N.J.A.C. 10:60

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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Title 10, Chapter 60 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq; and P.L. 2019, c. 150.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

R.2022 d.107, effective September 6, 2022.

See: 53 N.J.R. 1327(a), 54 N.J.R. 1721(a).

CHAPTER HISTORICAL NOTE:

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

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

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

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

Chapter 60, Home Care Services Manual, was repealed and Chapter 60, Home Care Services, was adopted as new rules by R.1991 d.65, effective February 19, 1991, operative March 1, 1991.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

Subchapter 2, Covered Home Care Services (Home Health Care Services and Personal Care Assistant Services), was repealed, Subchapter 3, Home and Community-Based Services Waiver Programs, was recodified as Subchapter 2, Home and Community-Based Services Waiver Programs, Subchapter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4, HCFA Common Procedure Coding System (HCPCS), and Subchapter 6, Billing Procedures for Home Care Services, was repealed by R.1994 d.41, effective January 18, 1994.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

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

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

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services, was readopted as R.2001 d.14, effective December 7, 2000, and Subchapter 3, Home Care Expansion Program, was repealed and Subchapter 3, Personal Care Assistant (PCA) Services, was adopted as new rules, Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was recodified as Subchapter 11, HCFA Common Procedure Coding System (HCPCS), and Subchapter 4, Personal Care Assistant Services for the Mentally Ill, was adopted as new rules, Subchapter 5, Traumatic Brain Injury Program, was recodified as Subchapter 9, Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI Waiver), Subchapter 5, Private Duty Nursing (PDN) Services, was adopted as new rules, and Subchapter 8, Home and Community-Based Services Waiver for Medically Fragile Children Under Division of Youth and Family Services Supervision (ABC Waiver), was adopted as new rules by R.2001 d.14, effective January 2, 2001. See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*. See, also, section annotations.

Chapter 60, Home Care Services, was readopted as R.2006 d.238, effective May 30, 2006. See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Subchapter 6, "Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Model Waivers 1, 2, and 3)", was renamed "Home and Community-Based Services Waivers for Blind or Disabled Children and Adults Community Resources for People With Disabilities (CRPD) Waiver Program" and Subchapter 11, "HCFA Common Procedure Coding System (HCPCS)", was renamed "Healthcare Common Procedure Coding System (HCPCS)" by R.2006 d.238 effective July 3, 2006. See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 60, Home Care Services, was scheduled to expire on May 30, 2013. See: *43 N.J.R. 1203(a)*.

Chapter 60, Home Care Services, was readopted, effective April 4, 2013. See: *45 N.J.R. 1139(c)*.

Subchapter 2, Home Health Agency (HHA) Services, was renamed Home Health Agency (HHA) Skilled Services; Subchapter 4, Personal Care Assistant Services for the Mentally Ill, Subchapter 6, Home and Community-Based Services Waivers for Blind or Disabled Children and Adults Community Resources for People with Disabilities (CRPD) Waiver Program, Subchapter 7, AIDS Community Care Alternatives Program (ACCAP Waiver), Subchapter 8, Home and Community-Based Services Waiver for Medically Fragile Children Under Division of Youth and Family Services Supervision (ABC Waiver), Subchapter 9, Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (TBI Waiver), and Subchapter 10, Home and Community-Based Services Waivers Administered by Other State Agencies, were repealed; and Subchapter 6, Managed Long-Term Services and Supports (MLTSS) Provided Under the New Jersey 1115 Comprehensive Medicaid Waiver, was adopted as new rules by R.2018 d.172, effective September 17, 2018. See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

In accordance with *N.J.S.A. 52:14B-5.1*.d(2), the expiration date of Chapter 60, Home Care Services, was extended by gubernatorial directive from April 4, 2020 to April 4, 2021. See: *52 N.J.R. 1020(b)*.

In accordance with *N.J.S.A. 52:14B-5.1*.d(2), Chapter 60, Home Care Services, was scheduled to expire on April 4, 2021. Pursuant to Executive Order No. 127 (2020) and P.L. 2021, c. 104, any chapter of the New Jersey Administrative Code that would otherwise have expired during the Public Health Emergency originally declared in Executive Order No. 103 (2020) was extended through January 1, 2022. Therefore, this chapter has not yet expired and is extended 180 days from the later of the existing expiration date or the date of publication of this notice of proposed readoption, whichever is later, which date is February 12, 2022, pursuant to *N.J.S.A. 52:14B-5.1*.c, Executive Order No. 244 (2021), and P.L. 2021, c. 104. See: *53 N.J.R. 1327(a)*.

Chapter 60, Home Care Services expired on February 12, 2022 and was adopted as new rules by R.2022 d.107, effective September 6, 2022. See: Source and Effective Date. See, also, section annotations.

Annotations

Notes

Chapter Notes

Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 60, Home Care Services, expires on September 6, 2029.

End of Document

N.J.A.C. 10:60-1.1

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§ 10:60-1.1 Purpose and scope

(a) The purpose of this chapter is to explain the rules under which home care services are administered to those individuals determined eligible to receive such services on a fee-for-service basis.

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

1. Home health services;

2. Personal care assistant services;

3. Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing (EPSDT/PDN) Services;

4. Home and Community-Based Services Waiver programs, which are administered by the Department of Human Services through 42 U.S.C. § 1915(c) waivers, as follows:

i. Home and Community-Based Services Waiver for Intellectually and/or Developmentally Disabled (DDD-CCW) Individuals; and

5. The New Jersey Comprehensive Waiver demonstration programs (Section 1115): NJ FamilyCare managed long-term services and supports (MLTSS).

(c) Home health agencies and health care service firm agencies are eligible to participate as Medicaid/NJ FamilyCare fee-for-service home care services providers. The services that each type of agency may provide and the qualifications required to participate as a Medicaid/NJ FamilyCare provider are listed at *N.J.A.C. 10:60-1.2* and *1.3*.

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

(e) N.J.A.C. 10:60-11, CMS Common Procedure Coding System-HCPCS, outlines the procedure codes used to submit a claim for services provided in accordance with this chapter.

History

HISTORY:

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)*.

Amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (b), inserted a reference to services in the introductory paragraph, and rewrote 3 through 5; in (c) through (f), changed N.J.A.C. references; in (c), inserted "and NJ KidCare fee-for-service" following "Medicaid"; in (e), deleted a reference to the Home Care Expansion Program; and in (f), substituted "(except CCPED and ECO)" for "the Home Care Expansion Program, and", and added a reference to the Traumatic Brain Injury Program.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Rewrote (b)4i; in (c), substituted "FamilyCare" for "KidCare"; and in (f), inserted a comma after the N.J.A.C. reference, substituted "CMS" for "HCFA" and inserted ", Assisted Living (AL)".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (c), substituted "Medicaid/NJ FamilyCare" for "Medicaid and NJ FamilyCare", and "at" for "in".

Annotations

Notes

Chapter Notes

Case Notes

Nine-year old child who was diagnosed with Down Syndrome, asthma, hypothyroidism and mental impairment was entitled to 17 hours a week of personal care under the Personal Preference Program because there was no evidence offered to rebut the insurer's conclusion that that allowance was properly reduced from 22 to 17 hours per week based upon the results of a PCA assessment. *A.I. v. Amerigroup, OAL DKT. NO. HMA 17827-16, 2017 N.J. AGEN LEXIS 78*, Initial Decision (February 6, 2017).

N.J.A.C. 10:60-1.2

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§ 10:60-1.2 Definitions

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

"Accreditation organization" means an agency approved by the Department of Human Services to provide quality oversight of Medicaid/NJ FamilyCare home care agencies and certify that services are being performed in accordance with acceptable practices and established standards. A current list of entities approved by the Department as accreditation organizations can be obtained by contacting the Department. Interested parties should ensure that the most current list is obtained before taking any action based on such a list. The Department can be contacted by calling (609) 292-3717 or online at http://*www.state.nj.us/humanservices/index.shtml*.

"Activities of daily living (ADL)" means activities related to self-care, performed either independently or with supervision or assistance, which include, but are not limited to, dressing and undressing, bathing, eating, grooming, ambulation, transferring, toileting, and mobility. The inability to independently perform such tasks may be used as a measure to determine a person's level of disability.

"Annual cost threshold (ACT)" means the annualized long-term services and support portion of the capitation rate for residence in a nursing facility or special care nursing facility as appropriate to a beneficiary's needs as determined by the Office of Community Options. The ACT is determined by the Department of Health in accordance with *N.J.A.C. 8:85*.

"Calendar day" means from 12:00 A.M. up to, but not including, the following 12:00 A.M.

"Calendar work week" means the time parameters which constitute a work week for personal care assistant services. These time parameters are from Sunday at 12:00 A.M. to Saturday at 11:59 P.M.

"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*).

"Complexity" means the degree of difficulty and/or intensity of treatment/procedures.

"Continuous ongoing" means that the beneficiary requires the provision of skilled nursing intervention, on an ongoing basis, up to 24-hours per day/seven days per week, where the beneficiary cannot be taught to self-perform the task and alternative support is not available.

"DDD" means the Division of Developmental Disabilities in the New Jersey Department of Human Services.

"DDS" means the Division of Disability Services in the New Jersey Department of Human Services.

"DoAS" means the Division of Aging Services in the New Jersey Department of Human Services.

"DHS" means the New Jersey Department of Human Services.

"DOH" means the New Jersey Department of Health.

"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 beneficiary and/or his or her family or interested person which anticipates the health care needs of the beneficiary 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 beneficiary to adjust to his or her changing needs and circumstance.

"DMAHS" means the Division of Medical Assistance and Health Services in the Department of Human 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 beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify that need.

"Face-to-face encounter" means direct contact between a beneficiary and a physician/practitioner authorized to certify home care services.

"Field security cost" means costs incurred by a home health agency in providing security personnel to accompany medical care staff of a home health agency during onsite visits to the patient's home.

"Hands-on personal care" means physical assistance given to a Medicaid/NJ FamilyCare beneficiary with bathing, dressing, grooming, toileting, mobility/ambulation, feeding, and transfers.

"Health care service firm" means any person or entity who operates a firm, registered with the Division of Consumer Affairs, that employs individuals directly or indirectly for the purpose of assigning the employed individuals to provide health care or personal care services either directly in the home or at a care-giving facility, and who, in addition to paying wages or salaries to the employed individuals while on assignment; pays, or is required to pay, Federal Social Security taxes and State and Federal unemployment insurance; carries, or is required to carry, worker's compensation insurance; and sustains responsibility for the action of the employed individuals while they render health care services.

"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 the Title XVIII (Medicare) Program; and

3. Is approved for participation as a home health agency provider by the New Jersey Medicaid/NJ FamilyCare program or the Medicaid/NJ FamilyCare agent.

"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 Division 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.

"Instrumental activities of daily living (IADL)" means those non-hands-on personal care assistance services that are essential to the beneficiary's health and comfort, including, but not limited to, housekeeping, food preparation, doing laundry, and shopping.

"Legally responsible relative" means the spouse or legal guardian of an adult or the parent or legal guardian of a minor child.

"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/NJ FamilyCare fee-for-service beneficiaries, upon request of the attending physician/practitioner.

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.A.C. 13:37*, having completed formal accredited nursing education programs.

"Managed long-term services and supports (MLTSS)" means services that are provided under the Comprehensive Waiver through Medicaid/NJ FamilyCare managed care organization plans, the purpose of which is to support beneficiaries who meet nursing home level of care in the most appropriate setting to meet their specific needs.

"Medical Assistance Customer Center (MACC)" means one of the community-based Division offices located throughout the State.

"Minimal assistance" means non-weight bearing support with minimal physical assistance from the caregiver, when the beneficiary needs physical help in guided maneuvering of limbs or other non-weight bearing assistance such as getting in and out of the tub, dressing, or assistance in washing difficult to reach places.

"Moderate assistance" means weight bearing support, hand-over-hand assistance, in which the beneficiary is involved with physically performing less than 50 percent of the tasks on their own.

"National Plan and Provider Enumerations System (NPPES)" means the system that assigns National Provider Identifiers (NPIs), maintains and updates information about health care providers with NPIs, and disseminates the NPI Registry and NPPES downloadable file. The NPI Registry is an online query system that allows users to search for a health care provider's information.

"National Provider Identifier (NPI)" means a unique 10-digit identification number issued to health care providers by the Centers for Medicare and Medicaid Services (CMS).

"Non-routine supplies" means non-routine supplies defined in the Medicare Medical Review Supply List published August 1994 by United Government Services, incorporated herein by reference, as amended and supplemented. (A copy of the list may be obtained from United Government Services, 115 Stevens Ave., Valhalla, N.Y. 10595.)

"Nurse delegation" means that the registered professional nurse is responsible for the nature and quality of all nursing care, including the assessment of the nursing needs, the plan of nursing care, the implementation of the plan of nursing care, and the monitoring and evaluation of the plan. The treating registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel, including certified nursing assistants (CNAs) and certified homemaker-home health aides (CHHA) pursuant to *N.J.A.C. 13:37-6.2*.

"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 of Medical Assistance and Health Services or Division of Disability Services staff, or an agent designated by either Division, to a home health agency, accredited health care services firm, or hospice agency to monitor compliance with this chapter.

