CHAPTER 60

HOME CARE SERVICES

Authority

N.J.S.A. 30:4D–6b(2), 7, 7a, b and c; 30:4D–12, 30:4E; 42 CFR 440.70, 170.

Source and Effective Date

R.1991 d.65, effective February 19, 1991 (operative March 1, 1991). See: 22 N.J.R. 3116(a), 23 N.J.R. 420(b).

Executive Order No. 66(1978) Expiration Date

Chapter 60, Home Services Manual, expires on February 19, 1996.

Chapter Historical Note

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

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services Manual, was readopted as R.1985 d.488, effective August 27, 1985. See: 17 N.J.R. 28(a), 17 N.J.R. 2433(a). Pursuant to Executive Order No. 66(1978), Chapter 60 was readopted as R.1990 d.458, effective August 15, 1990. See: 22 N.J.R. 1663(a), 22 N.J.R. 2966(c). Subchapter 4, Home Care Expansion Program, was adopted as new rules by R.1990 d.466, effective September 17, 1990. See: 22 N.J.R. 597(a), 22 N.J.R. 2967(a).

Chapter 60 was repealed and a new Home Care Services Manual was adopted as R.1991 d.65. See: Source and Effective Date. See, also, Subchapter Historical Notes and section annotations for subsequent rulemaking activity.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:60–1.1 Purpose and scope

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

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

1. Home health services;

2. Personal care assistant services;

3. Home and Community–Based Services Waiver programs, which include the following:

i. Home and Community–Based Services Waiver for the Elderly and Disabled, known as the Community Care Program for the Elderly and Disabled (CCPED);

ii. Home and Community–Based Services Waiver for Blind or Disabled Children and Adults (Model Waivers I, II, and III); and

iii. Home and Community–Based Services Waiver for Persons with AIDS and Children under five who are HIV Positive, known as AIDS Community Care Alternatives Program (ACCAP); and

4. Home Care Expansion Program (HCEP).

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

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

(e) Requirements of the Home and Community–Based Services Waiver Programs and the Home Care Expansion Program are provided in N.J.A.C. 10:60–2 and 3, respectively.

(f) N.J.A.C. 10:60–4 HCFA Common Procedure Coding System—HCPCS, outlines the procedure codes used to submit a claim for services provided under the Personal Care Assistant services program, Home and Community–Based Services Waiver programs, and the Home Care Expansion Program.

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

10:60–1.2 Definitions

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

"Case Management" is defined as the process of on-going monitoring by the Medicaid District Office staff, of the delivery and quality of home care services, as well as the recipient/caregiver's satisfaction with the services. Such case management does not include the case management services provided under the waiver programs and HCEP (N.J.A.C. 10:60–2.3(b)1, 2.9(b)1 and 3.3(a)1). Case management ensures timely and appropriate provider responses to changes in care needs and assures delivery of coordinated services which promote maximum restoration and prevents unnecessary deterioration.

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

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

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

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

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

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

1. Is approved by the New Jersey State Department of Health, including requirements for Certificate of Need and licensure when applicable;

2. Is certified as a home health agency under Title XVIII (Medicare) Program; and

3. Is approved for participation as a home health agency provider by the Division of Medical Assistance and Health Services.

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

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

1. Successfully completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division is retained in the agency's personnel file.

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

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

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

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

"Levels of care" means two levels of home health care services, acute and chronic, provided by a certified, licensed home health agency, as needed, to Medicaid recipients, upon request of the attending physician.

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

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

"Licensed practical nurse" means a person who is licensed by the State of New Jersey as a practical nurse, pursuant to N.J.S.A. 45:11–27 et seq., having completed formal accredited nursing education programs.

"Medicaid District Office" (MDO) means one of the Division's offices located throughout the State, which, for purposes of this manual, administers a home care quality assurance program through its case management staff via post-payment review.

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

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

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

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

"Personal care assistant" means a person who:

1. Successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate or other documentation issued by the New Jersey Department of Law and Public Safety, Board of Nursing is retained in the agency's personnel file.

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

3. Is supervised by a registered professional nurse employed by a Medicaid approved homemaker/personal care assistant provider agency.

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

"Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association

and the American Physical Therapy Association or its equivalent; and

1. If practicing in the State of New Jersey, is licensed by the State of New Jersey; or

2. If treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable. The practitioner shall also meet all applicable Federal requirements.

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

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

"Preadmission screening (PAS)" means that process by which all eligible Medicaid recipients, and individuals who may become Medicaid eligible within 180 days following admission to a Medicaid certified nursing facility, and who are seeking admission to a Medicaid certified nursing facility receive a preadmission screening by the Medicaid District Office professional staff to determine appropriate placement prior to admission to a nursing facility pursuant to N.J.S.A. 30:4D–17.10 (P.L. 1988, c.97).

"Primary caregiver" means an adult relative or significant other adult who accepts 24 hour responsibility for the health and welfare of the recipient. For the recipient to receive private duty nursing services in the Home and Community–Based Services Waiver Programs, the primary caregiver must reside with the recipient and provide a minimum of 8 hours of hands-on care to the recipient in any 24 hour period.

"Prior authorization" means the process of approval by the MDO for certain services prior to the provision of these services. Prior authorization also may be applied in other service areas in situations of an agency's continued noncompliance with program requirements. In accordance with N.J.A.C. 10:60–1.4, if a patient is enrolled in the Garden State Health Plan or a private HMO, authorization for reimbursement is required by the GSHP physician case manager or private HMO prior to rendering any service.

"Private duty nursing" means individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to recipients under Model Waiver III and the AIDS Community Care Alternatives Program, as well as eligible Early and Periodic Screening Diagnosis and Treatment (EPSDT) recipients.

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

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

"Quality assurance", for the purpose of this manual, means a system by which the Medicaid District Office staff shall conduct post-payment reviews to determine the recipient/caregiver's satisfaction with the quality, quantity and appropriateness of home care services provided to Medicaid recipients.

"Registered professional nurse" means a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.S.A. 45:11–26 et seq.

"Social worker" means a person who has a master's degree from a graduate school of social work accredited by the Council on Social Work Education, has one year of post-masters social work experience in a health care setting and is licensed to practice social work in the State of New Jersey.

"Social work assistant" means a person who has a baccalaureate degree in social work, or psychology, or sociology or other field related to social work and has had at least one year of social work experience in a health care setting.

"Speech-language pathologist" means a person who has a certificate of clinical competence from the American Speech–Language–Hearing Association; has completed the equivalent education requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate; and

1. If practicing in the State of New Jersey, is licensed by the State of New Jersey; or

2. If treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable. The practitioner shall also meet all applicable Federal requirements.

Amended by R.1993 d.588, effective November 15, 1993.
See: 25 N.J.R. 2803(a), 25 N.J.R. 5167(a).
Amended by R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–1.3 Providers eligible to participate

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

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

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

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

i. A new provider shall be issued a Medicaid Provider Billing Number by the fiscal agent. Those Personal Care Assistance (PCA) providers already enrolled as providers of homemaker services in the CCPED program (see N.J.A.C. 10:60–2) shall use the same Medicaid Provider Billing Number issued for CCPED.

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

4. A hospice agency, as defined in N.J.A.C. 10:60–1.2.

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

1. Exception: A private duty nursing agency currently approved by the Division to provide private duty nursing services (except for the licensed home health agency which is exempt from the accreditation requirement) shall have up to January 3, 1996 to become an accredited agency and meet the Division's requirements for accreditation. New private duty nursing agencies applying to become Medicaid providers after December 19, 1994 shall conform to the accreditation requirement at the time of application.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Amended by R.1994 d.623, effective December 19, 1994.
See: 26 N.J.R. 2840(a), 26 N.J.R. 5021(a).

10:60–1.4 Covered home health services

(a) Home health care services covered by the New Jersey Medicaid program are limited to those services provided directly by a home health agency approved certified for Medicaid by the New Jersey Department of Health and approved in accordance [1] to participate in the New Jersey Medicaid program or through arrangement by that agency for other services.

