

CHAPTER 60
HOME CARE SERVICES

Authority

N.J.S.A. 30:4D-6b(2), 7, 7a, 7b, and 7c; 30:4D-12,
30:4E; 42 CFR 440.70, 170, 180, and 181.

Source and Effective Date

R.1996 d.18, effective December 7, 1995.
See: 27 N.J.R. 3667(a), 28 N.J.R. 184(a).

Executive Order No. 66(1978) Expiration Date

Chapter 60, Home Care Services, expires on December 7, 2000.

Chapter Historical Note

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

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services Manual, was readopted as R.1985 d.488, effective August 27, 1985. See: 17 N.J.R. 28(a), 17 N.J.R. 2433(a). Pursuant to Executive Order No. 66(1978), Chapter 60 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Chapter 60, Home Care Services Manual, was repealed and Chapter 60, Home Care Services, was adopted as new rules by R.1991 d.65, effective February 19, 1991 (operative March 1, 1991). See: 22 N.J.R. 3116(a), 23 N.J.R. 420(b). Subchapter 2, Covered Home Care Services (Home Health Care Services and Personal Care Assistant Services), was repealed; Subchapter 3, Home and Community-Based Services Waiver Programs, was recodified as Subchapter 2; Subchapter 4, Home Care Extension Program was recodified as Subchapter 3; and Subchapter 5, 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). Subchapter 5, Traumatic Brain Injury Program, was adopted as new rules by R.1994 d.426, effective August 15, 1994. See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services, was readopted as R.1996 d.18, effective December 7, 1995. See: Source and Effective Date.

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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);
4. Home Care Expansion Program (HCEP); and
5. Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing (EPSDT/PDN) Services.

(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, the Home Care Expansion Program, and Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing Services.

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).
Amended by R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

10:60-1.2 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.

“Early and periodic screening, diagnosis and treatment/private duty nursing (EPSDT/PDN)” means the private duty nursing services provided to Early and Periodic Screening, Diagnosis and Treatment Program recipients under 21 years of age who live in the community and whose medical condition and treatment plan justify that need.

“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 non-compliance 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).
Amended by R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

10:60-1.3 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 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.

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 war-

rants, 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 Eligibility for early and periodic screening and diagnosis and treatment/private duty nursing services

(a) EPSDT eligible individuals under 21 years of age who are enrolled in the Medicaid program and who require private duty nursing services which will allow them to be cared for in a community setting, may be referred for EPSDT/PDN services.

1. Individuals eligible for Medicaid services through the Medically Needy program, are not eligible for the EPSDT program, in accordance with N.J.A.C. 10:49-5.3(a)2.

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

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

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

1. Private duty nursing shall be provided for EPSDT-eligible Medicaid recipients in the community only and not in hospital inpatient or nursing facility settings.
2. The Medicaid District Office (MDO) shall determine and approve the total PDN hours for reimbursement, in accordance with (e) below. A maximum of 16 hours of private duty nursing services may be provided in any 24-hour period.
3. The determination of the total EPSDT/PDN hours approved, up to the maximum of 16 hours per 24-hour period, shall take into account alternative sources of care available to the caregiver (for example, medical day care, or private duty nursing covered by private insurance).
4. In emergency situations, for example, when the sole caregiver has been hospitalized, the MDO may authorize, for a limited time, additional hours beyond the 16 hour limit.

(d) To qualify for payment of EPSDT/PDN services, the recipient shall be referred by a parent, primary physician, hospital discharge planner, special child health services case manager or current PDN provider. Requests for services shall be submitted to the Medicaid District Office (MDO) servicing the county where the child is currently located using a "Request for EPSDT Private Duty Nursing Services (FD-389)" form. The Request shall be completed and signed by a physician and agreed to and signed by a parent or guardian. All sections of the Request must be completed and a physician's case summary and current treatment plan shall be attached. Incomplete requests shall be returned to the referral source for completion prior to further action by the Medicaid agency.

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

(e) Upon receipt of the fully completed Request (FD-389), the Medicaid Regional Staff Nurse (RSN) will conduct an assessment of the need for PDN services, as well as the level (LPN or RN) and amount of service required. A letter notifying the family and the person who referred the individual of the decision following the RSN's assessment will be issued by the MDO on the "Medicaid District Office Authorization/Approval/Denial Form (FD-390)." The number of hours approved, the level of services, and the length of time of the approval (up to a maximum of six months) will be noted on the form.

(f) If the prospective PDN provider has not yet been selected at the time of the assessment and approval of the need for PDN services, the PDN agency, when selected, shall submit a request to the MDO for the PDN services on the "Prior Authorization Request Form (FD-365)" which contains a pre-printed prior authorization (PA) number. Telephone requests for prior authorization (PA) can be accommodated in an emergency but shall be followed immediately by a written request.

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

(h) Requests for continuation, or modification of PDN services during the treatment period, shall be submitted by the PDN agency, in writing, to the MDO on the "Prior Authorization Request Form (FD-365)." In an emergency, requests for modification of services may be made by telephone but shall be followed immediately by a written prior authorization (PA) request, in accordance with N.J.A.C. 10:60-1.13(c).

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

(i) Claims for payment for PDN services shall be submitted on the Health Insurance Claim Form (HCFA 1500). The PA number from the "Medicaid District Office Authorization/Approval/ Denial Form (FD-390)" shall be noted on the claim form. Providers shall bill each date of service on a separate line (FIELD 24A) of the claim form. If more than one procedure code is billed for the same date of service, separate lines shall be used when billing each procedure code. Providers shall not span dates of service on a line of the claim form.

1. Private duty nursing provider charges may vary but reimbursement cannot exceed the maximum rates allowed by the Division in accordance with N.J.A.C. 10:60-4.2(e).

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

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

New Rule, R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

10:60-1.14 Advance directives

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

1. Such agencies shall:

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

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

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

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

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

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

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

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

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Recodified from 10:60-1.13 by R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

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

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

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

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/week-end/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 deter-

mination 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 waived 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 waived 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 State-wide 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. 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 non-resident 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)

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/week-end/holiday)
Z1615	Personal Care Assistant Service (Individual/½ hour/week-end/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

HCPCS Code	Description
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	
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

HCPCS Code	Description
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

(e) HCPCS CODES FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT/PRI-VATE DUTY NURSING:

Z1710	WT PDN—RN, EPSDT, Per Hour	\$30.00
Z1730	WT PDN—RN, EPSDT, Enhanced, Per Hour	\$35.00
Z1735	WT PDN—LPN, EPSDT, Per Hour	\$25.00

Amended by R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Amended by R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

SUBCHAPTER 5. TRAUMATIC BRAIN INJURY PROGRAM

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 comple-

tion, 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 Trau-

matic 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
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.

Level	Response	Patient Function
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

Level	Response	Patient Function
VIII	Purposeful, appropriate	community or in school and workshop settings. 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, judgment, intellectual ability, and tolerance of stress relative to premorbid capabilities.