"Performance standards" for the purpose of this chapter means the criteria established by this Division in order to measure the beneficiary/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 Division-approved healthcare services firm, home health agency, or hospice agency.

"Personal care assistant (PCA) services" means health related tasks associated with the cueing, supervision, and/or the completion of the activities of daily living, as well as instrumental activities of daily living (IADL) related tasks performed by a qualified individual in a beneficiary's home, or at a place of employment or post-secondary educational or training program, under the supervision of a registered professional nurse, certified as medically necessary, in accordance with a beneficiary's written plan of care.

"Physical therapist" means a person who meets all the applicable Federal requirements, 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.

"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 the physician practices.

"Plan of care" means the individualized and documented program of health care services provided by all members of the home health agency, health care services firm, or hospice agency involved in the delivery of home care services to a beneficiary. The plan includes short-term and long-term goals for rehabilitation, restoration or maintenance made in cooperation with the beneficiary and/or responsible family members or interested person. Appropriate instruction of beneficiary, 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 beneficiary's condition.

"Practitioner" means advanced practice nurses and physician assistants who, within the scope of their license, are permitted to prescribe home health care services.

"Practitioner Orders for Life Sustaining Treatment (POLST)" means a form that enables patients to indicate their preferences regarding life-sustaining treatment. This form, signed by a patient's attending physician, advanced practice nurse, or physician assistant, provides instructions for health care

personnel to follow for a range of life-prolonging interventions. This form becomes part of a patient's medical records, following the patient from one healthcare setting to another, including hospital, nursing home, or hospice.

"Preadmission screening (PAS)" means that process by which all eligible Medicaid/NJ FamilyCare fee-for-service beneficiaries, and individuals who may become Medicaid/NJ FamilyCare eligible within 180 days following admission to a Medicaid/NJ FamilyCare certified nursing facility, and who are seeking admission to a Medicaid/NJ FamilyCare certified nursing facility or requesting MLTSS services under the comprehensive waiver program receive an in-person standardized assessment by professional staff designated by the DoAS to determine nursing facility (NF) level of care and to provide counseling on options for care.

"Primary caregiver" means an adult relative or significant other adult, at least 18 years of age, who resides with the beneficiary and accepts 24-hour responsibility for the health and welfare of the beneficiary. For the beneficiary to receive private duty nursing services under MLTSS or EPSDT, the primary caregiver must reside with the beneficiary and provide a minimum of eight hours of care to the beneficiary in any 24 hour period.

"Prior authorization" means the process of approval by the Division 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. 10:60-2.1*, if a patient is enrolled in an HMO, authorization for reimbursement is required by the 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 beneficiaries under MLTSS, as well as eligible EPSDT beneficiaries.

"Private duty nursing agency" means either a licensed Medicare-certified home health agency, an accredited home health care services firm, or a hospice agency, approved by DMAHS to provide private duty nursing services under MLTSS and to eligible EPSDT beneficiaries. 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 chapter, means a system by which Division staff shall conduct post payment reviews to determine the beneficiary/caregiver's satisfaction with the quality, quantity, and appropriateness of home health care services provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries.

"Registered professional nurse" means a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to *N.J.A.C. 13:37*.

"Residential health care facility (RHCF)" means a facility, licensed in accordance with *N.J.A.C. 8:43*, which provides food, shelter, supervised health care and related services to four or more persons 18 years of age or older who are unrelated to the owner or administrator.

"Routine supplies" means routine supplies defined in the Medicare Medical Review Supply List published August 1994 by United Government Services, incorporated herein by reference, as amended and supplemented.

"Skilled nursing interventions" means procedures that require the knowledge and experience of a licensed registered nurse. The needed services are of such complexity that the skills of a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse are required to furnish the services. Services must be so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. The term

"professional or technical personnel" refers to the RN who is responsible for the provision of the skilled nursing intervention, or the delegation of these duties to an LPN who provides the service under the supervision of the RN. The registered nurse shall determine if the intervention could be or should be taught to and delegated to a caregiver who could safely perform it so as to not endanger or risk the beneficiary's health and safety.

"Social worker" means a person who is licensed by the State of New Jersey as a licensed social worker or licensed clinical social worker, pursuant to *N.J.S.A. 45:15BB-1* et seq. and *N.J.A.C. 13:44G*.

"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 meets all applicable Federal requirements, 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.

"Taxonomy code" means a code that describes the provider or organization's type, classification, and the area of specialization.

"Telehealth technology" means the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient, and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

"Therapy session" means an occupational, physical, cognitive, or speech therapy, hands-on and/or face-to-face, interaction of the participant and therapist, performed individually or in group settings, not including the preparation of reports or progress notes. A session is equal to a unit of service for billing purposes.

"Type 1 NPI" means a code that describes an individual provider in the NPPES system.

"Type 2 NPI" means a code that describes an organizational provider in the NPPES system.

"Visit" means any combination of units of home health services which are provided when the home health agency staff arrives at the Medicaid/NJ FamilyCare fee-for-service beneficiary's residence and ends when the home health agency staff leaves the beneficiary's residence.

History

HISTORY:

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)*.

Amended by R.1997 d.277, effective July 7, 1997.

See: *29 N.J.R. 1454(a)*, *29 N.J.R. 2831(a)*.

Added "Calendar work week".

Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: *30 N.J.R. 3198(a)*, *30 N.J.R. 4377(a)*.

Substituted references to beneficiaries for references to recipients throughout; inserted "Field security cost", "Non-routine supplies", "Routine supplies", "Unit" and "Visit"; in "Hospice service" and "Levels of care", inserted references to NJ KidCare fee-for-service; in "On-site monitoring", substituted a reference to this chapter for a reference to this manual; in "Personal care assistant", substituted "Division-approved" for "Medicaid-approved" in 3; in "Preadmission screening (PAS)", inserted a reference to NJ KidCare; and in "Quality assurance", substituted a reference to this chapter for a reference to this manual, and inserted a reference to NJ KidCare.

Amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Rewrote the section.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "Family Care" for "KidCare" and "Community Resources for People with Disabilities (CRPD)" for "Model Waiver 3" throughout; added definitions "DDD", "DDS", and "DMAHS"; deleted definitions "Division" and "Unit"; in definition "Home health agency", inserted "the" preceding "Title" in 2; rewrote definitions, "Homemaker agency", "Hospice service", "On-site monitoring" and "Private duty nursing agency"; and substituted definition "'Medical Assistance Customer Center' (MACC)" for definition "'Medicaid District Office' (MOD)".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Administrative correction.

See: *51 N.J.R. 1462(a)*.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Added definitions "National Plan and Provider Enumerations System (NPPES)", "National Provider Identifier (NPI)", "Practitioner", "Practitioner Orders for Life Sustaining Treatment (POLST)", "Taxonomy code", "Type 1 NPI", and "Type 2 NPI"; rewrote definitions "Health care service firm", "Legally responsible relative", "Levels of care", "Preadmission screening (PAS)", "Quality assurance", and "Visit".

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Patient who was able to independently perform the necessary activities of daily living was not entitled to Personal Care Assistant (PCA) hours was not entitled to such services because they were needed solely for the purpose of carrying out household duties, and such services were not properly provided in the absence of a documented need

for "hands-on" personal care needs. *I.S. v. DMAHS et al., OAL DKT. NO. HMA 04985-18, 2019 N.J. AGEN LEXIS 247*, Final Agency Determination (January 2, 2019).

ALJ rejected an agency decision allowing a provider to terminate private duty nursing (PDN) services provided to a 13-year old Medicaid recipient who had a complex, chronic medical history that included hydrocephalus; chronic migraines; gastroesophageal reflux disease; and gastrostomy/jejunostomy tube placement. The evaluation on which termination was premised was incorrect in that it did not reflect that the child had both a jejunostomy tube and a gastrostomy tube, which was unusual. Moreover, the child had been receiving the same number of hours of PDN care for 12.5 years and nowhere in the evaluation on which the termination was based did the assessor identify any changes in his medical condition on which the termination properly was premised. *J.O'N. v. Amerigroup, OAL DKT. NO. HMA 17414-15, 2016 N.J. AGEN LEXIS 669*, Initial Decision (August 5, 2016).

Determination that a Medicaid recipient was entitled only to 22 Personal Care Assistant (PCA) hours per week rather than the 38 that he previously received was sustained on review because the recipient's proof relative to his need did not take into account the services that he was receiving at an adult day care facility, which hours were not taken into consideration in the prior assessment and now necessarily reduced the total number of PCA hours available. *J.Y. v. Horizon NJ Health, OAL DKT. NO. HMA 18143-15, 2016 N.J. AGEN LEXIS 355*, Initial Decision (May 19, 2016).

Challenge to a reduction in the personal care assistant (PCA) service hours allocated to an 84 year old women who suffered from advanced Alzheimer's dementia, coronary artery disease, diabetes, kidney failure, congestive heart failure, renal failure, blindness and low vision, generalized weakness, sleep apnea, psoriasis, and bladder incontinence was successful. The patient met the criteria for "severely impaired" and her needs, when fairly assessed, were such that she required "extensive" support to perform ADLs. Nor did the assessment allocate any time for other needs such as shopping and food preparation. On balance, there was insufficient evidence supporting the reduction of PCA hours. *P.R.-P. v. United Healthcare, OAL DKT. NO. HMA 04703-15, 2016 N.J. AGEN LEXIS 199*, Initial Decision (April 13, 2016).

Reduction in personal care assistant (PCA) hours granted to an 82-year old Medicaid recipient was sustained by an ALJ on findings that the recipient did not demonstrate why the assessment on which his PCA hours were reduced was incorrect or why he could not function on 19 hours of PCA per week. The recipient did not dispute the basic findings in the assessment but simply claimed he needed more time to complete some of those tasks. *W.S., Jr. v. United Healthcare, OAL DKT. NO. HMA 2044-15, 2015 N.J. AGEN LEXIS 454*, Initial Decision (July 16, 2015).

Initial Decision (2006 N.J. AGEN LEXIS 350) adopted, which found that the staff at a Pennsylvania university offering a specialized on-campus program to assist resident students with all activities of daily living qualified under *N.J.A.C. 10:60-5.3* as adult primary caregivers residing with petitioner who had accepted 24-hour responsibility for her care; thus, petitioner, a 19-year-old student suffering from nemaline myopathy, a form of muscular dystrophy, was eligible for eight hours of private duty nursing services under the Early and Periodic Screening, Diagnosis and Treatment program. *A.G. v. DMAHS, OAL Dkt. No. HMA 10133-05, 2006 N.J. AGEN LEXIS 678*, Final Decision (June 22, 2006).

End of Document

N.J.A.C. 10:60-1.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:60-1.3 Providers eligible to participate

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

1. A home health agency.

i. Out-of-State home health agencies providing services to Medicaid/NJ FamilyCare beneficiaries out of State, must meet the requirements of that state, including licensure, if applicable, and must meet all applicable Federal requirements;

2. A health care service firm;

3. A private duty nursing agency; and

4. A hospice agency.

(b) In order to be approved as a Medicaid/NJ FamilyCare-participating provider, the applicant shall have a valid National Provider Identifier (NPI) obtained from the National Plan and Provider Enumeration System (NPPES) and a valid taxonomy code obtained from the NPPES.

(c) Once approved as a Medicaid/NJ FamilyCare provider, the provider shall remain a provider in good standing by successfully completing provider revalidation when requested by DMAHS.

(d) Health care service firms shall be accredited, initially and on an ongoing basis, by an accreditation organization approved by the Department.

(e) Entities seeking to become accreditation organizations approved by the Department shall petition the Division of Disability Services (DDS) in writing to become a Medicaid/NJ FamilyCare-approved accrediting entity. DDS will oversee the process, review credentials, and, within 90 days of the date of the initial request for consideration, make a recommendation to the DMAHS Director for final decision. DDS may, at its discretion, request documentation from the party to support the request. In such case, the 90-day timeframe shall be tolled pending responsive submission of all such necessary documentation.

History

HISTORY:

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).

Amended by R.1998 d.16, effective January 5, 1998.

See: *29 N.J.R. 4262(a)*, *30 N.J.R. 72(a)*.

In (b)1, amended date.

Amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (a)1i, substituted a reference to beneficiaries for a reference to recipients; and in (a)2i, changed N.J.A.C. reference.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

In (b), inserted "the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)", and substituted "National Association for Home Care and Hospice" for "Foundation for Hospice and Homecare"; and deleted (b)1.

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Rewrote the section.

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N.J.A.C. 10:60-1.4

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§ 10:60-1.4 Out-of-State approved home health agencies

For services rendered on or after January 1, 1999, out-of-State home health agencies shall be reimbursed using the prospective payment rate established pursuant to *N.J.A.C. 10:60-2.5*. There is no cost filing required. No retroactive settlement shall be made.

History

HISTORY:

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.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: *30 N.J.R. 3198(a)*, *30 N.J.R. 4377(a)*.

In (a), added "For services rendered prior to January 1, 1999," at the beginning; and added (b).