1. Medicaid reimbursement is available for these services when provided to Medicaid recipients in their place of residence, such as a private home, residential hotel, residential health care facility, rooming house and boarding home.

i. In residential health care facilities, homemaker-home health aide or personal care assistant services are excluded from Medicaid coverage.

ii. Home health services shall not be available to Medicaid recipients in a hospital or nursing facility.

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

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

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

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

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

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

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

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

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

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

(1) Wound care/decubitus care and management;

(2) Enterostomal care and management;

(3) Parenteral medication administration; and

(4) Indwelling catheter care.

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

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

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

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

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

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

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

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

xi. Supervising and teaching other nursing service personnel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Developing long and short-term goals to meet the individualized needs of the recipient and a treatment plan to achieve these needs;

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

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

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

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

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

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

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

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

v. Preparing psychosocial histories and clinical notes.

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

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

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

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

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

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

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

vii. Preparing clinical and dietary progress notes.

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

i. When a recipient requires more than one month of medical supplies, prior authorization for the supplies shall be requested and received from the appropriate Medicaid District Office. Requests for prior authorization of an unusual or an excessive amount of medical supplies provided by an approved medical supplier shall be accompanied by a personally signed, legible prescription from the attending physician. If a recipient is an enrollee of the Garden State Health Plan or a private HMO, prior authorization shall be obtained from the GSHP physician case manager or private HMO.

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

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

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

7. Personal care assistant services shall be as described in N.J.A.C. 10:60–1.10.

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

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Administrative Correction.
See: 26 N.J.R. 2285(a).

[1] So in original.

Case Notes

Home care visits could not be added to cost report in absence of timely claim. Long Branch Public Health Nursing Association, Inc. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 10.

10:60–1.5 Certification of need for services

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

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

10:60–1.6 Plan of care

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

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

2. A summary of case history, including medical, nursing, and social data;

3. The period covered by the plan;

4. The number and nature of service visits to be provided by the home health agency;

5. Additional health related services supplied by other providers;

6. A copy of physician's orders and their updates;

7. Medications, treatments and personnel involved;

8. Equipment and supplies required;

9. Goals, long and short-term;

10. Preventive, restorative, maintenance techniques to be provided, including the amount, frequency and duration;

11. The recipient's, family's, and interested persons involvement (for example, teaching); and

12. Discharge planning in all areas of care (coordinated with short and long-term goals);

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

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

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

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

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

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

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

10:60–1.7 Clinical records

(a) Clinical records containing pertinent past and current information, recorded according to accepted professional standards, shall be maintained by the home health agency for each recipient receiving home health care services. The clinical record shall include, at a minimum, the following:

1. A plan of care as described in N.J.A.C. 10:60–1.6;

2. Appropriate identifying information;

3. The name, address and telephone number of recipient's physician;

4. Clinical notes by nurses, social workers, and special therapists, which shall be written, signed and dated on the day each service is provided;

5. Clinical notes to evaluate a recipient's response to service on a regular, periodic basis, which shall be written, signed and dated by each discipline providing services;

6. Summary reports of pertinent factors from the clinical notes of the nurses, social workers, and special therapists providing services, which shall be submitted to the attending physician at least every two months; and

7. When applicable, transfer of the recipient to alternative health care, which shall include transfer of appropriate information from the recipient's record.

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

10:60–1.8 Basis of payment for home health services

(a) For home health services, the New Jersey Medicaid program follows the Medicare principles of reimbursement, which are based upon the lowest of:

1. 100 percent of reasonable covered costs; or

2. The published cost limits; or

3. Covered charges.

(b) Interim reimbursement shall be made on the basis of 100 percent or less (if reasonable allowable cost is anticipated to be less) of covered charges.

(c) Retroactive settlement and final reimbursement shall be based on Medicare principles of reimbursement.

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

10:60–1.9 Out–of–State approved home health agencies

(a) Final reimbursement shall be made to out-of-State approved home health agencies on the basis of 80 percent of covered reasonable charges. There is no cost filing required. No retroactive settlement shall be made.

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

10:60–1.10 Personal care assistant services

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

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

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

2. Personal care assistant services shall be reimbursable when provided to Medicaid recipients in their place of residence, including:

i. A private home;

ii. A rooming house;

iii. A boarding home (not Class C);

iv. A Division of Youth and Family Services' (DYFS) foster care home; or

v. A Division of Developmental Disabilities (DDD) foster care home.

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

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

i. Care of the teeth and mouth;

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

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

iv. Using the toilet or bed pan;

v. Changing bed linens with the recipient in bed;

vi. Ambulation indoors and outdoors, when appropriate;

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

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

ix. Dressing;

x. Relearning household skills; and

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

2. Household duties that are essential to the recipient's health and comfort, performed by a personal care assistant shall include, but not be limited to:

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

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

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

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

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

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

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

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

ix. Planning, preparing and serving meals.

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

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

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

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

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

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

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

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

1. The registered professional nurse, in accordance with the physician's certification of need for care, shall perform an assessment and prepare a plan of care for the personal care assistant to implement. The assessment and plan of care shall be completed at the start of service. However, in no case shall the nursing assessment and plan of care be done more than 48 hours after the start of service. The plan of care shall include the tasks assigned to meet the specific needs of the recipient, hours of service needed, and shall take into consideration the recipient's strengths, the needs of the family and other interested persons. The plan of care shall be dated and signed by the personal care assistant and the registered nurse and shall include short-term and long-term nursing goals. The personal care assistant shall review the plan, in conjunction with the registered professional nurse.

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

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

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

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

2. Clinical records shall contain, at a minimum,

i. An initial nursing assessment;

ii. A six-month nursing reassessment;

iii. A recipient-specific plan of care;

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

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

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

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

viii. Documentation of the formulation of an advance directive.

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

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

10:60–1.11 Basis of payment for personal care assistant services

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

(b) Personal care assistant services reimbursement rates (see N.J.A.C. 10:60–4) are all inclusive maximum allowable rates. No direct or indirect cost over and above the established rates may be considered for reimbursement. At all times the provider shall reflect its standard charge on the Health Insurance Claim Form, 1500 N.J. (see Fiscal Agent Billing Supplement, Appendix A, incorporated herein by reference) even though the actual payment may be different. A provider shall not charge the New Jersey Medicaid program in excess of current charges to other payers.

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

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

10:60–1.12 Limitations of home care services

(a) When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the MDO staff may opt

to limit or deny the provision of home care services on a prospective basis.

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

(c) Private duty nursing services shall be limited to a maximum of 16 hours in a 24 hour period, per person in Model Waiver III and ACCAP. There must be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60–1.2) who accepts 24 hour per day responsibility for the health and welfare of the recipient unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60–2.9(b)2 for exceptions to 16 hour maximum in a 24 hour period.)

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

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

(e) Personal care assistant services provided by a family member shall not be considered covered services and shall not be reimbursed by the New Jersey Medicaid program.

(f) Personal care assistant services shall be limited to a maximum of 25 hours per week. However, if there is a medical need for additional hours of service, this limit may be exceeded by the provider up to an additional 15 hours per week, under certain criteria, which follow:

1. If the caregiver is employed, ill, frail, or temporarily absent from the home for sickness or family emergency and therefore unable to participate adequately in providing medically necessary care to ensure the safety or well-being of the recipient;

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

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

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

(g) Additional hours under (f) above shall be medically indicated, as documented by the recipient's physician, and shall not be a companion service. The agency providing these increased services must notify the Medicaid District Office (MDO), either in writing or by telephone, about the recipient receiving more than 25 hours of PCA services. Failure to notify the MDO may result in non-payment of the hours in excess of the 25 hours. Services provided to these recipients will be included by the MDO in the post-payment quality assurance reviews.

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

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

10:60–1.13 Advance directives

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

1. Such agencies shall:

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

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

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

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

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

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

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

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

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

10:60–1.14 Relationship of the home care provider with the Medicaid District Office (MDO)

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

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

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

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

10:60–1.15 Standards of performance for post payment quality assurance review

(a) An initial visit to evaluate the need for home health services or personal care assistant services shall be made by the provider. Following the initial visit, the provider shall advise the MDO, using the HCFA 485 form or other MDO approved notification form, that services have begun for the recipient.

