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, Bureau of Home and Community Services.

Amended by R.1997 d.277, effective July 7, 1997.
See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(a).

**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 Bureau of Home and Community Services' 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).
Amended by R.1997 d.277, effective July 7, 1997.
See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(a).

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## 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 | Maximum Rate |
|---|---|---|
| Z1600 | Personal Care Assistant Service (Individual/hourly/weekday) | $14.00 |
| Z1605 | Personal Care Assistant Service (Group/hourly/weekday) | $11.00 |
| Z1610 | Initial Nursing Assessment Visit | $35.00 |
| Z1611 | Personal Care Assistant Service (Individual/½ hour/weekday) | $ 7.00 |
| Z1612 | Personal Care Assistant Service (Group/½ hour/weekday) | $ 5.50 |
| Z1613 | Nursing Reassessment Visit | $35.00 |
| Z1614 | Personal Care Assistant Service (Individual/hourly/weekend/holiday) | $16.00 |
| Z1615 | Personal Care Assistant Service (Individual/½ hour/weekend/holiday) | $ 8.00 |
| Z1616 | Personal Care Assistant Service (Group/hourly/weekend/holiday) | $12.00 |
| Z1617 | Personal Care Assistant Service (Group/½ hour/weekend/holiday) | $ 6.00 |

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

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

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

| | |
|---|---|
| Z1245 | Home Health Aide Visit, up to 4 hours |
| Z1250 | Home Health Aide Visit, 5 to 8 hours |
| Z1255 | Physical Therapy, daily |
| Z1260 | Speech-Language Therapy, visit |
| Z1265 | Occupational Therapy, visit |

Z1270 Medical Social Services visit
Z1275 Skilled Nursing Care Visit
Z1280 Medical Supplies (per month)
Z1339 Home Health Aide (per hour)

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

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

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

Z1202 Initial Comprehensive Needs Assessment
Z1203 Collection of Disability Information

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

| HCPCS Code | Description |
|---|---|
| MODEL WAIVERS I, II, and III | |
| Z1700 | Case Management, per recipient/per month |
| MODEL WAIVER III and AIDS COMMUNITY CARE ALTERNATIVES PROGRAM | |
| Z1710 | PDN-RN, Per Hour/Weekday |
| Z1715 | PDN-LPN, Per Hour/Weekday |
| Z1720 | PDN-RN, Per Hour/Weekend/Evening/Holiday |
| Z1725 | PDN-LPN, Per Hour/Weekend/Evening/Holiday |
| Z1730 | PDN-RN Specialty, Per Hour/Weekday |
| Z1735 | PDN-LPN Specialty, Per Hour/Weekday |
| Z1740 | PDN-RN Specialty, Per Hour/Weekend/Evening/Holiday |
| Z1745 | PDN-LPN Specialty, Per Hour/Weekend/Evening/Holiday |

(d) HCPCS FOR AIDS COMMUNITY CARE ALTERNATIVES PROGRAM

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

(e) HCPCS CODES FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT/PRIVATE 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).
Amended by R.1997 d.277, effective July 7, 1997.
See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(a).
In (a), added "Maximum Rate" column to HCPCS Code table

## 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 Bureau of Home and Community Services (BHCS) 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).
Amended by R.1997 d.277, effective July 7, 1997.
See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(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 Bureau of Home and Community Services (BHCS) 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 BHCS 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.