:36	Patient supervision at State psychiatric hospitals	24 N.J.R. 1728(a)	R.1992 d.302	24 N.J.R. 2730(b)
10:46-1.3, 2.1, 3.2, 4.1, 5	Developmental Disabilities: determination of eligibility for division services	24 N.J.R. 211(a)		
10:49	New Jersey Medicaid Program: basic requirements for recipients and providers	24 N.J.R. 1728(b)	R.1992 d.317	24 N.J.R. 2837(a)
10:50-1.1–1.4, 1.6, 1.7, 2.1, 2.2	Livery services: Medicaid reimbursement, age of vehicles, workers' compensation coverage; invalid coach services	24 N.J.R. 2517(a)		
10:52-1.6	Medicaid reimbursement for outpatient laboratory services	24 N.J.R. 917(a)	R.1992 d.327	24 N.J.R. 2898(a)
10:53-1.5	Medicaid reimbursement for outpatient laboratory services	24 N.J.R. 917(a)	R.1992 d.327	24 N.J.R. 2898(a)
10:60-2.3, 3.15, 4.2	Home Care Services: personal care assistant services; eligibility for Home Care Expansion Program	24 N.J.R. 2687(c)		
10:72	New Jersey Care: Special Medicaid Programs Manual	24 N.J.R. 2145(a)		
10:72-1.1, 3.4, 4.1	New Jersey Care: Medicaid eligibility of children	24 N.J.R. 1860(a)		
10:81-1.6, 1.11, 1.12, 2.1, 2.2, 2.4, 2.7, 2.8, 3.8, 3.9, 3.18, 3.19, 4.2, 4.23, 5.2, 5.7, 5.8, 7.1, 7.4, 7.20, 8.22, 8.24, 9.1, 14.1, 14.18, 14.20, 14.21	Public Assistance Manual: Family Development Program and REACH/JOBS provisions	24 N.J.R. 2147(a)		
10:81-11.4, 11.9	Public Assistance Manual: provision of information regarding services to AFDC clients; legal representation in child support matters	24 N.J.R. 2327(a)		
10:81-11.5, 11.7, 11.9, 11.20, 11.21	Public Assistance Manual: child support and paternity services	24 N.J.R. 2328(a)		
10:82-1.2–1.5, 1.11, 2.7–2.11, 4.4, 4.8	Assistance Standards Handbook: AFDC program requirements	24 N.J.R. 2155(a)		
10:82-2.8	Assistance Standards Handbook: administrative correction regarding earned income in AFDC segments	———	———	24 N.J.R. 2626(b)
10:82-4.9	Assistance Standards Handbook: DYFS monthly foster care rates	24 N.J.R. 2160(a)		
10:83-1.2	Emergency Assistance benefits for SSI recipients	24 N.J.R. 326(a)		
10:83-1.2	Emergency Assistance benefits for SSI recipients: public hearing and extension of comment period	24 N.J.R. 1204(a)		
10:85-3.2, 10.1	General Assistance Manual: Family Development Program and work training requirements	24 N.J.R. 2160(b)		
10:86	Family Development Program Manual	24 N.J.R. 2161(a)		

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10:120-1.2	Youth and Family Services: scope of responsibilities and services	23 N.J.R. 3420(b)		
10:122B	Division of Youth and Family Services: requirements for foster care	23 N.J.R. 3693(a)		
10:122C	DYFS: approval of foster homes	23 N.J.R. 3696(a)		
10:122D	DYFS: foster care services	23 N.J.R. 3703(a)		
10:122E	DYFS: removal of foster children and closure of foster homes	23 N.J.R. 3708(a)		
10:123A	Youth and Family Services: Personal Attendant Services Program	23 N.J.R. 2091(b)	R.1992 d.314	24 N.J.R. 2914(a)
10:131	DYFS: Adoption Assistance and Child Welfare Act of 1980 requirements	24 N.J.R. 2522(a)		
10:133	DYFS: initial response and service delivery	23 N.J.R. 3714(a)		
10:133A	DYFS: initial response and screening	23 N.J.R. 3717(a)		
10:133B	DYFS: information and referral	23 N.J.R. 3720(a)		
10:133C-3	DYFS: assessment of family service needs	24 N.J.R. 217(a)		
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10A:4-4.1	Prohibited inmate acts: administrative correction	_____	_____	24 N.J.R. 2731(a)
10A:5-1.3, 7	Temporary close custody	24 N.J.R. 1676(a)		
10A:8	Inmate orientation and handbook	24 N.J.R. 2330(a)		
10A:10	Interjurisdictional agreements and statutes	24 N.J.R. 1939(a)	R.1992 d.310	24 N.J.R. 2731(b)
10A:16	Medical and health services	24 N.J.R. 1677(a)	R.1992 d.283	24 N.J.R. 2452(a)
10A:18	Inmate mail, visits, and telephone use	24 N.J.R. 1204(b)	R.1992 d.262	24 N.J.R. 2627(a)
10A:23	Lethal injection	24 N.J.R. 1677(a)	R.1992 d.283	24 N.J.R. 2452(a)