1. If the HCFA 485 is used, it shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services, however, shall be kept on file in the agency, with the prescription. Providers shall include the HSP (Medicaid) Case Number when completing the form. For the non-Medicare certified agency, the provider shall submit to the MDO an MDO approved notification form which shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services shall be kept on file in the agency.

2. The HCFA 485, or other appropriate MDO approved agency form, shall be submitted to the MDO upon initiation of services and once every 12 months thereafter on a continuing basis. Providers shall notify the MDO when services have been terminated.

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

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

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

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

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

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

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

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

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

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

1. The aide shall arrive and leave each day as scheduled by the agency.

2. The same aide shall be assigned on a regular basis, with the intent of assuring continuity of care for the recipient, unless there are unusual documented circumstances, such as a difficult recipient/caregiver relationship, difficult location, or personal reasons of aide or recipient/caregiver.

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

4. Appropriate training and orientation shall be provide by licensed personnel to assure the delivery of required services.

5. The aide shall provide appropriate services as reflected in the plan of care and identified on the assignment sheet;

6. Home care services shall be provided to the recipient to maintain the recipient's health or to facilitate treatment of an illness or injury.

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

1. The services shall be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the individual shall improve materially in a reasonable and generally predictable period of time, or that the services are necessary towards the establishment of a safe and effective maintenance program.

2. The complexity of rehabilitative services is such that it can only be performed safely and effectively by a therapist. The services shall be consistent with the nature and severity of the illness or injury. The amount and frequency of these services shall be reasonable and necessary, and the duration of each visit shall be a minimum of 30 minutes.

3. The services shall be specific and effective treatment for the recipient's condition and shall be provided in accordance with accepted standards of medical practice.

4. For physical therapy standards, see N.J.A.C. 10:60–1.4(d)3ii(*l*).

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

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

2. The plan of care shall indicate the appropriate action taken to obtain the available community resources to assist in resolving the recipient's problems or to provide counseling services which are reasonable and necessary to treat the underlying social or emotional problems which are impeding the recipient's recovery.

3. The services shall be responsive to the problem and the frequency of the services shall be for a prescribed length of time.

(g) Visits of a dietitian or nutritionist shall be provided as needed to resolve nutritional problems which are or may be an impediment to the effective treatment of the recipient's medical condition or rate of recovery.

1. Nutritional services shall be provided as ordered by the physician and furnished by a dietitian or nutritionist in accordance with accepted standards of professional practice.

2. The plan of care shall indicate the nutritional care needs and the goals to meet those needs.

3. Services shall be provided to the recipient and/or the family/interested others involved with the recipient's nutritional care.

4. The services shall be specific and for a prescribed period of time.

5. The progress notes and care plan shall reflect significant changes or problems which require changes in the scope and timeliness of service delivery visits.

(h) The services shall be provided to the satisfaction of the recipient/caregiver.

1. There shall be documented evidence that the recipient/caregiver has participated in the development of the plan of care.

2. Identified problems shall be resolved between the agency and the recipient/caregiver, when possible.

3. The agency shall make appropriate referrals for unmet recipient needs.

4. The recipient/caregiver shall be promptly informed of changes in aides and/or schedules.

5. Recipients/caregivers shall be aware of the agency name, telephone number, and contact person in the event of a problem.

(i) The home health agency shall be aware of the recipient's need for, and shall make the appropriate arrangements for, securing medical equipment, appliances and supplies, as follows:

1. The agency shall assist the recipient in obtaining equipment, appliances, and supplies when needed under Medicare and/or Medicaid guidelines;

2. The agency shall monitor equipment, appliances and supplies to assure that all items are serviceable and used safely and effectively; and

3. The agency shall be responsible for contacting the provider for problems relating to the utilization of equipment, appliances and supplies.

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

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

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

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

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

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

10:60–1.16 On-site monitoring visits

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

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

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

10:60–1.17 Provisions for fair hearings

Providers and recipients can request fair hearings as set forth in the Administration chapter at N.J.A.C. 10:49–9.10.

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

SUBCHAPTER 2. HOME AND COMMUNITY–BASED SERVICES WAIVER PROGRAMS

Subchapter Historical Note

Subchapter 2, formerly Covered Home Care Services (Home Health Care Services and Personal Care Assistant Services), was repealed by R.1994 d.41 and the current Subchapter 2, Home and Community–Based Services Waiver Programs, was recodified from Subchapter 3, effective January 18, 1994. See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–2.1 Community Care Program for the Elderly and Disabled (CCPED)

(a) The Federal Omnibus Budget Reconciliation Act of 1981 (Section 2176, P.L. 97–35) encouraged the development of community-based service programs rather than institutional service programs. This law was codified as Section 1915(c) of the Social Security Act (see 42 U.S.C. 1936n).

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

(b) The Community Care Program for Elderly and Disabled (CCPED) is a waivered program, administered by the

Division of Medical Assistance and Health Services, initiated to help eligible recipients remain living in the community rather than in a nursing facility.

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

10:60–2.2 Eligibility requirements for CCPED

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

1. Recipients financially eligible for Medicaid services under the community eligibility standards are not covered under CCPED. CCPED also does not serve recipients who are eligible under the New Jersey Care ... Special Medicaid Programs, including the Medically Needy segment of that program, or enrolled in the Garden State Health Plan or private HMO serving the Medicaid eligible population.

(b) Program eligibility criteria are as follows:

1. An applicant 65 years or older shall be eligible for Medicare benefits or have other medical insurance which includes physician coverage and hospitalization.

2. An applicant under 65 shall be determined disabled by the Social Security Administration (SSA) and be eligible for Medicare benefits or be determined disabled by the Division of Medical Assistance and Health Services, Disability Review Section, and have other medical insurance which includes physician coverage and hospitalization.

3. An applicant shall be ineligible in the community for Supplemental Security Income (SSI), or the applicant's total income, excluding deemed income, shall exceed the appropriate SSI community standard up to the Medicaid institutional standard. Parental and spousal income are not considered in the determination of eligibility.

4. An applicant's own resources shall not exceed the Medicaid Only limits. Resources of a parent are not deemed. While the spouse's resources are considered, up to one-half of the total resources are protected for the use of the spouse.

5. An applicant shall be in need of the type of care provided in an institutional setting and meet, at a minimum, the New Jersey's Medicaid Program's nursing facility's level of care criteria.

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

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

(d) A Medicaid Eligibility Identification (MEI) card shall be distributed to the recipient eligible for CCPED. Approved services are listed on the card as exhibited in N.J.A.C. 10:49, Appendix A.

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

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

10:60–2.3 Services available under CCPED

(a) Services provided under CCPED complement the services provided under the Medicare Program or other physician and hospital benefit coverage for non-Medicare eligible individuals. A modified package of seven Medicaid covered services is available.

(b) Services provided under CCPED include the following:

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

i. Case management is not provided when a recipient is in an inpatient hospital setting and the stay extends beyond a full calendar month.

2. Home health care: Provided by a licensed home health agency, which may include skilled nursing care; homemaker/home health aide services; physical and occupational therapy; speech-language pathology services; medical social services and medical supplies. Medical supplies are limited to a maximum of $50.00 per month. Covered home care services are provided according to medical, nursing and other health-related needs, as documented in the recipient's plan of care.

3. Homemaker services: Personal care, household tasks, and activities of daily living, provided to a recipient in the home by either a home health agency or a homemaker agency.

4. Medical day care: A program of medically supervised, health and health related services provided in an ambulatory care setting to recipients who are non-residents.

5. Social adult day care: A comprehensive social and health related outpatient program for the frail, moderately handicapped, slightly confused recipient who needs care during the day.

6. Medical transportation: Non-emergency transporting of a recipient by an approved, suitable vehicle to obtain health services. Transportation may be provided by invalid coach or by lower modes of service that are arranged/provided by the county welfare agency/board of social services.