Recodified from *N.J.A.C. 10:60-1.9* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (b), amended N.J.A.C. references. Former *N.J.A.C. 10:60-1.4*, Covered home health services, recodified to *N.J.A.C. 10:60-2.1*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

In (b), deleted "(d) and (f)" following N.J.A.C. reference.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Deleted former paragraph (a) and designator (b).

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N.J.A.C. 10:60-1.5

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§ 10:60-1.5 Limitations on home care services

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), DDS or DMAHS retains the right to limit or deny the provision of home care services on a prospective basis.

History

HISTORY:

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.1997 d.277, effective July 7, 1997.

See: *29 N.J.R. 1454(a)*, *29 N.J.R. 2831(a)*.

In (f), amended internal cite and added last sentence; and in (g), substituted "obtain prior authorization ... with *N.J.A.C. 10:49-6.1*" for "notify the Medicaid District Office (MDO), either in writing or by telephone" and amended "failure to comply" clause to conform.

Recodified from *N.J.A.C. 10:60-1.12* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Rewrote the section. Former *N.J.A.C. 10:60-1.5*, Certification of need for services, recodified to *N.J.A.C. 10:60-2.2*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Section was "Limitations of home care services". Deleted designation (a), and substituted "DDS or DMAHS" for "the Division".

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Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which explained that in attempting to meet the declared purpose of New Jersey's Private Duty Nursing services under *N.J.A.C. 10:60-5.1* et seq., which is to provide individual and continuous care, the provision of these services may be, consistent with federal regulations, limited by medical necessity and utilization control procedures that ensure the fiscal solvency of the Medicaid program. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

End of Document

N.J.A.C. 10:60-1.6

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§ 10:60-1.6 Advance directives

All agencies providing home health, private duty nursing, hospice, and personal care participating in the New Jersey Medicaid/NJ FamilyCare program are subject to the provisions of State and Federal statutes regarding advance directives and Practitioner Orders for Life Sustaining Treatment (POLST) forms including, but not limited to: appropriate notification to beneficiaries of their rights, development of policies and practices, as well as communication to and education of staff, community, and interested parties. Detailed information is located at N.J.A.C. 10:49-9.15, and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (*42 U.S.C. §§ 1396a(a)(58)* and *1396a(w)*).

History

HISTORY:

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)*.

Recodified from *N.J.A.C. 10:60-1.14* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (a), inserted references to NJ KidCare and changed P.L. reference in the introductory paragraph; and substituted references to beneficiaries for references to recipients throughout. Former *N.J.A.C. 10:60-1.6*, Plan of care, recodified to *N.J.A.C. 10:60-2.3*.

Repeal and New Rule, R.2001 d.294, effective August 20, 2001.

See: *32 N.J.R. 2687(b)*, *33 N.J.R. 2808(a)*.

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Inserted a comma following "hospice" and following "community", and substituted "Medicaid/NJ FamilyCare" for "Medicaid" and "beneficiaries" for "patients".

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Deleted comma following "directives" and inserted "and Practitioner Orders for Life Sustaining Treatement (POLST) forms"; substituted a semicolon for a comma preceeding "appropriate", "as well as" for "and", and "is" for "may be".

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N.J.A.C. 10:60-1.7

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§ 10:60-1.7 Relationship of the home care provider with the Medical Assistance Customer Center (MACC) and the NJ FamilyCare Managed Care Organization or DHS-designated entity

Prior authorization shall be required for all Medicaid/NJ FamilyCare-eligible individuals and non-Medicaid/NJ FamilyCare eligible individuals applying for nursing facility (NF) services. Managed long-term services and supports (MLTSS) provided under the 1115 New Jersey Comprehensive Medicaid Waiver may require determination of clinical eligibility through the pre-admission screening (PAS) process. Division of Aging Services (DoAS) professional staff will conduct clinical eligibility assessments and/or determinations of individuals in health care facilities and community settings to evaluate eligibility for nursing facility level of care. Counseling on options for care including potential appropriate setting for the delivery of services is conducted by the Office of Community Choice Options (OCCO) or professional staff designated by DoAS.

History

HISTORY:

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 10:60-1.14 by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), *28 N.J.R. 289(a)*.

Recodified from *N.J.A.C. 10:60-1.15* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (a), inserted "NJ KidCare--Plan A-eligible" in the first sentence, substituted "DHSS" for "MDO" in the second sentence, and substituted "LTCFO" for "MDO" in the third sentence; in (b), substituted reference to the DHSS for references to the MDO in the first and sixth sentences, added the last sentence, and substituted references to beneficiaries for references to recipients throughout. Former *N.J.A.C. 10:60-1.7*, Clinical records, recodified to *N.J.A.C. 10:60-2.4*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Section was "Relationship of the home care provider with the Medicaid District Office (MDO) and the DHSS Long-Term Care Field Office (LTCFO)". In (a), substituted "FamilyCare" for "KidCare"; and rewrote (b).

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Section was "Relationship of the home care provider with the Medical Assistance Customer Center (MACC) and the DHSS Long-Term Care Field Office (LTCFO)". Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Deleted designator (a), substituted "Medicaid/NJ FamilyCare-eligible" for Medicaid-eligible or NJ FamilyCare-eligible" and "non-Medicaid/NJ FamilyCare" for "non-Medicaid"; inserted "Division of Aging Services" and parenthesis around "DoAS"; and deleted (b).

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N.J.A.C. 10:60-1.8

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§ 10:60-1.8 Standards of performance for concurrent and post payment quality assurance review

(a) An initial visit to evaluate the need for home health services or personal care assistant (PCA) services for a fee-for-service beneficiary shall be made by the provider. For PCA services, the provider agency shall request prior authorization using form FD-365 and a State-approved PCA Assessment tool in accordance with procedures as described at *N.J.A.C. 10:60-3.9*. PCA services for fee-for-service beneficiaries shall not be rendered until authorization is provided by DDS.

1. On a random selection basis, MACC staff may conduct post-payment quality assurance reviews. At the specific request of the MACC, the provider shall submit a plan of care and other documentation for those Medicaid/NJ FamilyCare fee-for-service beneficiaries selected for a quality assurance review.

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

(b) The professional staff from the MACC will use the standards listed at (c) through (j) below to conduct a post-payment quality assurance review of home care services as provided to the Medicaid/NJ FamilyCare fee-for-service beneficiary.

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

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

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

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

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

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

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

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

2. The agency shall strive for consistency when assigning staff to beneficiaries with the intent of assuring continuity of care for the beneficiary, unless there are unusual documented circumstances, such as a difficult beneficiary/caregiver relationship, difficult location, or personal reasons of aide or beneficiary/caregiver.

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

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

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

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

7. Registered nurse delegated tasks shall be provided by licensed practical nurses (LPN), certified nursing assistants (CNA), or certified home health aides (CHHA).

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

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

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

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

4. For physical therapy standards, see *N.J.A.C. 10:60-2.1(d)*5ii(1)(E).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History

HISTORY:

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 10:60-1.15 by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), *28 N.J.R. 289(a)*.

Recodified from *N.J.A.C. 10:60-1.16* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Rewrote (a); in (b), inserted a reference to NJ KidCare fee-for-service; in (e)4, amended the N.J.A.C. reference; in (i)1, inserted "or Medicare and/or NJ KidCare" following "Medicare and/or Medicaid"; and substituted references to

beneficiaries for references to recipients throughout. Former *N.J.A.C. 10:60-1.8*, Basis of payment for home health services, recodified to *N.J.A.C. 10:60-2.5*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "DDS or DMAHS" for "the Division", "CMS" for "HCFA", "FamilyCare" for "KidCare", and "MACC" for "MDO" throughout; in the introductory paragraph of (a), substituted "MACCs" for "MDO's", "the date on which" for "when"; in (a)1, substituted "authorizing" for "prescribing", and inserted ", as necessary or appropriate, based on the service"; and in (a)4, substituted "DDS or DMAHS will" for "the Division shall", "DDS' or DMAHS'" for "the Division's" and "*N.J.A.C. 10:60-1.10*" for "N.J.A.C. 10:60-10".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote (a); in the introductory paragraph of (d), substituted "Home" for "Homemaker-home"; and added (d)7.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Rewrote the section.

Annotations

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N.J.A.C. 10:60-1.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:60-1.9 On-site monitoring visits

(a) For an accredited health care service firm, home health agency, or hospice agency, on-site monitoring visits will be made periodically by DDS or DMAHS staff, or by staff of an accreditation organization, as approved by DMAHS, to the agency to review compliance with personnel, recordkeeping, and service delivery requirements using forms as approved by either Division. The results of such monitoring visits shall be reported to the agency, by DDS or DMAHS, or by staff of an accreditation organization, as approved by DMAHS, and when indicated, a plan of correction shall be required. Continued non-compliance with requirements shall result in such sanctions as curtailment of accepting new beneficiaries for services, suspension, or rescission of the agency's provider agreement.

1. The professional staff from the MACC will use the standards listed in this chapter to conduct a post-payment quality assurance review of home care services as provided to the Medicaid/NJ FamilyCare fee-for-service beneficiary.

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

History

HISTORY:

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 10:60-1.16 by R.1996 d.43, effective January 16, 1996.

See: 27 N.J.R. 279(a), *28 N.J.R. 289(a)*.

Recodified from *N.J.A.C. 10:60-1.17* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (a), substituted "Division" for "Medicaid District Office" preceding "and when indicated,"; substituted references to beneficiaries for references to recipients throughout the section. Former *N.J.A.C. 10:60-1.9*, Out-of-State approved home health agencies, recodified to *N.J.A.C. 10:60-1.4*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "DDS or DMAHS" for "Division" and "the Division" throughout; in (a), substituted "will" for "shall" following "visits" in the first sentence; and in (b), substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote (a).

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (a)1, substituted "Medicaid/NJ FamilyCare" for "Medicaid or NJ FamilyCare".

Annotations

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N.J.A.C. 10:60-1.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:60-1.10 Provisions for fair hearings

Providers and Medicaid/NJ FamilyCare-Plan A beneficiaries can request fair hearings as set forth in the Administration chapter at *N.J.A.C. 10:49-9.14*. NJ FamilyCare-Plan B and C fee-for-service beneficiaries can utilize the grievance board as set forth at N.J.A.C. 10:49-9.

History

HISTORY:

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 10:60-1.17 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.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: *30 N.J.R. 3198(a)*, *30 N.J.R. 4377(a)*.

Substituted a reference to beneficiaries for a reference to recipients.

Recodified from *N.J.A.C. 10:60-1.18* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Rewrote the section. Former *N.J.A.C. 10:60-1.10*, Personal care assistant services, repealed.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "FamilyCare" for "KidCare" two times.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Substituted "Medicaid/NJ FamilyCare" for "Medicaid or NJ FamilyCare" and "at" for "in".

Annotations

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End of Document

N.J.A.C. 10:60-1.11

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§ 10:60-1.11 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-3.7* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Annotations

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N.J.A.C. 10:60-1.12

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:60-1.12 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-1.5* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Annotations

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N.J.A.C. 10:60-1.13

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§ 10:60-1.13 (Reserved)

History

HISTORY:

Repealed by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Eligibility for early and periodic screening and diagnosis and treatment/Private duty nursing services".

Annotations

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N.J.A.C. 10:60-1.14

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§ 10:60-1.14 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-1.6* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Annotations

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N.J.A.C. 10:60-1.15

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§ 10:60-1.15 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-1.7* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Annotations

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N.J.A.C. 10:60-1.16

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:60-1.16 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-1.8* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Annotations

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End of Document

N.J.A.C. 10:60-1.17

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:60-1.17 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-1.9* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Annotations

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N.J.A.C. 10:60-1.18

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§ 10:60-1.18 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-1.10* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:60-2.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 2. HOME HEALTH AGENCY (HHA) SKILLED SERVICES

§ 10:60-2.1 Covered home health agency services

(a) Home health care services covered by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs are limited to those services provided directly by a home health agency approved to participate in the New Jersey Medicaid/NJ FamilyCare program or through arrangement by that agency for other services.

1. Medicaid/NJ FamilyCare reimbursement is available for these services when provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries 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/NJ FamilyCare fee-for-service coverage.

ii. Home health services shall not be available to Medicaid/NJ FamilyCare fee-for-service beneficiaries 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 beneficiary 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 beneficiary 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 beneficiary's responses to care and treatment;

v. Teaching, supervising and consulting with the beneficiary 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 beneficiaries;

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

(3) Developing the beneficiary'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 beneficiary with practice in the use of prosthetic and orthotic devices and durable medical equipment as ordered;

ix. Providing the beneficiary 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. Skilled nursing supervision of a home health aide, licensed practical nurse or personal care assistant shall be covered as an overhead administrative cost and shall not be billed as a separate unit of service.

3. If two health care workers are required to provide care and the second worker is not in a supervisory capacity, two or more units of service may be covered for the simultaneous care. If two health care workers are present, but only one is needed to provide the care, only the unit(s) of service for the one worker providing the care shall be covered.

4. 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 beneficiary 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 beneficiary's room, personal laundry, shopping, meal planning and preparation. In contrast, personal care services may include assisting the beneficiary 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 beneficiary, as well as the need for physician/practitioner prescribed personal care and other health services, and not solely the beneficiary's medical diagnosis.

ii. The registered professional nurse, in accordance with the physician's/practitioner'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 beneficiary and the resources of the beneficiary, 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 beneficiary'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 beneficiary and determine whether goals are being met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

v. Preparing psychosocial histories and clinical notes.