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11:1-32.4	Automobile insurance: limited assignment distribution servicing carriers	24 N.J.R. 519(a)		
11:1-32.4	Workers' compensation self-insurance	24 N.J.R. 1944(a)		
11:1-32.4	Workers' compensation self-insurance: extension of comment period	24 N.J.R. 2708(b)		
11:1-33	Public Advocate reimbursement disputes	24 N.J.R. 2706(a)		
11:2-17.7	Payment of health insurance claims	23 N.J.R. 3196(c)		
11:2-17.11	Payment of third-party claims: written notice to claimant	24 N.J.R. 522(a)		
11:2-26	Insurer's annual audited financial report	24 N.J.R. 1940(a)		
11:2-26	Insurer's annual audited financial report: extension of comment period	24 N.J.R. 2708(a)		
11:2-27	Determination of insurers in hazardous financial condition	23 N.J.R. 3197(a)	R.1992 d.282	24 N.J.R. 2456(a)
11:2-33	Workers' compensation self-insurance	24 N.J.R. 1944(a)		
11:2-33	Workers' compensation self-insurance: extension of comment period	24 N.J.R. 2708(b)		
11:3-2	Personal automobile insurance plan	24 N.J.R. 331(a)		
11:3-3	Automobile insurance: limited assignment distribution servicing carriers	24 N.J.R. 519(a)		
11:3-19.3, 34.3	Automobile insurance eligibility rating plans: incorporation of merit rating surcharge	24 N.J.R. 2332(a)		
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11:3-35.5	Automobile insurance rating: eligibility points of principal driver	24 N.J.R. 2331(a)		
11:3-36.12	Automobile physical damage inspection procedures: operative date	24 N.J.R. 2708(c)		
11:3-41	Association Producer Voluntary Placement Plan	23 N.J.R. 2275(a)	Expired	
11:3-42	Association Producer Assignment Program	23 N.J.R. 2297(a)	Expired	
11:3-43	Private passenger automobile insurance: personal lines rating plans	23 N.J.R. 3221(a)		
11:4-14.1, 15.1, 16.2, 19.2, 28.3, 36	BASIC health care coverage	24 N.J.R. 1205(a)		
11:4-16.5	Individual health insurance: disability income benefits riders	24 N.J.R. 338(a)		
11:4-16.8, 23, 25	Medicare supplement coverage: minimum standards	24 N.J.R. 12(a)		
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11:5-1.9, 1.38	Real Estate Commission: extension of comment period regarding fee cap for mortgage services; transmittal of funds to lenders	24 N.J.R. 2129(a)		
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12:56-10	Wage and Hour: employment of learners; sub-minimum wage	24 N.J.R. 2129(b)	R.1992 d.328	24 N.J.R. 2924(a)
12:60-3.2, 4.2	Prevailing wages on public works contracts: telecommunications worker	24 N.J.R. 2689(a)		
12:100-4.2, 10, 17.1, 17.3	Safety standards for firefighters	24 N.J.R. 73(a)		
12:235-9.4	Workers' Compensation: appeal procedures regarding discrimination complaint decisions	24 N.J.R. 1684(a)		
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13:32	Rules of Board of Examiners of Master Plumbers	24 N.J.R. 2334(a)		
13:34-1.1	Board of Marriage Counselor Examiners: annual license fees and charges	24 N.J.R. 2522(b)		
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13:35-6.5	Medical practice: preparation of patient records	24 N.J.R. 50(a)		
13:35-6.17	Corporate medical practice: stay of operative date concerning "financial interest" and referrals to health care facilities	———	———	24 N.J.R. 2460(a)
13:35-6A	Medical practice: declaration of death upon basis of neurological criteria	23 N.J.R. 3635(a)	R.1992 d.309	24 N.J.R. 2731(c)
13:37	Certification of homemaker-home health aides: open public forum	24 N.J.R. 1861(a)		
13:40-5.1	Land surveys: setting of corner markers	24 N.J.R. 51(a)		
13:40-5.1	Land surveys: extension of comment period regarding setting of corner markers	24 N.J.R. 554(a)		
13:43-3.1, 4.1	Board of Shorthand Reporting: fee schedule	24 N.J.R. 1232(a)	R.1992 d.275	24 N.J.R. 2460(b)
13:44E-2.7	Chiropractic practice: referral fees	24 N.J.R. 1470(a)		
13:44F	Rules of State Board of Respiratory Care	24 N.J.R. 2336(a)		
13:44G-14.1	Board of Social Work Examiners: fees for licensure, certification, and services	24 N.J.R. 2523(a)		