7. Respite care: A temporary service offered on an intermittent basis to recipients being cared for at home. The purpose of this service is to relieve the informal caregivers, allowing for a leave of absence in order to reduce stress or to meet a family crisis. Respite care can be provided in a recipient's home by a home health agency, homemaker agency, or in a nursing facility for limited periods of time. Nursing home respite care is limited to 30 days per calendar year.

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

(d) Other services covered by the New Jersey Medicaid Program are not available to the CCPED recipient.

10:60–2.4 Procedures used as financial controls for CCPED

(a) Total program costs shall be restricted by limits placed on the number of community care slots assigned each county and on per recipient costs. The Division may elect to exclude individuals for whom there is an expectation that costs to Medicaid for waiver services may exceed the cost of nursing facility care.

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

(c) CCPED Statewide per recipient service cost limits shall be determined by the Division of Medical Assistance and Health Services once a year and distributed to the case management sites and Medicaid District Offices.

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

10:60–2.5 Basis for home health agency reimbursement and cost reporting (CCPED)

(a) A home health agency participating in the CCPED program shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for home health services provided. Fees shall be based on the lower of audited cost report data which is inflated to the current year, Medicare cost limits or agency charges. Agencies shall be precluded from receiving additional reimbursement for the cost of the community care services above the fee established by the Medicaid program. This applies to both freestanding and hospital-based home health agencies.

1. The provider at all times shall reflect its standard charge on the Health Insurance Claim Form, 1500 N.J., even though the actual payment may be different.

(b) The Health Insurance Claim Form, 1500 N.J., shall be used for billing.

(c) CCPED cost reporting information for home health agencies is as follows:

1. Cost finding techniques shall be applied within Medicare's principles to both those recipients receiving services covered by the waiver, as well as those recipients not covered by the waiver.

2. All costs associated with the provision of services to CCPED recipients shall be included in the routine Medicare/Medicaid cost-reporting mechanisms (HCFA 1728–86 free-standing agencies; HCFA 2552–85 hospital-based agencies). Non-reimbursable cost centers shall be established for all services other than skilled nursing, physical therapy, occupational therapy, speech-language pathology services, medical social services, home health aide visits, respite care rendered by home health aides and certain medical supplies.

3. All visits provided to CCPED recipients shall be included in the total number of visits provided for each service respectively. This shall establish a cost per visit as applied to the Medicare and Medicaid Programs.

4. When worksheet D4 (Computation of Medicaid Cost) is completed, only the data applicable to services rendered to regular Medicaid recipients not enrolled in the Community Care Program shall be reconciled.

5. The process at (c)1 through 4 above allows the provider:

i. To be reimbursed on a fee-for-service basis for Community Care Program recipients;

ii. To maintain compliance with Medicare reimbursement principles; and

iii. To have all costs associated with these services allocated to respective payors.

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

10:60–2.6 Basis for homemaker agency reimbursement (CCPED)

(a) A homemaker agency providing services under CCPED shall be reimbursed by the New Jersey Medicaid Program on a fee-for-service basis for services provided. Fees shall be paid on an hourly/weekday or hourly/weekend/holiday basis.

(b) The Health Insurance Claim Form, 1500 N.J., shall be used for billing.

10:60–2.7 Model Waiver Programs

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

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

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

10:60–2.8 Eligibility requirements for Model Waivers

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

1. Recipients shall be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria. Model Waiver III requires the need for private duty nursing services.

2. For Model Waiver I and II, a recipient's total income shall exceed the SSI community standard, up to the institutional cap or the recipient must be ineligible in the community because of SSI deeming rules. Model Waiver III, however, shall serve the recipient who is eligible for Medicaid in the community, including New Jersey Care ... Special Medicaid Programs, as well as the recipient whose total income exceeds the community standard, up to the institutional cap. Model Waiver III shall not serve a Medicaid recipient eligible under the Medically Needy segment of the New Jersey Care ... Special Medicaid Programs nor enrolled in the Garden State Health Plan or a private Health Maintenance Organization (HMO) serving the Medicaid eligible population.

3. Recipients shall be blind or disabled children and adults. All recipients who have not been determined disabled by the Social Security Administration (SSA) must be determined disabled by the Division of Medical Assistance and Health Services, Disability Review Section, using the same SSA criteria.

4. There is no deeming of spousal income or parental income or resources in the determination of eligibility. While the spouse's resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse.

5. A recipient's resources cannot exceed the resource limit established for recipients eligible under the Medicaid Only Program. Financial eligibility is established by the county welfare agency/board of social services located in the recipient's county of residence.

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

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

(c) A Medicaid Eligibility Identification (MEI) card (FD–73/178) shall be issued to the Model Waiver recipient by the county welfare agency/board of social services for the recipient applying for Model Waiver I or II and also for the recipient applying for Model Waiver III who is not categorically eligible for Medicaid in the community. The county welfare agency/board of social services may issue a temporary MEI card.

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

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

10:60–2.9 Services included under the Model Waiver programs

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

(b) Additional waivered services are as follows:

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

i. Special child health service units under contract to the New Jersey Department of Health shall provide case management to children up to the age of 21.

ii. Recipients 21 years of age or older shall be referred for case management services to those sites which provide case management services for New Jersey Medicaid's Community Care Program for the Elderly and Disabled.

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

2. Private-duty nursing: A waivered service provided under Model Waiver III only and not under Model Waiver I or II. Private-duty nursing shall be provided in the community only, not in an inpatient hospital setting. The recipient shall have a live-in primary caregiver (adult relative or significant other adult) who accepts 24–hour responsibility for the health and welfare of the recipient. A maximum of 16 hours of private-duty nursing may be provided in any 24–hour period. A minimum of eight hours of hands on care shall be provided by the primary caregiver. There is no 24 hour coverage except for a limited period of time under the following emergency circumstances and when prior authorized by the Office of Home Care Programs:

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

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

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

(d) The need for private duty nursing services is established initially by the RSN upon completion of the PAS–1 and HSDP (N.J.A.C. 10:60–1.11(a)). The number of hours of private duty nursing included in the service plan is based upon the recipient's medical need and the cost of service. The total cost of all services provided through Model Waiver III must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the recipient's medical status changes, and correspondingly, as the service cost cap changes.

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

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

i. A referral source;

ii. Diagnoses;

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

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

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

vi. A six-month nursing reassessment;

vii. A nursing care plan;

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

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

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

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

i. Diagnoses;

ii. A physician treatment plan and interim orders;

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

iv. A nursing care plan;

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

vi. A record of medication administered.

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

i. A completed application for employment;

ii. Evidence of a personal interview;

iii. Evidence of a current license to practice nursing;

iv. Satisfactory employment references;

v. Evidence of a physical examination; and

vi. Ongoing performance evaluation.

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

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

10:60–2.10 Basis for reimbursement for Model Waiver services

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

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

(b) The Health Insurance Claim Form, 1500 N.J., is used when billing for case management, private-duty nursing services and personal care assistant services.

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

(c) Home health services are billed on the UB–82 HCFA–1450 form (see Fiscal Agent Billing Supplement).

(d) See N.J.A.C. 10:60–4 for codes to be used when submitting claims for waiver services for Model Waiver Program, I, II or III.

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

10:60–2.11 Procedures used as financial controls

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

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

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

10:60–2.12 AIDS Community Care Alternatives Program (ACCAP)

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

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

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

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

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

10:60–2.13 Application process for ACCAP

(a) Individuals who are not currently Medicaid eligible or recipients currently eligible for Medicaid through the Aid to Families with Dependent Children (AFDC) and who wish to apply for ACCAP, shall make application to the county welfare agency/board of social services located in the county where the individual resides.

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

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

10:60–2.14 Eligibility criteria

(a) Recipients eligible for ACCAP shall be:

1. Diagnosed as having AIDS, or be a child up to the age of five who is HIV positive;

2. In need of institutional care and meet, at a minimum, the nursing facility level of care criteria established by the New Jersey Medicaid Program (N.J.A.C. 10:63–1.3);

3. Categorically needy, that is, recipients who are Medicaid eligible in the community, except for those served under the Medically Needy segment of the New Jersey Care ... Special Medicaid Programs; or enrolled in the GSHP or private HMO serving the Medicaid eligible population.