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

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

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

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

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

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

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

vii. Preparing clinical and dietary progress notes.

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

i. When a beneficiary requires more than one month of medical supplies, prior authorization for the supplies shall be requested and received from the Division. Requests for prior authorization of an unusual or an excessive amount of medical supplies provided by an approved medical supplier shall be accompanied by a personally signed, legible prescription from the attending physician/practitioner. If a beneficiary is an enrollee of a private HMO, prior authorization shall be obtained from the private HMO.

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

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

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

9. Personal care assistant services shall be as described in N.J.A.C. 10:60-3.

(e) Medical equipment is an item, article, or apparatus which is used to serve a medical purpose, is not useful to a person in the absence of disease, illness, or injury, and is capable of withstanding repeated use (durable). When durable medical equipment is essential in enabling the home health agency to carry out the plan of care for a beneficiary, a request for authorization for the equipment shall be made by an approved medical supplier. The request for authorization shall be submitted to DDS or DMAHS and shall include a personally signed, legible prescription from the attending physician/practitioner, as well as a personally signed legible prescription from the MCO, if applicable. Durable medical equipment, either rented or owned by the home health agency, shall not be billed to the New Jersey Medicaid/NJ FamilyCare program, as applicable (see Medical Supplier Services chapter, *N.J.A.C. 10:59*).

History

HISTORY:

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

Administrative Correction.

See: 26 N.J.R. 2285(a).

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.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: *30 N.J.R. 3198(a)*, *30 N.J.R. 4377(a)*.

In (d), inserted new 2 and 3, and recodified former 2 through 7 as 4 through 9.

Recodified from *N.J.A.C. 10:60-1.4* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (a), inserted references to NJ KidCare fee-for-service throughout, and inserted a reference to NJ KidCare in the introductory paragraph; substituted references to beneficiaries for references to recipients throughout the section. Former *N.J.A.C. 10:60-2.1*, Community Care Program for the Elderly and Disabled (CCPED), recodified to N.J.A.C. 10:60-10.1(a) and (b).

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "FamilyCare" for "KidCare" throughout; and in (e), substituted "DDS or DMAHS" for "the Division", and deleted "-1.5 through 1.7".

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

Case Notes

Patient who was able to independently perform the necessary activities of daily living was not entitled to Personal Care Assistant (PCA) hours was not entitled to such services because they were needed solely for the purpose of carrying out household duties, and such services were not properly provided in the absence of a documented need for "hands-on" personal care needs. *I.S. v. DMAHS et al., OAL DKT. NO. HMA 04985-18, 2019 N.J. AGEN LEXIS 247*, Final Agency Determination (January 2, 2019).

Sixty-year old man diagnosed with ankylosing spondylitis, hypertension, arthritis and blindness in his left eye but without any cognitive impairment was not entitled to Personal Care Assistance (PCA). Though he would benefit

from assistance with housekeeping-type tasks, such duties were considered to be "covered services" only when combined with personal care and other health services. Since he did not need personal care or other health services, the determination to terminate his PCA hours was proper. *J.P. v. United Healthcare, OAL DKT. NO. HMA 10549-16, 2016 N.J. AGEN LEXIS 1009*, Initial Decision (November 23, 2016).

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

N.J.A.C. 10:60-2.2

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 2. HOME HEALTH AGENCY (HHA) SKILLED SERVICES

§ 10:60-2.2 Certification of need for home health services

(a) To qualify for payment of home health services by the New Jersey Medicaid/NJ FamilyCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the home health agency by the attending physician/practitioner. The nurse or therapist shall immediately record and sign verbal orders and obtain the physician's/practitioner's counter signature, within 30 days of the date of the order.

(b) Except as provided in (b)1 below, home health services shall not be provided or reimbursed, except when provided in accordance with all of the certification and face-to-face encounter provisions of Sections 6407(a) and (d), 3108 and 10605 of the Patient Protection and Affordable Care Act, 111 Pub.L. 148, as amended and supplemented, incorporated herein by reference, *42 U.S.C. § 1395n*, incorporated herein by reference, and *42 CFR 424.22(a)* and (b), incorporated herein by reference.

1. Telehealth technology may be used to provide the face-to-face encounter required under (b) above.

2. The "face-to-face encounter" between an authorized physician/practitioner and a NJ Medicaid/FamilyCare beneficiary for the initial certification for the provision of home care services must occur no more than 90 days prior to the date home care is started or within 30 days of the start of home care, including the date of the encounter.

i. Recertification of the need for home care services shall be done at least every 60 days and must be signed and dated by the physician/practitioner who reviews the plan of care. A face-to-face encounter is not required for recertification.

3. An authorized physician/practitioner must provide the home care provider the date, time, and location of the "face-to-face encounter" and his or her signature confirming that the encounter was conducted.

4. Home care providers are required to maintain proof of a "face-to-face encounter" including the date, time, location, and signature of the authorizing physician/practitioner. Such documentation may be subject to review by the New Jersey Department of Human Services or its authorized agent.

5. Failure to comply with the "face-to-face encounter" and documentation requirements in (b) and (b)2, 3, and 4 above, may result in the recoupment of Medicaid/NJ FamilyCare payments for home care services.

(c) For beneficiaries who are enrolled in managed care, all home health services must be determined to be medically necessary and prior authorized by the MCO before services are rendered.

History

HISTORY:

New Rule, R.1994 d.41, effective January 18, 1994.

See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

§ 10:60-2.2 Certification of need for home health services

Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: *30 N.J.R. 3198(a)*, *30 N.J.R. 4377(a)*.

Inserted a reference to NJ KidCare fee-for-service and substituted a reference to beneficiaries for a reference to recipients in the first sentence.

Recodified from *N.J.A.C. 10:60-1.5* by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Former *N.J.A.C. 10:60-2.2*, Eligibility requirements for CCPED, recodified to N.J.A.C. 10:60-10.1(c) through (g).

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Section was "Certification of need for services". Substituted "FamilyCare" for "KidCare".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

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N.J.A.C. 10:60-2.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:60-2.3 Plan of care

(a) An interdisciplinary plan of care shall be developed by agency personnel in cooperation with the attending physician/practitioner, and be approved by the attending physician/practitioner. It shall include, but not be limited to, medical, nursing, therapies, nutrition, home health aide services, and social care information. The plan shall be re-evaluated by the nursing staff at least every 60 days and revised as necessary, appropriate to the beneficiary's condition. The following shall be part of the plan of care:

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

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

3. The period covered by the plan;

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

5. Additional health related services supplied by other providers;

6. A copy of physician's/practitioner's initial orders and any subsequent verbal or written orders for changes to the plan of care;

7. Medications, treatments and personnel involved;

8. Equipment and supplies required;

9. Goals, long and short-term;

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

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

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

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

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

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

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

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

History

HISTORY:

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 *N.J.A.C. 10:60-1.6* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Substituted references to beneficiaries for references to recipients throughout. Former *N.J.A.C. 10:60-2.3*, Services available under CCPED, recodified to N.J.A.C. 10:60-10.1(h) through (k).

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the introductory paragraph of (a).

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Rewrote the section.

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N.J.A.C. 10:60-2.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:60-2.4 Clinical records

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

1. A plan of care as described in N.J.A.C. 10:60-2.3;

2. Appropriate identifying information;

3. The name, address, and telephone number of beneficiary's physician/practitioner;

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

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

6. Summary reports of pertinent factors from the clinical notes of the nurses, social workers, and special therapists providing services, which shall be submitted to the attending physician/practitioner at least every 60 days; and

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

History

HISTORY:

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 N.J.A.C. 10:60-1.7 and amended by R.2001 d.14, effective January 2, 2001.

See: 32 N.J.R. 3940(a), 33 N.J.R. 66(a).

In (a)1, amended the N.J.A.C. reference; substituted references to beneficiaries for references to recipients throughout the section. Former N.J.A.C. 10:60-2.4, Procedures used as financial controls for CCPED, repealed.

Amended by R.2022 d.107, effective September 6, 2022.

See: 53 N.J.R. 1327(a), 54 N.J.R. 1721(a).

Substituted "physician/practitioner" for "physician" twice; in (a)3, inserted a comma following "address"; and in (a)6, substituted "60 days" for "two months".

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N.J.A.C. 10:60-2.5

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§ 10:60-2.5 Basis of payment for home health services

(a) Effective for services rendered on or after January 1, 1999, home health agencies shall be reimbursed the lesser of reasonable and customary charges or the service-specific unit rates described in this subsection. The following are the service-specific Statewide unit rates by each service:

Revenue Code	Description	Base Amount Per Unit
420	Physical Therapy	$ 24.06
430	Occupational Therapy	$ 23.81
440	Speech Therapy	$ 20.27
550	Skilled Nursing	$ 29.14
560	Medical Social Services and Dietary/Nutritional Services	$ 25.90
570	Home Health Aide	$ 6.22

(b) Effective January 1, 2000, and thereafter, the reimbursement rates shall be the service-specific Statewide per unit rates found in (a) above, incrementally adjusted each January 1, beginning on January 1, 2000, using Standard and Poor's DRI Home Health Market Basket Index, published in the New Jersey Register as a notice of administrative change, in accordance with N.J.A.C. 1:30-2.7, and posted on the DMAHS' fiscal agent's website https://www.njmmis.com under "Rate and Code Information". Home health agencies shall maintain both unit and visit statistics for all services provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries.

(c) Effective January 1, 1999, home health agencies shall bill the Medicaid/NJ FamilyCare fiscal agent as follows:

1. The unit of service shall be a 15 minute interval of a skilled nursing visit, a home health aide visit, a speech therapy visit, a physical therapy visit, an occupational therapy visit, a nutrition visit, or a medical social service visit, as defined at N.J.A.C. 10:60-1.2. A home health agency shall not bill when a Medicaid/NJ FamilyCare fee-for-service beneficiary is not home or cannot be found, and hands-on medical care was not provided;

2. The service-specific Statewide rate shall be billed for each full 15 minute interval of face-to-face service in which hands-on medical care was provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary;

i. For instance, one unit of service shall be billed for services provided from the initial minute through 29 minutes. The second unit of service shall be billed for services provided from 30 minutes through 44 minutes. The third unit of service shall be billed for services provided from 45 minutes to 59 minutes and the fourth unit of service shall be billed for services provided from 60 minutes through 74 minutes;

3. Items including, but not limited to, nursing supervision, travel time, paperwork, and telephone contact at the home are included in the service-specific Statewide rate and, therefore, the time associated with these items is not billed directly;

4. A separate line shall be billed for each day the service is provided. A home health agency shall not "span bill" for services;

5. Routine supplies shall be considered visit overhead costs and billed as part of a unit of service. Non-routine supplies shall be billed using Revenue Code 270 on the institutional claim form and HCPCS codes in accordance with N.J.A.C. 10:59-2;

6. A home health agency shall only bill the revenue codes listed in (a) above and Revenue Code 270. No other revenue codes will be reimbursed for home health services.

(d) Home health agencies shall submit a cost report for each fiscal year to the Director, Office of Reimbursement, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712 or the Director's designee. The cost report shall be legible and complete in order to be considered acceptable.

1. Cost reports and audited financial statements shall be due on or before the last day of the fifth month following the close of the period covered by the report.

2. A 30-day extension of the due date of a cost report may be granted by the Division for "good cause." "Good cause" means a valid reason or justifiable purpose; it is one that supplies a substantial reason, affords a legal excuse for delay, or is the result of an intervening action beyond one's control. Acts of omission and/or negligence by the home health agency, its employees, or its agents, shall not constitute "good cause."

3. To be granted the extension in (d)2 above, the provider shall submit a written request to, and obtain written approval from, the Director, Office of Reimbursement, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712 or the Director's designee, at least 30 days before the due date of the cost report.

4. If a provider's agreement to participate in the Medicaid/NJ FamilyCare fee-for-service program terminates or the provider experiences a change of ownership, the cost report is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

5. Failure to submit an acceptable cost report on a timely basis may result in suspension of payments. Payments for claims received on or after the date of suspension may be withheld until an acceptable cost report is received.

(e) Medicare/Medicaid and Medicaid/NJ FamilyCare third-party claims for home health services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with *N.J.A.C. 10:49-7.3* and the provisions of this chapter.

(f) When Medicaid/NJ FamilyCare is not the primary payer on a home health services claim, payment by Medicaid/NJ FamilyCare will be made at the lesser of:

1. The Medicaid/NJ FamilyCare allowed amount minus any other payment(s); or

2. The beneficiary liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

(g) In no event will a Medicaid/NJ FamilyCare payment for home health services exceed the total charge amount submitted on the claim.

(h) The State will perform a post-payment review of home health claims for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) when Part A benefits exhaust during home health services. Based on the post-payment review, the Division will determine whether paying the beneficiary's liability for the home health services will result in a lower cost to the Division. If paying the beneficiary's liability results in a lower cost to the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

1. Where benefits have been exhausted under Medicare Part A, the charges to be billed to the Medicaid/NJ FamilyCare Program must be itemized for the Medicare Part A non-covered services in order to determine the liability of Medicare Part B and other third-party payers.