13:45A-9.2, 9.3, 9.4	Advertising of merchandise by manufacturer	24 N.J.R. 684(a)		
13:45B	Employment and personnel services	23 N.J.R. 2470(a)		
13:45B	Employment and personnel services: extension of comment period	23 N.J.R. 2919(a)		
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13:47K-5.2	Weights and measures: magnitude of allowable variations for packaged commodities	24 N.J.R. 1233(a)		
13:59-1.1, 1.2, 1.3, 1.4, 1.8	State Police: release of criminal history information	24 N.J.R. 1963(a)	R.1992 d.308	24 N.J.R. 2735(a)
13:70-13A.8	Thoroughbred racing: stay pending appeal of official's decision	24 N.J.R. 555(a)	R.1992 d.265	24 N.J.R. 2461(a)
13:71-3.3	Harness racing: stewards appeal hearings	24 N.J.R. 555(b)	R.1992 d.266	24 N.J.R. 2461(b)
13:71-3.8	Harness racing: stay pending appeal of official's decision	24 N.J.R. 556(a)	R.1992 d.267	24 N.J.R. 2461(c)
13:71-10.5	Harness racing: programmed trainer	24 N.J.R. 2340(a)		
13:71-20.6	Harness racing: passing lane in homestretch	24 N.J.R. 686(a)	R.1992 d.268	24 N.J.R. 2462(a)
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14:5A	Nuclear generating plant decommissioning: periodic cost review and trust funding reporting	23 N.J.R. 3239(b)		
14:6-5	Natural gas service: preproposal on inspection and operation of master meter systems	24 N.J.R. 1862(b)		
14:9B	Private domestic wastewater treatment facilities	24 N.J.R. 1863(a)		
14:10-5	Competitive telecommunications services	24 N.J.R. 1868(a)		
14:10-7	Telephone access to adult-oriented information	24 N.J.R. 1238(a)		
14:11	Board of Regulatory Commissioners: administrative orders	24 N.J.R. 1684(b)		
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16:28A-1.8	Bus stop zones along Route 10 in Parsippany-Troy Hills	24 N.J.R. 1967(a)	R.1992 d.304	24 N.J.R. 2736(a)
16:28A-1.15, 1.54	No stopping or standing zones along Route 23 in Hardyston Township and Route 181 in Jefferson Township	24 N.J.R. 1240(a)	R.1992 d.288	24 N.J.R. 2463(a)
16:28A-1.32	No stopping or standing zones along U.S. 46 in Clifton	24 N.J.R. 1689(a)	R.1992 d.277	24 N.J.R. 2463(b)
16:28A-1.57	Parking along U.S. 206 in Lawrence Township	24 N.J.R. 2342(a)		
16:32-1	Designated routes for double-trailer trucks	24 N.J.R. 929(b)	R.1992 d.270	24 N.J.R. 2463(c)
16:41	Permits for work or activities involving State highway rights-of-way	24 N.J.R. 2237(a)		
16:44-1.8	Renewal of contractor classification rating	24 N.J.R. 703(a)	R.1992 d.271	24 N.J.R. 2464(a)
16:53D-1.1	Zone of Rate Freedom for regular route autobus carriers: 1993 percentage maximums	24 N.J.R. 2343(a)		
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17:16-20.1, 20.3	State Investment Council: international government and agency obligations	24 N.J.R. 1690(a)	R.1992 d.274	24 N.J.R. 2464(b)
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17:26	Repeal interim rules regarding Spill Compensation and Control Act (see 7:1J)	24 N.J.R. 1255(a)		
17:29-4.7	Charitable fund-raising among employees of local government units: administrative correction	———	———	24 N.J.R. 2925(b)
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18:7-13.1	Corporation Business Tax: abatements of penalty and interest	23 N.J.R. 3275(a)		
18:22-1.3, 3.3, 6.1, 6.2, 6.3, 8.1, 9.2, 9.6, 10.1	Public utility corporations	24 N.J.R. 2531(b)		
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18:35-1.27	Gross Income Tax: interest on overpayments	24 N.J.R. 2419(a)		
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19:16	Compulsory interest arbitration of labor disputes in public fire and police departments: summary of public comments and agency responses to preproposal	24 N.J.R. 704(a)		
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19:43-1.1–1.5, 1.8, 1.12, 1.13, 1.14	Junkets; casino service industries	24 N.J.R. 2695(b)		
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19:45-1.11, 1.12	Implementation of pai gow poker	24 N.J.R. 569(a)		
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