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

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

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

(c) All recipients determined to be eligible for ACCAP shall be issued a Medicaid Eligibility Identification card.

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

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

10:60–2.15 ACCAP services

(a) All Medicaid services, except for nursing facility services, are available under ACCAP in accord with an individualized plan of care. Additionally, the following services are available to the eligible recipient:

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

i. Special Child Health Units under contract to the New Jersey State Department of Health shall provide case management services to children up to the age of 21.

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

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

2. Private-duty nursing (PDN): Care provided by a registered professional nurse or licensed practical nurse. PDN is continuous rather than part-time or intermittent, provided in the community only, not in an inpatient hospital setting. A nurse shall be employed by a licensed home health agency, voluntary non-profit homemaker/home health aide agency, private employment agency and temporary-help service agency approved by Medicaid to provide PDN services. PDN services may be provided up to 16 hours per day, per person, but only when there is a live-in primary adult caregiver who accepts 24–hour per day responsibility for the health and welfare of the individual (see N.J.A.C. 10:60–2.9(b)2 for recordkeeping requirements) unless the sole purpose of the private duty nursing is the administration of IV therapy. A minimum of eight hours of hands-on care in any 24 hour period shall be provided by the primary caregiver.

i. The need for private duty nursing services is established initially by the RSN upon completion of the PAS–1 and HSDP (N.J.A.C. 10:60–1.14(a)). The number of hours of private duty nursing included in the service plan is based upon the recipient's medical need and the cost of service. The total cost of all services provided through ACCAP must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the recipient's medical status changes, and correspondingly, as the service cost cap changes.

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

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

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

6. Specialized group foster care home for children: This allows for an array of health care services provided in a residential health care program for children from birth to 18 years of age. All children served by the home are under the supervision of the Division of Youth and Family Services (DYFS). Specialized group foster care home for children services must be prior authorized by

the MDO staff, using the FD–352 form (see Appendix A, Fiscal Agent Billing Supplement).

7. Hospice care: This provides optimum comfort measures (including pain control), support and dignity to recipients certified by an attending physician as terminally ill, with a life expectancy of up to six months. Family and/or other caregivers are also given support and direction while caring for the dying recipient. Services shall be provided by a Medicaid approved, Medicare certified hospice agency and available to a recipient on a daily, 24–hour basis. Hospice care shall be approved by the attending physician. Hospice services include: skilled nursing visits; hospice agency medical director services; medical social service visits; occupational therapy, physical therapy and speech-language pathology services; intravenous therapy; durable medical equipment; medication related to symptom control of terminal illness and case management. Reimbursement shall be at an established fee paid on a per diem basis.

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

Amended by R.1992 d.438, effective November 2, 1992.
See: 24 N.J.R. 2687(c), 24 N.J.R. 4054(a).
Limit of 25 hours per week deleted at (a)4.
Amended by R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–2.16 Basis for reimbursement for ACCAP services

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

(b) The Health Insurance Claim form, 1500 N.J., is used when requesting reimbursement for waiver services provided.

(c) See N.J.A.C. 10:60–4 for codes used when submitting claims for ACCAP.

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

SUBCHAPTER 3. HOME CARE EXPANSION PROGRAM

Subchapter Historical Note

Subchapter 3, formerly Home and Community–Based Service Programs, was recodified as Subchapter 2 by R.1994 d.41 and the current Subchapter 3, Home Care Expansion Program, was recodified from Subchapter 4, effective January 18, 1994. See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–3.1 Scope and authority

(a) The Home Care Expansion Act (P.L. 1988, c.92) was signed into law August 4, 1988 and its program, the Home Care Expansion Program (HCEP), became effective May 1, 1989. The intent of the program is to offer home care services to elderly and disabled persons in New Jersey who are in need of long-term home care services and whose income or resources exceed the financial requirements for Medicaid or the Division of Medical Assistance and Health Services' Home and Community–Based Waiver Programs. It is anticipated that the provision of home care services shall delay or avoid institutionalization.

(b) The Home Care Expansion Program (HCEP) is administered by the Division of Medical Assistance and Health Services and is available state-wide. Program slots are limited based upon the available annual appropriation and are allocated to each county. Each county has designated home and community-based programs case management sites which is utilized for HCEP.

10:60–3.2 Eligibility requirements for HCEP

(a) Financial eligibility shall be determined by the Division's Bureau of Pharmaceutical Assistance to the Aged and Disabled (PAAD) initially and on an annual basis using existing PAAD processes and policies where applicable.

(b) To qualify for services, an applicant shall meet the following criteria:

1. Be a resident of New Jersey for at least 30 days;

2. Have a gross annual income of less than $18,000 if single, or if married, less than $21,000 in combination with that of a spouse;

3. Have resources less than $15,000, as an individual or in combination with a spouse.

i. Real property is not considered an available resource for purposes of determining eligibility for HCEP. However, if real property is sold, then the proceeds of the sale would be considered as a countable resource.

ii. The Home Care Expansion Program only considers liquid resources. Examples of liquid resources are cash or any item which can be readily converted to cash. These can include, but are not limited to, stocks, bonds, mutual funds, money market funds, certificates of deposit, savings accounts, checking accounts, trusts, annuities, saving bonds, treasury notes, treasury bills and treasury bonds.

iii. If an application is received for a child who meets other program requirements, only the child's income and/or resources shall be considered. There is no deeming of parental income or resources;

4. Be eligible for, or receiving, Medicare benefits, or have other health insurance which includes hospital and physician coverage;

5. Be 65 years or older; or, if under 65 years of age, be determined permanently and totally disabled by the Social Security Administration (SSA) or by the Division of Medical Assistance and Health Services, Disability Review Section.

i. The beneficiary shall be responsible for costs incurred relevant to the disability determination, that is, physician's examination, etc.; and

6. Be in need of nursing facility services which are medically necessary to avoid or delay institutionalization.

(c) Voluntary assignments or transfers of real or personal property by an applicant (and/or spouse), for less than adequate consideration, will cause the applicant to be automatically deemed ineligible for HCEP benefits. The period of ineligibility shall extend for up to 30 months from the date of such assignment or transfer unless a preponderance of evidence, submitted by the applicant, proves that the action was carried out for reason(s) other than to cause the applicant to become or remain eligible for HCEP benefits.

1. Voluntary assignment or transfer is defined as a gift, trade, sale, or other transfer of any claim, right, interest, or property, including any future right or interest. Less than adequate consideration means for less than fair market value. Where no evidence or inadequate evidence is submitted to support the applicant's contention, the applicant shall be ineligible for HCEP benefits for the number of months which results from dividing the uncompensated value of the resource by the Statewide average lowest semi-private room rate for nursing home care. The period of ineligibility shall not exceed 30 months.

(d) An applicant who is eligible for the Community Care Program for the Elderly and Disabled (CCPED) shall be eligible for HCEP if CCPED services are unavailable in the applicant's county of residence.

1. When CCPED services are available in the applicant's county of residence, the applicant shall not be eligible for HCEP.

2. An applicant who is eligible for Medicaid services under the community standard, including New Jersey Care ... Special Medicaid Programs, is not eligible for HCEP.

(e) The total cost of services for the beneficiary in the community may not exceed 70 percent of the cost of institutional care.

(f) The following relate to identifying the beneficiary eligible for HCEP services:

1. Although HCEP is not a Title XIX (Medicaid) Program, a standard Medicaid Eligibility Identification (MEI), FD–73/178, card is issued to the beneficiary.

2. Program services for which the beneficiary is eligible are listed on the card in the upper right-hand corner.

(g) There is no retroactive eligibility in HCEP. No service received prior to the date of enrollment can be reimbursed by HCEP. The date of enrollment is the date that financial eligibility and medical need for services are established, and a program slot is available.