(i) If prior authorization is required for Medicaid/NJ FamilyCare program purposes, it shall be obtained and shall be submitted with the institutional claim form.

History

HISTORY:

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.1998 d.586, effective December 21, 1998 (operative January 1, 1999).

See: *30 N.J.R. 3198(a)*, *30 N.J.R. 4377(a)*.

Rewrote the section.

Administrative change.

See: *32 N.J.R. 809(a)*.

Recodified from *N.J.A.C. 10:60-1.8* by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Former *N.J.A.C. 10:60-2.5*, Basis for home health agency reimbursement and cost reporting (CCPED), repealed.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Section was "Basis of payment of home health services". Substituted "FamilyCare" for "KidCare" throughout; in (e), substituted "DMAHS" for "the Division"; in the address in (e)2ii, substituted "Financial Support" for "Provider Rate Setting" and "#23" for "#43"; and in (h), substituted "Office of Financial Support" for "Administrative and Financial Services" and "#23" for "#43".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (c)1, inserted "a nutrition visit,", substituted "at" for "in", and updated the N.J.A.C. reference.

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N.J.A.C. 10:60-2.6

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§ 10:60-2.6 Limitations on home health agency 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 Division retains the right to limit or deny the provision of home care services on a prospective basis.

(b) For limitations on Personal Care Assistant (PCA) services see *N.J.A.C. 10:60-3.8*.

History

HISTORY:

New Rule, R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Former *N.J.A.C. 10:60-2.6*, Basis for homemaker agency reimbursement (CCPED), repealed.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Section was "Limitations of home health agency services".

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N.J.A.C. 10:60-2.7

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§ 10:60-2.7 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-6.1* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Model Waiver Programs".

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N.J.A.C. 10:60-2.8

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§ 10:60-2.8 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:60-6.2* by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Eligibility requirements for Model Waivers".

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N.J.A.C. 10:60-2.9

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§ 10:60-2.9 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-6.3 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Services included under the Model Waiver programs".

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N.J.A.C. 10:60-2.10

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§ 10:60-2.10 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-6.4 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Basis for reimbursement for Model Waiver services".

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N.J.A.C. 10:60-2.11

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§ 10:60-2.11 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-6.5 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Procedures used as financial controls".

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N.J.A.C. 10:60-2.12

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§ 10:60-2.12 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-7.1 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "AIDS Community Care Alternatives Program (ACCAP)".

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N.J.A.C. 10:60-2.13

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§ 10:60-2.13 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-7.2 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Application process for ACCAP".

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N.J.A.C. 10:60-2.14

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§ 10:60-2.14 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-7.3 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Eligibility criteria".

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N.J.A.C. 10:60-2.15

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§ 10:60-2.15 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-7.4 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "ACCAP services".

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N.J.A.C. 10:60-2.16

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§ 10:60-2.16 (Reserved)

History

HISTORY:

Recodified to N.J.A.C. 10:60-7.5 by R.2001 d.14, effective January 2, 2001.

See: *32 New Jersey Register 3940(a)*, *33 New Jersey Register 66(a)*.

Section was "Basis for reimbursement for ACCAP services".

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N.J.A.C. 10:60-3.1

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 3. PERSONAL CARE ASSISTANT (PCA) SERVICES

§ 10:60-3.1 Purpose and scope

(a) Personal care assistant services shall be provided by a certified licensed home health agency, a certified hospice agency or by a health care service firm that is accredited, initially, and on an on-going basis, by an accrediting body approved by DMAHS.

(b) Personal care assistant services include health-related tasks associated with the cueing, supervision, and/or completion of the activities of daily living (ADL), as well as instrumental activities of daily living (IADL) related tasks performed by a qualified individual in a beneficiary's place of residence or place of employment, or at a post-secondary educational or training program, under the supervision of a registered professional nurse, certified as medically necessary by a physician/practitioner in accordance with a written plan of care. These services are available from a home health agency, hospice agency, or a health care services firm. The purpose of personal care assistant services is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses.

1. Personal care assistant services are those services described at *N.J.A.C. 10:60-3.3(a)*1.

2. Instrumental activities of daily living are those activities described at *N.J.A.C. 10:60-3.3(b)*.

3. Health related tasks are those services described at *N.J.A.C. 10:60-3.3(a)*3.

4. A qualified individual is a person who is a personal care assistant, as the term is defined at *N.J.A.C. 10:60-1.2*.

(c) In order to qualify for PCA services, beneficiaries must be in need of moderate, or greater, hands-on assistance in at least one activity of daily living (ADL), or, minimal assistance or greater in three different ADLs, one of which must require hands-on assistance.

1. Assistance with IADLs, such as meal preparation, laundry, housekeeping/cleaning, shopping, or other non-hands-on personal care tasks shall not be permitted as a stand-alone PCA service.

2. When a beneficiary lives with a legally responsible relative, the LRR is expected to provide assistance with non-hands-on IADL care tasks that benefit the household as a whole, such as household/cleaning of shared living spaces, laundry of common use items, shopping for items to be shared among household members, such as cleaning supplies or food for shared meals, and meal preparation.

History

HISTORY:

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

In (b), substituted "include personal care, household duties and" for "are", deleted designation "1.", and inserted "assistant services"; and added (b)1 through (b)4.

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (b), substituted "health-related" for "health related", and "physician/practitioner" for "physician or advanced practice nurse".

Annotations

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Case Notes

Health insurer's determination to reduce Personal Care Assistant (PCA) service hours allocated to a 74 year old man who suffered from dementia, Parkinson's disease and various other conditions was rejected by an ALJ. The insurer's own reassessment nurse had calculated that the patient needed 62.33 PCA hours a week but that allocation had been reduced to 53 by the insurer's medical director based only on the assessment tool and her own impression of the patient's needs. The nurse's determination that the patient needed 62.33 PCA hours per week should have been approved. *R.L. v. United Health Care, OAL DKT. NO. HMA 08079-17, 2017 N.J. AGEN LEXIS 823*, Initial Decision (November 13, 2017).

DMAHS director modified an Initial Decision awarding 21 hours per week of Personal Care Assistant (PCA) services to a 24 year old male with autism, severe cognitive disabilities, obsessive-compulsive disorder and communication deficits, reducing the allowance to 16.5 hours per week. While the ALJ should not have made any award for certain tasks such as laundry, the ALJ's decision only allowed time for 16 meals per week when in fact the caregiver provided the patient with 18, so additional time was properly allocated. *I.W. v. Horizon NJ Health, OAL DKT. NO. HMA 08128-16, 2017 N.J. AGEN LEXIS 1053*, Final Agency Determination (May 15, 2017).

Challenge by a recipient of Personal Care Assistant (PCA) services to an order terminating those services was rejected because while the evidence showed that the recipient derived a significant degree of comfort and emotional well-being from the presence of an aide, the recipient in fact was able to perform the activities of daily living without hands-on assistance and thus did not qualify for PCA services at that time. *D.F. v. United Healthcare, OAL DKT. NO. HMA 02584-17, 2017 N.J. AGEN LEXIS 312*, Initial Decision (May 10, 2017).

Twenty-four year old male who suffered from autism, severe cognitive disabilities, obsessive-compulsive disorder and communication deficits was entitled to an allowance for Personal Care Assistant (PCA) Services of 21 hours per week because his condition was such that he needed nearly constant monitoring, could not shower or perform personal hygiene tasks without supervision, could not eat without assistance and supervision, and required close supervision for all activities of daily living. *I.W. v. Horizon NJ Health, OAL DKT. NO. HMA 8128-16, 2017 N.J. AGEN LEXIS 146*, Initial Decision (March 13, 2017).

Nine-year old child who was diagnosed with Down Syndrome, asthma, hypothyroidism and mental impairment was entitled to 17 hours a week of personal care under the Personal Preference Program because there was no evidence offered to rebut the insurer's conclusion that that allowance was properly reduced from 22 to 17 hours per week based upon the results of a PCA assessment. *A.I. v. Amerigroup, OAL DKT. NO. HMA 17827-16, 2017 N.J. AGEN LEXIS 78*, Initial Decision (February 6, 2017).

Personal care assistant (PCA) hours allotted to an 86-year old woman with various medical problems and cognitive deficits were improperly reduced because the 25 hour allotment previously made was still appropriate. The women needed assistance with toileting, preparation of her meals, supervision to assure that she ate her meals, and maintenance of cleanliness of the bathroom. Because such duties were essential to the woman's health and comfort, they were appropriately undertaken during PCA hours. *L.M. v. Horizon NJ Health, OAL DKT. NO. HMA 15804-16, 2017 N.J. AGEN LEXIS 15*, Initial Decision (January 10, 2017).

Managed care organization (MCO) that "inherited" an insured who was receiving Personal Care Assistant Services (PCA) based on an assessment by the predecessor MCO did not have the burden to disprove the prior assessment or award of PCA hours. *D.B. v. United Healthcare, OAL DKT. NO. HMA 03233-16, 2016 N.J. AGEN LEXIS 1154*, Final Administrative Determination (August 3, 2016).

Provider's reduction of personal health care assistant service hours allotted to an adult male who was diagnosed with autism and obsessive-compulsive disorder was rejected on findings that the allocations made by the provider per *N.J.A.C. 10:60-3.1* were clearly insufficient to address the danger that he would injure himself if permitted to undertake certain tasks like bathing and toileting without supervision. *T.W. v. United Healthcare, OAL DKT. NO. HMA 13094-15, 2015 N.J. AGEN LEXIS 427*, Initial Decision (November 13, 2015).

Reduction in personal care assistant (PCA) hours granted to an 82-year old Medicaid recipient was sustained by an ALJ on findings that the recipient did not demonstrate why the assessment on which his PCA hours were reduced was incorrect or why he could not function on 19 hours of PCA per week. The recipient did not dispute the basic findings in the assessment but simply claimed he needed more time to complete some of those tasks. *W.S., Jr. v. United Healthcare, OAL DKT. NO. HMA 2044-15, 2015 N.J. AGEN LEXIS 454*, Initial Decision (July 16, 2015).

N.J.A.C. 10:60-3.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 3. PERSONAL CARE ASSISTANT (PCA) SERVICES

§ 10:60-3.2 Basis for reimbursement for personal care assistant services

(a) Personal care assistant services shall be reimbursable when provided to Medicaid/NJ FamilyCare beneficiaries in their place of residence or place of employment, or at a post-secondary educational or training program. The term "place of residence" shall include, but is not limited to:

1. A private home;

2. A rooming house;

3. A boarding home (not Class C);

4. A Child Protection and Permanency resource family home;

5. A Division of Developmental Disabilities (DDD) group home, skill development home, supervised apartment, or other congregate living program where personal care assistance is not provided as part of the service package which is included in the beneficiary's living arrangement; or

6. Temporary emergency housing arrangements including, but not limited to, a hotel or shelter.

History

HISTORY:

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Rewrote (a)5.

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Annotations

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§ 10:60-3.2 Basis for reimbursement for personal care assistant services

ALJ found that a community health plan acted improperly when it reduced a member's personal care assistant (PCA) hours below the 33 hours weekly on which she had been previously maintained and that the health plan had not provided the member with an opportunity to fully explore the ostensible grounds for the reduction because the key witness who had performed the assessment on which the health plan had relied in reducing the PCA hours was not presented as a witness who could testify on the contents of her report. *B.G. v. United Healthcare, OAL DKT. NO. HMA 10992-15, 2015 N.J. AGEN LEXIS 708*, Initial Decision (October 13, 2015).

N.J.A.C. 10:60-3.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

§ 10:60-3.3 Covered personal care assistant services

(a) Hands-on personal care assistant services are described as follows:

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

i. Care of the teeth and mouth;

ii. Grooming, such as care of hair, including shampooing, shaving, and the ordinary care of nails if the need for such assistance is due to the beneficiary's upper extremities or motor skills being affected by a disability, or whose level of cognitive disability requires such assistance regardless of mobility level of the upper extremities;

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

iv. Using the toilet or bed pan;

v. Changing bed linens with the beneficiary in bed;

vi. Ambulation indoors and outdoors, when appropriate;

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

viii. Assistance with eating, including, but not limited to, placing food and/or liquids into mouth, and assistance with swallowing difficulties;

ix. Dressing; and

x. Accompanying the beneficiary, for the purpose of providing personal care assistance services, to clinics, physician/practitioner office visits, and/or other trips made for the purpose of obtaining medical diagnosis or treatment, or to otherwise serve a therapeutic purpose.

(b) Instrumental activities of daily living (IADL) services are non-hands-on personal care assistant services that are essential to the beneficiary's health and comfort and shall include, but are not limited to:

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

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

3. Care of bathroom used by the beneficiary, including maintaining cleanliness of toilet, tub, shower, sink, and floor;

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

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

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

7. Listing food and household supplies needed for the health and maintenance of the beneficiary;

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

9. Planning, preparing (including special therapeutic diets for the beneficiary), and serving meals; and

10. Relearning household skills.

(c) Health related activities, performed by a personal care assistant, shall be limited to:

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

2. Rubbing the beneficiary's back if not contraindicated by physician;

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

4. Assisting the beneficiary 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 beneficiary can use equipment safely;

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

6. Nurse delegated tasks approved by the supervising registered professional nurse.

History

HISTORY:

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (a)1x, substituted "physician/practitioner" for "physician", and inserted a comma following "treatment".

Annotations

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Patient who was able to independently perform the necessary activities of daily living was not entitled to Personal Care Assistant (PCA) hours was not entitled to such services because they were needed solely for the purpose of carrying out household duties, and such services were not properly provided in the absence of a documented need for "hands-on" personal care needs. *I.S. v. DMAHS et al., OAL DKT. NO. HMA 04985-18, 2019 N.J. AGEN LEXIS 247*, Final Agency Determination (January 2, 2019).

§ 10:60-3.3 Covered personal care assistant services

Health insurer's determination to reduce Personal Care Assistant (PCA) service hours allocated to a 74 year old man who suffered from dementia, Parkinson's disease and various other conditions was rejected by an ALJ. The insurer's own reassessment nurse had calculated that the patient needed 62.33 PCA hours a week but that allocation had been reduced to 53 by the insurer's medical director based only on the assessment tool and her own impression of the patient's needs. The nurse's determination that the patient needed 62.33 PCA hours per week should have been approved. *R.L. v. United Health Care, OAL DKT. NO. HMA 08079-17, 2017 N.J. AGEN LEXIS 823*, Initial Decision (November 13, 2017).

ALJ's conclusion that a recipient of Personal Care Assistance (PCA) based on her diagnoses including Down Syndrome, diabetes and Alzheimer's was entitled to more than the 53 hours allocated by an insurer was not clearly supported by the record with the result that the matter was properly returned to the insurer for an evaluation of the recipient's specific needs including the specific services identified in governing regulations. *K.M. v. Wellcare of N.J., OAL DKT. NO. HMA 03808-17, 2017 N.J. AGEN LEXIS 1293*, Order Remanding for Further Proceedings (August 31, 2017).

Assessment of the needs for Personal Care Assistance (PCA) of a 48 year old woman diagnosed with Down Syndrome, diabetes and Alzheimer's as calculated by an RN using the mandated PCANT tool as requiring 53 hours of PCA shortchanged the woman because she also required services such as assistance with personal hygiene, grooming, bathing, toileting, transfer and ambulation, dressing, and meal preparation. That being so, a reevaluation of the woman's needs considering services detailed in *N.J.A.C. 10:60-3.3(a)* was properly ordered. *K.M. v. Wellcare of N.J., OAL DKT. NO. HMA 03808-17, 2017 N.J. AGEN LEXIS 496*, Initial Decision (June 30, 2017).

DMAHS director modified an Initial Decision awarding 21 hours per week of Personal Care Assistant (PCA) services to a 24 year old male with autism, severe cognitive disabilities, obsessive-compulsive disorder and communication deficits, reducing the allowance to 16.5 hours per week. While the ALJ should not have made any award for certain tasks such as laundry, the ALJ's decision only allowed time for 16 meals per week when in fact the caregiver provided the patient with 18, so additional time was properly allocated. *I.W. v. Horizon NJ Health, OAL DKT. NO. HMA 08128-16, 2017 N.J. AGEN LEXIS 1053*, Final Agency Determination (May 15, 2017).

Twenty-four year old male who suffered from autism, severe cognitive disabilities, obsessive-compulsive disorder and communication deficits was entitled to an allowance for Personal Care Assistant (PCA) Services of 21 hours per week because his condition was such that he needed nearly constant monitoring, could not shower or perform personal hygiene tasks without supervision, could not eat without assistance and supervision, and required close supervision for all activities of daily living. *I.W. v. Horizon NJ Health, OAL DKT. NO. HMA 8128-16, 2017 N.J. AGEN LEXIS 146*, Initial Decision (March 13, 2017).

Personal care assistant (PCA) hours allotted to an 86-year old woman with various medical problems and cognitive deficits were improperly reduced because the 25 hour allotment previously made was still appropriate. The women needed assistance with toileting, preparation of her meals, supervision to assure that she ate her meals, and maintenance of cleanliness of the bathroom. Because such duties were essential to the woman's health and comfort, they were appropriately undertaken during PCA hours. *L.M. v. Horizon NJ Health, OAL DKT. NO. HMA 15804-16, 2017 N.J. AGEN LEXIS 15*, Initial Decision (January 10, 2017).

Agency not only agreed that a 51-year old male who suffered from various health conditions including mental retardation needed 18 hours of Personal Care Assistant (PCA) services - or twice the number of hours offered by the provider - but added an additional two hours per week on the ground that the same was needed for medical visits and the administration of medication. That finding was based, at least in part, on the parties' recognition that the patient was experiencing an age-related cognitive decline and becoming more impaired over time. *D.S. v. Horizon NJ Health, OAL DKT. NO. HMA 09417-16, 2016 N.J. AGEN LEXIS 1367*, Final Administrative Determination (December 9, 2016).

Sixty-year old man diagnosed with ankylosing spondylitis, hypertension, arthritis and blindness in his left eye but without any cognitive impairment was not entitled to Personal Care Assistance (PCA). Though he would benefit

from assistance with housekeeping-type tasks, such duties were considered to be "covered services" only when combined with personal care and other health services. Since he did not need personal care or other health services, the determination to terminate his PCA hours was proper. *J.P. v. United Healthcare, OAL DKT. NO. HMA 10549-16, 2016 N.J. AGEN LEXIS 1009*, Initial Decision (November 23, 2016).

Because the record of the hearing before the ALJ did not address whether an insured needed medication management of the type contemplated by the regulations governing eligibility for adult day care services (ADHC), the agency rejected the ALJ's determination that the insured had acted appropriately in denying the insured's application for such services. On remand, resources such as nursing notes were properly consulted to determine whether the insured actually required the type of daily assistance with medications provided at an ADHC facility. *A.B. v. Horizon NJ Health, OAL DKT. NOs. HMA 08219-16, 2016 N.J. AGEN LEXIS 1378*, Remand Order (November 16, 2016).

Medical provider's termination of personal care assistant (PCA) hours afforded to a 17-year old with significant, multiple disabilities including quadriplegia, microcephaly, seizures and blindness, rendering him wholly unable to perform any of the activities of daily living was reversed on finding that 10 PCA hours per week would provide a minimum standard of care for the applicant, who also received significant private duty nursing due to his many disabilities. *M.J. v. United Healthcare, OAL DKT. NO. HMA 9861-16, 2016 N.J. AGEN LEXIS 956*, Initial Decision (November 1, 2016).

Health insurer acted improperly when it eliminated the 13 hours of personal care assistant (PCA) services that an elderly man was receiving. The man's throat cancer interfered with his efforts to speak clearly and required him to use a feeding tube. Though there were services such as personal hygiene, toileting and ambulation that the man was able to undertake without assistance, he did require assistance with communication, meal planning and preparation, and maintaining cleanliness of his kitchen, bedroom and bathroom areas. Those needs were such that he was properly afforded eight hours a week of PCA services. *J.L. v. United Healthcare, OAL DKT. NO. HMA 004148-16, 2016 N.J. AGEN LEXIS 579*, Initial Decision (July 8, 2016).

Elderly woman who was diagnosed with arthritis, spinal stenosis, hyperthyroidism, chronic pain and right-side weakness from a stroke prevailed on her challenge to her health care provider's decision to reduce her Personal Care Assistance (PCA) hours from 56 to 35. Though the assessment tool that was used presumably supported the reduction, it was only a "jumping off point" for a determination of patient need and the evidence showed that the services needed by the woman were exactly the kind contemplated by law including assistance with hygiene, grooming, bathing, toileting, transfer, ambulation, dressing, meal preparation and cleanliness. Because the woman demonstrated a need for assistance well beyond the PCA hours yielded via strict application of the tool, the provider's reduction was improper. *B.R. v. United Healthcare, OAL DKT. NO. HMA 20718-15, 2016 N.J. AGEN LEXIS 219*, Initial Decision (April 25, 2016).

Though a disabled Medicaid recipient was not entitled to 40 hours of personal care assistance (PCA), the recipient did establish an entitlement to 30 hours of such assistance. The difference between the 40 hours of PCA sought by the recipient and the 30 hours of PCA recommended by an ALJ included a disallowance of recreation and volunteer activities, food preparation relating to the recipient's preference for a vegetarian diet, and additional time needed for laundering the recipient's clothing separate from the clothing of other family members. *A.V. v. Horizon N.J. Health, OAL DKT. NO. HMA 04469-15, 2015 N.J. AGEN LEXIS 508*, Initial Decision (July 23, 2015).

Reduction in personal care assistant (PCA) hours granted to an 82-year old Medicaid recipient was rejected by an ALJ on findings that the evaluators who assessed the recipient in fact underestimated the recipient's demonstrated needs for PCA services in the areas of dressing, bathing, toileting, personal hygiene/grooming, including his leg/foot care, petitioner's necessary doctor appointments, and his household needs, including meal preparation and shopping. *D.B. v. United Healthcare, OAL DKT. NO. HMA 03869-15, 2015 N.J. AGEN LEXIS 455*, Initial Decision (July 1, 2015).

§ 10:60-3.3 Covered personal care assistant services

Number of hours of Personal Care Assistant services (PCA) received by a patient were properly reduced from 40 to 25 hours a week. An ALJ had found that the patient, who had Down Syndrome, needed the additional hours because she needed a skilled level of care, but skilled nursing care was beyond the scope of PCA services. Nor was there any evidence that the needed services could not be performed within 25 hours a week. In fact, the evidence tended to show that any additional hours would be used for supervision or companionship, neither of which were authorized PCA services. *D.W. v. DMAHS and Div. of Disability Servs., OAL DKT. NO. HMA 2324-12, 2014 N.J. AGEN LEXIS 1287*, Final Administrative Determination (December 19, 2014).

End of Document

N.J.A.C. 10:60-3.4

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§ 10:60-3.4 Certification of need for personal care assistant services

(a) To qualify for payment of personal care assistant services by the New Jersey Medicaid/NJ FamilyCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the health care services firm by a physician/practitioner as medically necessary, at the time of initial application for services and annually thereafter for recertification. The nurse shall immediately record and sign verbal orders and obtain the physician's/practitioner's counter signature within 30 days.

(b) The certification of need for services must be on file in the beneficiary record at the service provider agency before the home health aide begins providing services for the beneficiary. For those cases that originate while a beneficiary is enrolled in a New Jersey Medicaid/NJ FamilyCare managed care plan, the managed care plan authorization is based on medical necessity and shall serve as the certification of medical necessity for personal care assistant services. Services provided during a period where a beneficiary temporarily loses managed care eligibility, but is expected to reenroll the following month, shall be provided fee-for-service until the beneficiary is reenrolled in his or her managed care plan as a continuation of services without the need to obtain any additional certification.

(c) The physician's/practitioner's certification as described at (a) above must confirm that the home care assistance for the beneficiary is medically necessary. Such certification may be contained in a physician/practitioner's order, a prior authorization by a Medical Director in a managed care plan, a prescription, or documentation in the beneficiary Plan of Care (POC).

(d) A recertification of the beneficiary's need for services may be required more frequently in the event of a change in the disability status of the beneficiary enrolled in the PCA program.

(e) For fee-for-service beneficiaries, a recertification of the beneficiary's need for services shall be required in situations in which a certification was obtained from the beneficiary's attending physician/practitioner, and the beneficiary changes his or her physician/practitioner. Managed care plans can recertify the continued need for PCA services through continued prior authorization of services.

(f) For fee-for-service beneficiaries, if a beneficiary is approved to transfer his or her PCA services to another provider agency pursuant to *N.J.A.C. 10:60-3.10*, the new agency is responsible to obtain a new physician/practitioner's certification.

History

HISTORY:

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Section was "Certification of need for services". Substituted "FamilyCare" for "KidCare".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (a), substituted "physician/practitioner" for "physician or advance practice nurse (APN)" and "physician's/practitioner's" for "physician's/APN's"; and in (c), substituted "physician's/practitioner's" for "physician's", and "at" for "in".

Annotations

Notes

Chapter Notes

Case Notes

ALJ rejected a determination by a health care provider that reduced the personal care assistant hours allowed to a care recipient because there was no evidence of a change in the recipient's medical condition. That being so, there was insufficient evidence in the record to determination whether the reduction was appropriate and the matter was properly remanded. *L.S. v. Amerigroup, OAL DKT. NO. HMA 18655-15, 2016 N.J. AGEN LEXIS 80*, Decision Remanding for New Assessment (February 22, 2016).

N.J.A.C. 10:60-3.5

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 3. PERSONAL CARE ASSISTANT (PCA) SERVICES

§ 10:60-3.5 Duties of the registered professional nurse

(a) 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/practitioner'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 beneficiary, hours of service needed, and shall take into consideration the beneficiary'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 beneficiary'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, to determine that the plan of care has been properly implemented, and to document that hands-on personal care is being provided. At this time, appropriate revisions to the plan of care shall be made as needed. Additional supervisory visits shall be made as the situation warrants, such as a new PCA, nurse delegation, or in response to the physical or other needs of the beneficiary. In situations in which multiple personal care assistants are assigned to a case, the in-home supervisory visits shall be rotated until all staff have been assessed during each covered shift. All shift visits must be performed to allow face-to-face supervision of the aide being assessed.