Amended by R.1992 d.438, effective November 2, 1992.
See: 24 N.J.R. 2687(c), 24 N.J.R. 4054(a).
Gross income specified at (a)2.
Amended by R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–3.3 Services available under HCEP

(a) The seven services provided under HCEP are:

1. Case management: A process in which a social worker or professional nurse shall be responsible for planning, locating, coordinating, and monitoring a group of services designed to meet the individual health needs of the beneficiary being served. The case manager shall be responsible for the initial and ongoing assessment of the beneficiary's need for home care services, the determination of cost-share liability, and shall be the pivotal person in establishing a service package to meet those needs.

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

2. Home health care: Provided by a licensed home health agency which may include skilled nursing care; homemaker/home health aide services; physical therapy and occupational therapy; speech-language pathology services; medical social services and medical supplies. Medical supplies, provided by the home health agency, shall be limited to a maximum of $50.00 a month. Covered home care services are provided according to medical, nursing and other health-related needs, as documented in the beneficiary's plan of care;

3. Homemaker: Personal care, household tasks, and activities of daily living, provided to a beneficiary in the home by a certified homemaker-home health aide employed by either a home health agency or a homemaker agency;

4. Medical day care: A program of medically supervised, health and health-related services provided in an ambulatory care setting to a beneficiary who is a nonresident of the medical day care center;

5. Social adult day care: A comprehensive social and health-related outpatient program for the frail, moderately handicapped, slightly confused beneficiary who needs care during the day;

6. Medical transportation: Non-emergency transporting of a beneficiary by an approved, suitable vehicle to obtain health services. Transportation may be provided by an invalid coach or by lower modes of service that are arranged/provided by the County Welfare Agency/Board of Social Services; and

7. Respite care: A temporary service offered on an intermittent basis to a beneficiary being cared for at home. The purpose of this service is to relieve the informal caregivers, allowing for a leave of absence in order to reduce stress or to meet a family crisis. Respite care can be provided in a beneficiary's home by a home health agency, homemaker agency or in a nursing facility for limited periods of time.

(b) The services, listed under (a) above, may be limited in duration or amount depending upon the medical needs of the beneficiary; the availability and cost of the care; and program openings allowed by program funding. Services are rendered by providers approved by the Division of Medical Assistance and Health Services for the Community Care Program for the Elderly and Disabled.

(c) Services other than the seven in (a) above are not available to the beneficiary eligible for HCEP.

(d) Cost sharing for HCEP is as follows:

1. Beneficiaries may be required to share in the cost of their services when monthly income exceeds a standard monthly maintenance allowance. Beneficiaries shall be billed monthly for an established amount to be determined by the Division, which is set at $20.00 a month. The standard monthly maintenance allowance has been set to be equal to the Medicaid institutional standard "CAP," as defined in N.J.A.C. 10:71–5.6(c)5V.

2. The Bureau of Pharmaceutical Assistance to the Aged and Disabled (PAAD) is responsible for the billing and collection of the beneficiary's cost-share liability.

3. Non-payment of cost-share for two consecutive months shall result in termination from the program. Partial payment will be allowed for one month; cost-share shall be paid in full (current and arrears) within 60 days of the date of the initial bill.

Amended by R.1991 d.578, effective December 2, 1991.
See: 23 N.J.R. 2826(a), 23 N.J.R. 3651(a).
Established $20.00 flat monthly cost share amount and set the standard monthly maintenance allowance as equal to the Medicaid institutional standard CAP.
Amended by R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–3.4 Procedures used as financial controls for HCEP

(a) Total program costs are limited to the amount appropriated by the State legislature.

(b) Program cost is controlled by the number of beneficiaries served and per beneficiary costs.

(c) A case manager is responsible for the development of the service plan with each beneficiary/family, with input from provider agencies. A case manager is responsible for monitoring the cost of the service package as per program guidelines.

(d) HCEP Statewide service cost caps and allocation of program slots shall be coordinated by the Division of Medical Assistance and Health Services, Office of Home Care Programs.

10:60–3.5 Basis for reimbursement

(a) A fee-for-service reimbursement methodology shall be utilized for all HCEP services utilizing a Health Insurance Claim Form, 1500 N.J. Transportation providers will utilize the MC–12 form, Transportation Claim.

10:60–3.6 Termination from HCEP

(a) Beneficiaries shall be terminated from HCEP if:

1. His or her income is above program requirements;

2. His or her resources are above program requirements;

3. He or she is determined financially eligible for Medicaid benefits;

4. He or she is assessed as no longer in need of long-term home care services;

5. His or her cost-share payments are not paid in full for two consecutive months; or

6. He or she is determined eligible for CCPED and services are available in the applicant's county of residence.

(b) A beneficiary found ineligible because of an increase in annual income or resources is liable for repayment of all monies paid for HCEP services from the beginning of the calendar year, not only for those payments made after income or resources were increased. Program eligibility is based upon annual income and resources.

(c) A beneficiary terminated from HCEP shall be billed by the Bureau of Pharmaceutical Assistance to the Aged and Disabled for services rendered during a period of ineligibility.

(d) The Director of the Division may, in his or her discretion, take all necessary action to recover the cost of benefits incorrectly paid on behalf of the beneficiary. The Director may waive the Division's right to recover, when appropriate.

(e) A beneficiary who is terminated from HCEP participation may exercise his or her right to appeal the decision by submitting a request for a fair hearing in accordance with N.J.A.C. 10:49–9.10. Such request shall be submitted within 20 days from the date of the letter of termination.

1. If a hearing is granted in a situation where the beneficiary is assessed as no longer in need of home care services or cost-share has not been paid in full for two consecutive months, and the beneficiary is receiving services under HCEP, payment for these services can continue until a final decision is made. However, if the beneficiary chooses to continue to receive services and the termination is upheld at the fair hearing, the beneficiary will be billed for any service received after five days from the date of the Office of Home Care Programs' letter of termination.

2. If a hearing is granted in a situation where the beneficiary's income or resources are above program requirements, payment for the services will cease at the point that the ineligibility determination is made.

(f) A previously terminated beneficiary may be eligible for HCEP if:

1. His or her income and resources meet program requirements;

2. Home care services are needed to avoid institutionalization; and

3. His or her cost-share payments and any other monies owed to HCEP are paid.

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

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Subchapter Historical Note

Subchapter 4, formerly Home Care Expansion Program, was recodified as Subchapter 3 by R.1994 d.41 and the current Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was recodified from Subchapter 5, effective January 18, 1994. See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–4.1 Introduction

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

(b) These codes are used when requesting reimbursement for certain Home Care services and when a Health Insurance Claim Form, 1500 N.J., is required.

10:60–4.2 HCPCS Codes

(a) PERSONAL CARE ASSISTANT SERVICES FOR MEDICAID AND MODEL WAIVERS

HCPCS Code	Description
Z1600	Personal Care Assistant Service (Individual/hourly/weekday)
Z1605	Personal Care Assistant Service (Group/hourly/weekday)
Z1610	Initial Nursing Assessment Visit
Z1611	Personal Care Assistant Service (Individual/½ hour/weekday)
Z1612	Personal Care Assistant Service (Group/½ hour/weekday)
Z1613	Nursing Reassessment Visit
Z1614	Personal Care Assistant Service (Individual/hourly/weekend/holiday)
Z1615	Personal Care Assistant Service (Individual/½ hour/weekend/holiday)
Z1616	Personal Care Assistant Service (Group/hourly/weekend/holiday)
Z1617	Personal Care Assistant Service (Group/½ hour/weekend/holiday)

(b) COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED (CCPED) AND HOME CARE EXPANSION PROGRAM (HCEP)

HCPCS Code	Description
Z1240	Case Management, per recipient, per month

1. The following codes are to be used by licensed Home Health Agencies ONLY

Z1245	Home Health Aide Visit, up to 4 hours
Z1250	Home Health Aide Visit, 5 to 8 hours
Z1255	Physical Therapy, daily
Z1260	Speech–Language Therapy, visit
Z1265	Occupational Therapy, visit
Z1270	Medical Social Services visit
Z1275	Skilled Nursing Care Visit
Z1280	Medical Supplies (per month)
Z1339	Home Health Aide (per hour)

2. The following codes may be used by licensed Home Health Agencies or Homemaker Agencies

Z1200	Homemaker, hourly, weekday
Z1205	Initial Evaluation, R.N.
Z1290	Nursing Reassessment Visit
Z1295	Homemaker, hourly, weekend, holiday
Z1210	Respite Care, 8–hour day
Z1215	Respite Care, 8–hour night
Z1220	Respite Care Day—over 8 hours, up to 12 hours
Z1225	Respite Care Night—over 8 hours, up to 12 hours
Z1230	Respite Care over 12 hours, up to 24 hours
Z1285	Respite Care, Nursing Facility, daily
Z1235	Social Adult Day Care, daily
W9002	Medical Day Care, daily

3. In addition to the above, the following are appropriate to HCEP only and used only by HCEP case managers.

Z1202	Initial Comprehensive Needs Assessment
Z1203	Collection of Disability Information

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

HCPCS Code	Description
MODEL WAIVERS I, II, and III	
Z1700	Case Management, per recipient/per month
MODEL WAIVER III and AIDS COMMUNITY CARE ALTERNATIVES PROGRAM	

HCPCS Code	Description
Z1710	PDN–RN, Per Hour/Weekday
Z1715	PDN–LPN, Per Hour/Weekday
Z1720	PDN–RN, Per Hour/Weekend/Evening/Holiday
Z1725	PDN–LPN, Per Hour/Weekend/Evening/Holiday
Z1730	PDN–RN Specialty, Per Hour/Weekday
Z1735	PDN–LPN Specialty, Per Hour/Weekday
Z1740	PDN–RN Specialty, Per Hour/Weekend/Evening/Holiday
Z1745	PDN–LPN Specialty, Per Hour/Weekend/Evening/Holiday

(d) HCPCS FOR AIDS COMMUNITY CARE ALTERNATIVES PROGRAM

HCPCS Code	Description
Z1800	Case Management, Per Recipient/Month
Z1801	Case Management, Initial Month (one time only, per recipient)
Z1810	Hospice, daily
Z1820	Personal Care Assistant Service, Per Hour/Weekday/Individual
Z1821	Personal Care Assistant Service, Per ½ Hour/Weekday/Individual
Z1822	Personal Care Assistant Service, Per Hour/Weekend/Holiday/Individual
Z1823	Personal Care Assistant Service, Per ½ Hour/Weekend/Holiday/Individual
Z1824	Personal Care Assistant Service, Per Hour/Weekday/Group
Z1825	Personal Care Assistant Service, Per ½ Hour/Weekday/Group
Z1826	Personal Care Assistant Service, Per Hour/Weekend/Holiday/Group
Z1827	Personal Care Assistant Service, Per ½ Hour/Weekend/Holiday/Group
Z1828	Initial Nursing Assessment Visit
Z1829	Nursing Reassessment Visit
Z1830	Methadone Treatment at Home provided only by narcotic and drug treatment centers
Z1831	Urinalysis for Drug Addiction at Home provided only by narcotic and drug treatment centers
Z1832	Psychotherapy, Full Session at Home provided only by narcotic and drug treatment centers
Z1833	Psychotherapy, Half Session at Home provided only by narcotic and drug treatment centers
Z1834	Family Therapy at Home provided only by narcotic and drug treatment centers
Z1835	Family Conference at Home provided only by narcotic and drug treatment centers
Z1850	Intensive Supervision for Children with AIDS in Foster Care Homes, per recipient, per month provided only by DYFS
Z1851	Specialized Group Foster Home Care for Children, daily
Z1852	Intensive Supervision for Children with ARC in Foster Care Homes, per recipient, per month provided only by DYFS
Z1853	Intensive Supervision for HIV-positive Children in Foster Care Homes, per recipient, per month provided only by DYFS
Z1860	Medical Day Care, daily

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

SUBCHAPTER 5. TRAUMATIC BRAIN INJURY PROGRAM

Authority

N.J.S.A. 30:4D–6b(2)7, 7, 7a, b, and c; N.J.S.A. 30:4D–12; N.J.S.A. 30:4E; 42 CFR 440.70, 170; 1915(c) of the Social Security Act; 42 U.S.C. 1396n.

Source and Effective Date

R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

Subchapter Historical Note

Subchapter 5, formerly HCFA Common Procedure Coding System (HCPCS), was recodified as Subchapter 4 by R.1994 d.41, effective January 18, 1994. See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–5.1 Purpose and Scope

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

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

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

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

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services through the Office of Home Care Programs (OHCP) and the Surveillance Utilization Review Subsystem (SURS). The delivery of home care services to TBI Waiver recipients will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63–1.15.

Administrative Change.
See: 27 N.J.R. 686(a).

10:60–5.2 Eligibility criteria

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

1. Be not less than 18 nor more than 65 years of age at the time of enrollment;

2. Have a diagnosis of acquired brain injury which occurred after the age of 16;

3. Exhibit medical, emotional, behavioral and/or cognitive deficits;

4. Meet the Division's nursing facility standard care criteria for Pre–Admission Screening (PAS), at N.J.A.C. 10:60–1.2;

5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix B);

6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care . . . Special Medicaid Programs, or enrolled in Garden State Health Plan, or private Health Maintenance Organizations serving Medicaid recipients are not eligible for this program.

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

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

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

(c) Retroactive eligibility shall not be available to waiver recipients for those Medicaid services provided only by virtue of enrollment in the waiver program.

(d) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid Eligibility Identification (MEI) card.

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

10:60–5.3 Application process for TBI waiver

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

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

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

3. Individuals who are not currently Medicaid eligible shall be referred by OHCP to the county welfare agency (CWA) located in the county where the individual resides, for a determination of financial eligibility, which includes the referral for disability determination.

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

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

(d) The MDO shall review and approve the plan of care prepared by the case manager initially and at six month intervals. Program oversight shall be provided by the Division through the Office of Home Care Programs (OHCP) and the Surveillance Utilization Review Subsystem (SURS), and the delivery of services will be subject to a post-payment utilization review, per N.J.A.C. 10:63–1.15.

10:60–5.4 Termination criteria for the TBI waiver

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

1. He or she no longer meets the income and resource requirements for Medicaid;

2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;

3. He or she attains a Level eight or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

4. He or she refuses to accept case management services; or

5. He or she is categorically eligible for Medicaid State Plan services and does not require waiver services as part of the plan of care.

10:60–5.5 TBI waiver services

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

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

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

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

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

2. Personal care assistant services are health related tasks performed in the recipient's home or place of residence by a certified homemaker/home health aide who is under the supervision of a registered professional nurse. The frequency or intensity of supervision shall be designated by the plan of care. Tasks shall include assistance with eating, bathing, dressing, personal hygiene, activities of daily living. They may include assistance with meal preparation, but not the cost of the meal itself. When specified in the plan of care, this service shall also include such housekeeping chores as bedmaking, dusting and vacuuming, which are essential to the health and welfare of the recipient. A personal care assistant shall be under contract to, or employed by a licensed Medicare certified home health agency or accredited homemaker/home health aide agency or a community residential services provider (see (a)9 below). Personal care assistant services shall be provided consistent with Medicaid program limitations of hours in accordance with N.J.A.C. 10:60–1.9(f). Family members who provide personal care assistant services shall meet the same standards as providers who are unrelated to the recipient.

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

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

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

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

4. Environmental modification services are physical adaptations to the recipient's home, required by the recipient and included in the plan of care, which are necessary to ensure the health, welfare and safety of the recipient, or which enable the recipient to function with greater independence in the home, without which the recipient would require institutionalization. Such adaptations shall include the installation of ramps and grabbers, widening of doorways, modification of bathrooms, or installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies for the recipient's welfare. Vehicle modification for the recipient's/family vehicle shall also be included. Also included shall be electronic monitoring systems to protect the recipient's safety, as determined by the plan of care. Excluded are adaptations or improvements to the home which are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, and/or central air conditioning. All environmental modification services provided shall be in accordance with applicable State and local building codes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Works under the intermittent supervision of the employment agency;

(4) Is able to handle emergency situations;

(5) Understands and is able to work with individuals with TBI;

(6) Maintains confidentiality; and

(7) Has a valid driver's license and appropriate insurance coverage, if responsible for transporting residents.