3. A personal care assistant nursing reassessment visit shall be provided at least once every 12 months or more frequently if the beneficiary's condition warrants, to reevaluate the beneficiary's need for continued personal care assistance services. When a case is initiated under fee-for-service, the provider agency nurse shall complete the State-approved PCA Assessment tool at the time of the visit. When a beneficiary is enrolled in a Medicaid/NJ FamilyCare managed care plan, completing the State-approved PCA Assessment tool and subsequent authorization of hours shall be the responsibility of the managed care plan.

History

HISTORY:

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote (a)2 and (a)3.

§ 10:60-3.5 Duties of the registered professional nurse

Amended by R.2022 d.107, effective September 6, 2022.

See: 53 N.J.R. 1327(a), 54 N.J.R. 1721(a).

In (a)1, substituted "physician's/practitioner's" for "physician's".

Annotations

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Chapter Notes

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Hours provided to a single recipient under programs providing Personal Care Assistant (PCA) hours and Private Duty Nursing (PDN) hours, although separate programs, must be considered together in determining the appropriate number of PCA hours that should be provided to the recipient, who was immobilized by reason of cerebral palsy and stroke. Given the extended period of time that the matter had been pending, the Initial Decision reducing the number of PCA hours that were necessary was reversed and the provider was required to assess the recipients current condition within four weeks to determine medical necessity. G.P. v. Amerigroup, OAL DKT. NO. HMA 00032-17, 2019 N.J. AGEN LEXIS 245, Order Reversing and Remanding Initial Decision (February 14, 2019).

New assessment of a patient's need for Personal Care Assistant hours was required because the nurse who had performed the assessment being challenged did not testify at the hearing, so the patient had no opportunity to question her assessment. Moreover, since over six months had passed since the last assessment, a new assessment should be performed. L.S., v. Amerigroup, OAL DKT. NO. HMA 18645-17, 2018 N.J. AGEN LEXIS 739, Final Agency Determination (July 9, 2018).

Applicant who was diagnosed with renal failure, gout, hypertension and debility was properly denied continued personal care assistant (PCA) services. The applicant's testimony regarding his ability to perform activities of daily living was in conflict with information that he provided to a representative of the insurer who had visited the applicant to assess his needs in the context of his actual household. Another factor was that while his wife was present when the representative visited the applicant's household, the applicant testified that he lived alone. C.G. v. Horizon NJ Health, OAL DKT. NO. HMA 12890-16, 2016 N.J. AGEN LEXIS 1271, Initial Decision (December 27, 2016).

DMAHS rejected an ALJ's initial decision reducing the personal care assistant (PCA) service hours allocated to an insured who suffered from unspecified medical conditions because the nurse who performed the assessment on which the reduction was based did not testify at the hearing. Because the patient thus was deprived of an opportunity to question the nurse about her findings and scoring using the assessment tool, a new assessment was warranted. B.F. v. United Healthcare, OAL DKT. NO. HMA 01507-15, 2016 N.J. AGEN LEXIS 1326, Final Administrative Determination (October 13, 2016).

Young adult who was diagnosed with autism and epilepsy was entitled to retain her allowance of nine hours per week of Personal Care Assistant (PCA) services, not increased hours as sought by her. The request for an increase in hours was based on the mother's claim that the adult needed constant supervision but PCA hours were for care, not for supervision, and there was sufficient evidence that the number of hours allocated for each covered activity was consistent with the patient's assistance requirements. E.B. v. Horizon NJ Health, OAL DKT. NO. HMA 04645-16, 2016 N.J. AGEN LEXIS 649, Initial Decision (July 26, 2016).

Insurer failed to provide an adequate basis for its determination to reduce, from 28 to 13, the hours of personal care assistant services provided to an elderly woman who was diagnosed with systemic lupus erythematosus, insulin-dependent diabetes mellitus, hypertension, fibromyalgia, depression and alopecia. Her caregiver was her daughter, who assisted the woman with dressing, standing, toileting and medication, and the record showed that the woman's ability to perform functions without assistance had drastically decreased. *D.B. v. Horizon NJ Health, OAL DKT. NO. HMA 00902-16, 2016 N.J. AGEN LEXIS 578*, Initial Decision (June 29, 2016).

ALJ erred in rejecting a health care provider's determination reducing, from 56 to 35, the number of Personal Care Assistance (PCA) hours allocated to a 91 year old woman with arthritis, spinal stenosis, hyperthyroidism, chronic pain and right-side weakness. There was no evidence suggesting that any needed service or task cannot be performed within the weekly allocation of 35 hours. If the necessary personal care and household tasks can be accomplished within 35 hours per week, any additional hours would only be used for supervision or companionship which was not an authorized use of the service. *B.R. v. United Healthcare, OAL DKT. NO. HMA 20718-15, 2016 N.J. AGEN LEXIS 901*, Final Administrative Determination (June 22, 2016).

Agency rejected an ALJ's recommendation reversing a reduction of PCA hours provided to an insured by Insurer 1. The appeal became moot because the insured was no longer enrolled with Insurer 1. That also meant that a reassessment, by Insurer 2, of the insured's PCA needs was required. *P.R.-P. v. United Healthcare, OAL DKT. NO. HMA 04703-15, 2016 N.J. AGEN LEXIS 604*, Final Decision (May 23, 2016).

Determination that a Medicaid recipient was entitled only to 22 Personal Care Assistant (PCA) hours per week rather than the 38 that he previously received was sustained on review because the recipient's proof relative to his need did not take into account the services that he was receiving at an adult day care facility, which hours were not taken into consideration in the prior assessment and now necessarily reduced the total number of PCA hours available. *J.Y. v. Horizon NJ Health, OAL DKT. NO. HMA 18143-15, 2016 N.J. AGEN LEXIS 355*, Initial Decision (May 19, 2016).

Elderly woman who was diagnosed with arthritis, spinal stenosis, hyperthyroidism, chronic pain and right-side weakness from a stroke prevailed on her challenge to her health care provider's decision to reduce her Personal Care Assistance (PCA) hours from 56 to 35. Though the assessment tool that was used presumably supported the reduction, it was only a "jumping off point" for a determination of patient need and the evidence showed that the services needed by the woman were exactly the kind contemplated by law including assistance with hygiene, grooming, bathing, toileting, transfer, ambulation, dressing, meal preparation and cleanliness. Because the woman demonstrated a need for assistance well beyond the PCA hours yielded via strict application of the tool, the provider's reduction was improper. *B.R. v. United Healthcare, OAL DKT. NO. HMA 20718-15, 2016 N.J. AGEN LEXIS 219*, Initial Decision (April 25, 2016).

Reduction in personal care assistant (PCA) hours granted to an 82-year old Medicaid recipient was rejected by an ALJ on findings that the evaluators who assessed the recipient in fact underestimated the recipient's demonstrated needs for PCA services in the areas of dressing, bathing, toileting, personal hygiene/grooming, including his leg/foot care, petitioner's necessary doctor appointments, and his household needs, including meal preparation and shopping. *D.B. v. United Healthcare, OAL DKT. NO. HMA 03869-15, 2015 N.J. AGEN LEXIS 455*, Initial Decision (July 1, 2015).

N.J.A.C. 10:60-3.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:60-3.6 Clinical records

(a) Recordkeeping for personal care assistant services shall include the following:

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

2. Clinical records shall contain, at a minimum:

i. Nursing assessments completed by the nursing agency. The most recent nursing assessment shall be retained in the beneficiary's active chart; the previous three years of assessments shall be retained onsite.

ii. A beneficiary-specific plan of care;

iii. Signed and dated progress notes describing the beneficiary's condition;

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

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

vi. Documentation that the beneficiary has been informed of rights to make decisions concerning his or her medical care;

vii. Documentation of the formulation of an advance directive; and

viii. Documentation of approved nurse delegated tasks and documentation of training on performance of those tasks.

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 (a)2 above.

History

HISTORY:

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

In (a)2vii, deleted "and" from the end; in (a)2viii, inserted "; and"; and added (a)2ix.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

Case Notes

DMAHS reversed the determination of an ALJ that continued a recipient's 25 hours of personal care assistance (PCA) on a finding that the insurance provider had not offered evidence that the recipient's medical or mental condition had improved. Because the provider here had "inherited" the patient from a different insurer, the current provider did not have the burden to disprove the earlier assessment. Because the record below did not support the conclusion that the patient required 25 hours of PCA, the ALJ's report and recommendation were rejected and the case was remanded for further factual development. *M.S. v. United Healthcare, OAL DKT. NO. HMA 03925-16, 2017 N.J. AGEN LEXIS 1337*, Order Remanding Case (June 28, 2017).

Health care plan failed to carry its burden to show that the number of Personal Care Assistant (PCA) hours which were reasonably needed by an 88-year old member who had severe glaucoma in both eyes, thyroid cancer, only one functioning kidney and mental deficits was properly reduced from the 23 hours provided weekly by a prior health care plan to the 16 hours that the current plan had proposed. The plan was not entitled to impose a reduction in the number of PCA hours without some evidence relating to and justification as to how the member's circumstances had changed since the prior assessment. *F.V. v. Horizon NJ Health, OAL DKT. NO. HMA 16988-14, 2015 N.J. AGEN LEXIS 693*, Initial Decision (October 9, 2015).

End of Document

N.J.A.C. 10:60-3.7

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§ 10:60-3.7 Basis of payment for personal care assistant services

(a) Personal care assistant services shall be reimbursed on a per unit, 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.

1. When provided to beneficiaries who are not enrolled in a managed care organization, personal care assistant (PCA) services shall be reimbursed on a fee-for-service basis and a unit of service is defined as 60 minutes. When PCA services are provided to the same beneficiary on the same date of service multiple times throughout the day, the provider shall add non-continuous units of time together to reach a billing total. The initial service visit shall be rounded up to one full unit of service. Beyond the initial unit of service, all service times shall be added together and service times totaling more than 30 minutes shall be rounded up to one unit and service times totaling 30 minutes or less shall be rounded down.

(b) Personal care assistant services reimbursement rates (see N.J.A.C. 10:60-11) 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 CMS 1500 Claim Form (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/NJ FamilyCare programs 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.

History

HISTORY:

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 *N.J.A.C. 10:60-1.11* and amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (b), changed N.J.A.C. reference, changed form reference, and inserted a reference to NJ KidCare.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

In (b), substituted "CMS" for "HCFA", and "FamilyCare" for "KidCare".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

In (a), substituted "unit" for "hour", and inserted a comma following "weekend".

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Added (a)1.

Annotations

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Young adult who was diagnosed with autism and epilepsy was entitled to retain her allowance of nine hours per week of Personal Care Assistant (PCA) services, not increased hours as sought by her. The request for an increase in hours was based on the mother's claim that the adult needed constant supervision but PCA hours were for care, not for supervision, and there was sufficient evidence that the number of hours allocated for each covered activity was consistent with the patient's assistance requirements. *E.B. v. Horizon NJ Health, OAL DKT. NO. HMA 04645-16, 2016 N.J. AGEN LEXIS 649*, Initial Decision (July 26, 2016).

Insurer failed to provide an adequate basis for its determination to reduce, from 28 to 13, the hours of personal care assistant services provided to an elderly woman who was diagnosed with systemic lupus erythematosus, insulin-dependent diabetes mellitus, hypertension, fibromyalgia, depression and alopecia. Her caregiver was her daughter, who assisted the woman with dressing, standing, toileting and medication, and the record showed that the woman's ability to perform functions without assistance had drastically decreased. *D.B. v. Horizon NJ Health, OAL DKT. NO. HMA 00902-16, 2016 N.J. AGEN LEXIS 578*, Initial Decision (June 29, 2016).

N.J.A.C. 10:60-3.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:60-3.8 Limitations on personal care assistant services

(a) Medicaid/NJ FamilyCare reimbursement shall not be made for personal care assistant services provided to Medicaid/NJ FamilyCare-Plan A beneficiaries in the following settings:

1. A residential health care facility;

2. A Class C boarding home;

3. A hospital;

4. A nursing facility;

5. DDD group homes, skill development homes, supervised apartments or other congregate living programs where personal care assistance is provided as part of a service package which is included in the living arrangement;

6. Adult day health care and pediatric day health care centers;

7. TBI community residential service facilities; and

8. Adult Family Care, Assisted Living Program, and Assisted Living Residence.

(b) Except as specified under the personal preference program, 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/NJ FamilyCare-Plan B and C programs. No exceptions will be granted for legally responsible relatives (that is, a spouse or legal guardian of an adult, or a parent/legal guardian of a minor child). Exceptions for other family members or relatives to provide personal care assistant services may be granted on a case-by-case basis at the discretion of the Director of the Division of Disability Services, if requested by the PCA provider agency. Such exceptions may be granted only with valid justification regarding the need for the service and documentation of the unavailability of another PCA. Renewal of approved exceptions shall be requested annually, accompanied by valid justification and documentation of the beneficiary's circumstances. Exceptions and renewals shall be based on the individual circumstances of the beneficiary and in all cases shall require the PCA to be:

1. A currently certified homemaker/home health aide;

2. An employee of the home health agency requesting the exception; and

3. Directly supervised by a registered nurse employed by the PCA provider agency.

(c) Personal care assistance services shall not be approved or authorized when the purpose of the request is to provide:

1. Respite care;

2. Supervision, as a stand-alone service, regardless of age of the beneficiary;

3. Companionship;

4. Child care or babysitting;

5. Routine parenting tasks and/or teaching of parenting skills;

6. Services to individuals with mental health service needs, which are provided by the Division of Mental Health and Addiction Services.