8. Therapy services include physical and occupational therapy, speech-language pathology and cognitive therapy services. Therapies shall be offered alone or in combination to enhance or maintain recipient functioning as required by the plan of care. Therapies shall focus on the reattainment of physical or cognitive skill lost or

altered as a result of trauma. The aim is to maximize recipient functioning in real world situations through retraining, use of compensatory strategies and orthotic and prosthetic devices, if necessary.

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

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

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

iv. A cognitive therapy provider shall meet certification standards for cognitive therapy, established by the Society for Cognitive Rehabilitation Inc. (Society for Cognitive Rehabilitation, P.O. Box 33548, Decatur, GA 30033–0548, phone, 404–939–6338) and shall be under contract to a community residential services provider, rehabilitation hospital or agency which shall be reimbursed for the cognitive therapy services.

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

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

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

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

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

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

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

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

ii. CRS providers shall be licensed by the Division of Developmental Disabilities (DDD); home health agencies shall be licensed by the Department of Health (DOH); and homemaker/home health aide agencies shall be accredited in accordance with N.J.A.C. 10:60.

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

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

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

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

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

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

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

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

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

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

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

ii. Registered professional nurses shall be licensed by the State of New Jersey and certified as a clinical specialist in psychiatric or mental health nursing by the American Nurses Association (N.J.S.A. 45:11–26).

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

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

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

vi. A certified alcohol drug counselor (CADC) shall be certified by the Alcohol and Drug Counselor Certification Board of New Jersey (ADCCBNJ, 90 Monmouth St., Suite One, Red Bank, NJ 07701, Phone 908–741–3835).

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

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

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

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

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

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

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

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

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

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

10:60–5.6 Program costs

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

10:60–5.7 Basis for reimbursement for TBI services

(a) A fee-for-service reimbursement methodology shall be utilized for TBI waiver services. Providers shall be precluded from receiving additional reimbursement for the cost of these TBI Waiver services above the fee established by the Medicaid program. (See N.J.A.C. 10:60–5.8(c).)

(b) The health insurance claim form 1500 N.J. shall be used when billing for waiver services provided. Refer to the Fiscal Agent Billing Supplement (Appendix A of this chapter) for information in the completion of the 1500 N.J.

(c) Fees for TBI waiver services are established for each service by the Division, after a review of the range of fees charged for the service by providers throughout the State and in other states with similar waiver programs. Once a fee for a particular service has been established, that fee becomes the maximum fee that Medicaid will pay for that service. Providers seeking approval to render that service are subject to this fee ceiling.

10:60–5.8 Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) for Traumatic Brain Injury Program

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this subchapter are relevant only to the Traumatic Brain Injury Program.

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

(c) The HCPCS procedure codes for the Traumatic Brain Injury Program are as follows:

HCPCS Code	Description	Maximum Rates
Y7433	TBI—Case Management, Initial (First Month)	$200.00
Y7434	TBI—Case Management, Continuing (Subsequent Month)	125.00
Y7435	TBI—Community Residential Services (Level I Supervision) 2–4 hours	99.00
Y7436	TBI—Community Residential Services (Level II Supervision) over 4–8 hours	115.00
Y7437	TBI—Community Residential Services (Level III Supervision) over 8 hours	147.00

HCPCS Code	Description	Maximum Rates
Y7438	TBI—Structured Day Program (Full Day)	87.00
Y7439	TBI—Structured Day Program (Half Day)	44.00
Y7443	TBI—Supported Day Program (Per Hour)	30.00
Y7444	TBI—Personal Care Assistant Services (Weekdays, per hour)	14.00
Y7445	TBI—Personal Care Assistant Services (Weekends, and Holidays, Per Hour)	17.00
Y7446	TBI—Companion Services (Per Hour)	11.00
Y7448	TBI—Night Supervision (8 hours)	112.00
Y7449	TBI—Chore Services (Per hour)	10.00
Y7453	TBI—Respite Inpatient Variable NF Rate or per day for non-NF	100.00
Y7454	TBI—Personal Care Assistant Services RN Initial Nursing Assessment	35.00
Y7455	TBI—Personal Care Assistant Services, RN Reassessment	35.00
Y7456	TBI—Respite 8 hour day	88.00
Y7457	TBI—Respite 8 hour night	104.00
Y7458	TBI—Respite greater than 8 hour to 12 hour day	128.00
Y7459	TBI—Respite greater than 8 hour to 12 hour night	144.00
Y7463	TBI—Respite greater than 12 hour to 24 hour day	160.00
Y7554	TBI—Physical Therapy (Per Visit)	73.00
Y7555	TBI—Occupational Therapy (Per Visit)	73.00
Y7556	TBI—Speech Therapy (Per Visit)	73.00
Y7557	TBI—Cognitive Therapy (Per Visit)	73.00
Y7558	TBI—Counseling (Behavior) (Per Hour)	65.00
Y7559	TBI—Counseling (Individual/Family) (Per Hour)	65.00
Y7563	TBI—Counseling (Addiction) (Per Hour)	65.00
Y7564	TBI—Behavior Program (Assessment) (Per Hour)	75.00
Y7565	TBI—Behavior Program (Psychologist) (Continuing) (Per Hour)	75.00
Y7566	TBI—Behavior Program (Continuing) (Per Hour)	35.00
Y7567	TBI—Transportation (Per Trip) $.25 per mile	
Y7568	TBI—Environmental Modification (Per Service or Item)	1,000.00

SUBCHAPTER 6. (RESERVED)

Subchapter Historical Note

Subchapter 6, formerly Billing Procedures for Home Care Services, was repealed by R.1994 d.41, effective January 18, 1994. See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

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

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

Former Appendices A through H repealed by R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

APPENDIX B

RANCHO SCALE

Level	Response	Patient Function
I	No response	Patient is completely unresponsive to any stimulus.
II	Generalized response	Patient reacts to the environment, but not as a specific response to the stimulus—responses are often the same despite change of stimuli. The earliest response is often gross movement to deep pain.
III	Localized response	Patient reacts in a specific manner to the stimulus, but may inconsistently turn head to sound, withdraw an extremity to pain, squeeze fingers placed in the hand, or respond to family members more than others.
IV	Confused, agitated	Patient is in a heightened state of activity, but is still severely detached from the surroundings. Internal confusion and very limited ability to learn is combined with short attention span and easy fatigue. The patient is unable to cooperate and may be aggressive, combative, or incoherent.
V	Confused, inappropriate/ nonagitated	Patient appears alert and is able to respond to simple commands. Responses are best with familiar routines, people, and structured situations. Distractibility and short attention span lead to difficulty learning new tasks and agitation in response to frustrations. If physically mobile, there may be wandering. Much external structure is needed. Initiation and memory are limited.
VI	Confused, appropriate	Patient shows goal-directed behavior, but still is dependent on external structure and direction. Simple directions are followed consistently and there is carry-over of relearned skills (like dressing), yet new learning progresses very slowly with little carry-over. Orientation is better and there is no longer inappropriate wandering.
VII	Automatic, appropriate	Patient appears appropriate and oriented with familiar settings such as home and hospital, but is confused and often helpless in unfamiliar surroundings. The daily routine can be managed with minimal confusion as long as there are no changes. There is little recall of what has just been done. There is only a superficial understanding of the disability, with lack of insight into the significance of the remaining deficits. Judgment is impaired with inability to plan ahead. New learning is slow and minimal supervision is needed. Driving is unsafe; supervision is needed for safety in the community or in school and workshop settings.
VIII	Purposeful, appropriate	Patient may not function as well as before the injury, but is able to function independently in home and community skills, including driving. Alert, oriented, and able to integrate past and present events. Vocational rehabilitation is indicated. Difficulties dealing with stressful or unexpected situations can arise, as there may be a decrease in abstract reasoning, judg-

Level	Response	Patient Function
		ment, intellectual ability, and tolerance of stress relative to premorbid capabilities.