7. Services to beneficiaries with a medical diagnosis that does not indicate functional limitations (for example, high cholesterol);

8. Services to beneficiaries with acute short-term diagnosis (for example, a fracture) that is expected to heal;

9. Services to beneficiaries that are limited to non-hands-on personal care needs as described in *N.J.A.C. 10:60-3.3(b)* and (c).

(d) Personal care assistant services shall not be reimbursed if the personal care assistant resides in the beneficiary's home, except as provided in (b) above and *N.J.A.C. 10:60-3.9*.

(e) Personal care assistant services provided in places of employment shall not replace or duplicate those employer-provided services or accommodations mandated by the Americans with Disabilities Act of 1990, P.L. 101-336, *42 U.S.C. § 12111*. Tasks that are considered part of a beneficiary's job duties such as, reading business/office correspondence, organizing files and answering telephones shall not be reimbursable personal care assistant services.

(f) Personal care assistant services in educational settings shall not replace or duplicate those services mandated by the Individuals with Disabilities Education Act (IDEA), *20 U.S.C. §§ 1400* et seq., and Section 504 of the Rehabilitation Act of 1973, *29 U.S.C. § 794*. Tasks that are required for the beneficiary to obtain access to educational or classroom learning materials, such as note taking, shall not be reimbursable personal care assistant services.

(g) Personal care assistant services shall be limited to a maximum of 40 hours per calendar work week and shall be prior authorized in accordance with *N.J.A.C. 10:60-3.9*. Additional hours of service may be approved by the Division of Disability Services (DDS) or DMAHS on a case-by-case basis, based on exceptional circumstances.

(h) Personal care assistant services authorized for two or more beneficiaries living in the same residence shall require a combination of individual personal care services to address hands-on care needs and group hours to address the non-personal care needs (that is, meal preparation, shopping, laundry, housekeeping) for billing purposes.

(i) PCA units of service that are unused for any reason including, but not limited to, illness of the beneficiary or home health aide, or hospitalization of the beneficiary or aide, are not permitted to be saved and carried over for use on a subsequent date(s).

History

HISTORY:

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Section was "Limitations of personal care assistant services". Rewrote (a) and (b); deleted former (c); and added present (c) through (g).

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

§ 10:60-3.8 Limitations on personal care assistant services

Amended by R.2022 d.107, effective September 6, 2022.

See: 53 N.J.R. 1327(a), 54 N.J.R. 1721(a).

In (a) and (b). substituted "Medicaid/NJ FamilyCare" for "Medicaid or NJ FamilyCare"; in (b), inserted "or legal guardian of an adult" andsubstituted "parent/legal guardian" for "parent"; and in (c)4, substituted "babysitting" for "baby sitting".

Annotations

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DMAHS rejected an Initial Decision that allowed a patient to in essence renounce hours of Private Duty Nursing (PDN) services to which she was found to be entitled in favor of Personal Care Assistance (PCA) hours which she had been granted under the state's Personal Preference Program. PDN and PCA hours are not interchangeable as the former services must be performed by a licensed nurse. The patient failed to demonstrate that the 70 weekly PCA hours that she was granted were insufficient to meet her needs so the agency ruling was properly approved and the Initial Decision rejected. A.L. v. Horizon, OAL DKT. NO. HMA 9357-18, 2019 N.J. AGEN LEXIS 348, Final Agency Determination (May 17, 2019).

Increase in certain of the minutes accorded in an individual's PCA plan was rejected by the agency on findings that no justification was given for the award of extra time for transfers, bathing, linen change, housekeeping, laundry and meals. Specifically, an increase in time for meal preparation based on the time involved in preparing a "big salad" or "spaghetti sauce that did not come out of a can or bottle" was not medically necessary nor a sufficient justification for an increase in the minutes awarded for such tasks. A.C. v. Horizon NJ Health, OAL DKT. NO. HMA 12091-2018, 2019 N.J. AGEN LEXIS 104, Final Agency Determination (February 22, 2019).

Provider acted improperly when it denied a request for 112 hours of Personal Care Assistant (PCA) services to a 10-year old child with quadriplegic spastic cerebral palsy because the 40-hour per week limit cited by the provider only applied to adults who were over the age of 21. Where, as here, the patient was a child, she was entitled to receive any medically necessary service, and an assessment was needed to determine the number of medically-necessary PCA services needed by her on a daily basis. K R.-M. v. Horizon, OAL DKT. NO. HMA 10249-18, 2019 N.J. AGEN LEXIS 250, Final Agency Determination (January 17, 2019).

Agency approved of and adopted an ALJ's Initial Decision finding that a 27 year-old man with autism and profound mental retardation who resided full time in a residential facility where he was under continuous supervision was not also entitled to personal care assistance (PCA) hours for those days that his family took him home for a visit. The patient was already receiving those services in the facility so a PCA allocation to cover his time at home represented an improper duplication of services. C.J. v. Horizon NJ Health, OAL DKT. NO. HMA 06301-16, 2017 N.J. AGEN LEXIS 1171, Final Agency Determination (October 30, 2017).

ALJ's conclusion that a recipient of Personal Care Assistance (PCA) based on her diagnoses including Down Syndrome, diabetes and Alzheimer's was entitled to more than the 53 hours allocated by an insurer was not clearly supported by the record with the result that the matter was properly returned to the insurer for an evaluation of the recipient's specific needs including the specific services identified in governing regulations. K.M. v. Wellcare of N.J., OAL DKT. NO. HMA 03808-17, 2017 N.J. AGEN LEXIS 1293, Order Remanding for Further Proceedings (August 31, 2017).

DMAHS director approved an ALJ's Initial Decision on findings that an applicant who was seeking an increase in Personal Care Assistant (PCA) hours had not provided any evidence as to why the 31-hour allocation was insufficient to see to her needs. If the necessary personal care and household tasks can be accomplished within 31 hours per week, which appeared to be the case, additional hours would only be used for supervision or companionship, which was not an authorized use of PCA hours. *L.P. v. United Healthcare, OAL DKT. NO. HMA 07754-17, 2017 N.J. AGEN LEXIS 1172*, Final Agency Determination (August 22, 2017).

Twenty-seven year old man with autism and profound mental retardation who resided full time in a residential health care facility where he received continuous supervision was not entitled to receive personal care assistance (PCA) hours for the three or four days each month that his mother brought him to the family home for an overnight visit. That was because, inter alia, the patient was already receiving such services in the facility and they were available to him whether or not he was in the facility to utilize them so an allocation of PCA to cover time when he was visiting his family home would represent an improper duplication of services. Nor were there inadequacies in the notices received by the patient relative to the PCA determination. *C.J. v. Horizon NJ Health, OAL DKT. NO. HMA 06301-2016, 2017 N.J. AGEN LEXIS 607*, Initial Decision (August 14, 2017).

DMAHS reversed the determination of an ALJ that continued a recipient's 25 hours of personal care assistance (PCA) on a finding that the insurance provider had not offered evidence that the recipient's medical or mental condition had improved. Because the provider here had "inherited" the patient from a different insurer, the current provider did not have the burden to disprove the earlier assessment. Because the record below did not support the conclusion that the patient required 25 hours of PCA, the ALJ's report and recommendation were rejected and the case was remanded for further factual development. *M.S. v. United Healthcare, OAL DKT. NO. HMA 03925-16, 2017 N.J. AGEN LEXIS 1337*, Order Remanding Case (June 28, 2017).

Determination of a health care provider that a 23 year old spinal muscular atrophy patient who was paralyzed and ventilator-dependent did not qualify for personal care assistant services (PCA services) was reversed by an ALJ on findings that the provider's own assessment tool showed that the patient needed nearly 38 hours of PCA services each week. The ALJ rejected the provider's suggestion that the patient was receiving PCA-type services from personnel who were providing private duty nursing (PDN) because PDN and PCA were mutually exclusive services and the allowance of one did not limit eligibility for the other. More importantly, personnel providing PDN services were prohibited from performing non-medical services of the type provided by *PCA. T.M. v. United Healthcare, OAL DKT. NO. HMA 18965-16, 2017 N.J. AGEN LEXIS 378*, Initial Decision (June 8, 2017).

DMAHS director modified an Initial Decision awarding 21 hours per week of Personal Care Assistant (PCA) services to a 24 year old male with autism, severe cognitive disabilities, obsessive-compulsive disorder and communication deficits, reducing the allowance to 16.5 hours per week. While the ALJ should not have made any award for certain tasks such as laundry, the ALJ's decision only allowed time for 16 meals per week when in fact the caregiver provided the patient with 18, so additional time was properly allocated. *I.W. v. Horizon NJ Health, OAL DKT. NO. HMA 08128-16, 2017 N.J. AGEN LEXIS 1053*, Final Agency Determination (May 15, 2017).

Fifty-eight year old woman with cognitive impairments, schizophrenia, bipolar disorder and depression was entitled to a continuation of her allocation of 25 hours of personal care assistance (PCA) weekly and a determination of the insurer reducing that entitlement was rejected by an ALJ because there was no evidence of a change in the woman's medical condition justifying a reduction in the number of hours allocated for all assessment cycles over the past decade. *M.B. v. United Healthcare, OAL DKT. NO. HMA 03925-16, 2017 N.J. AGEN LEXIS 218*, Initial Decision (April 18, 2017).

Twenty-four year old male who suffered from autism, severe cognitive disabilities, obsessive-compulsive disorder and communication deficits was entitled to an allowance for Personal Care Assistant (PCA) Services of 21 hours per week because his condition was such that he needed nearly constant monitoring, could not shower or perform personal hygiene tasks without supervision, could not eat without assistance and supervision, and required close supervision for all activities of daily living. *I.W. v. Horizon NJ Health, OAL DKT. NO. HMA 8128-16, 2017 N.J. AGEN LEXIS 146*, Initial Decision (March 13, 2017).

§ 10:60-3.8 Limitations on personal care assistant services

An ALJ rejected as unsupported the claims of a provider that the number of personal care assistant services (PCA) hours provided to a 30-year old woman who suffered from cerebral palsy, neurological impairment, spinal meningitis, degenerative disk disease C-2 to C-7 and deafness was properly reduced from 40 per week to 35. There was no showing that the prior allocation of 40 hours per week was incorrect, that there had been a change in the patient's needs, or that her mother, who was her primary caregiver, was providing less than 8 hours of necessary care every day. *E.D. v. Horizon NJ Health, OAL DKT. NO. HMA 04471-16, 2017 N.J. AGEN LEXIS 129*, Initial Decision (March 6, 2017).

Though the DMAHS agreed with an ALJ that the allocation of Personal Care Assistant (PCA) hours to an 86-year old woman with various medical problems and cognitive deficits was properly kept at the previous level, which was 25 hours per week, the Division specifically rejected the suggestion that one element of a permissive allowance was such time as was needed to ensure that the woman did not wander out of the house because PCA services were to be used for specific health related tasks, not to provide supervision or companionship. *L.M. v. Horizon NJ Health, OAL DKT. NO. HMA 15804-16, 2017 N.J. AGEN LEXIS 478*, Final Administrative Determination (February 15, 2017).

Nine-year old child who was diagnosed with Down Syndrome, asthma, hypothyroidism and mental impairment was entitled to 17 hours a week of personal care under the Personal Preference Program because there was no evidence offered to rebut the insurer's conclusion that that allowance was properly reduced from 22 to 17 hours per week based upon the results of a PCA assessment. *A.I. v. Amerigroup, OAL DKT. NO. HMA 17827-16, 2017 N.J. AGEN LEXIS 78*, Initial Decision (February 6, 2017).

Challenge by an elderly man to the reduction of his Personal Care Assistant hours from 20 to zero each week was rebuffed by the DMAHS. Though the man suffered from diabetes and needed to have lotion applied to his feet three times each day, he did not need assistance with *ADLs. D.B. v. United Healthcare, OAL DKT. NO. HMA 03233-16, 2016 N.J. AGEN LEXIS 565*, Initial Decision (July 11, 2016).

ALJ erred in rejecting a health care provider's determination reducing, from 56 to 35, the number of Personal Care Assistance (PCA) hours allocated to a 91 year old woman with arthritis, spinal stenosis, hyperthyroidism, chronic pain and right-side weakness. There was no evidence suggesting that any needed service or task cannot be performed within the weekly allocation of 35 hours. If the necessary personal care and household tasks can be accomplished within 35 hours per week, any additional hours would only be used for supervision or companionship which was not an authorized use of the service. *B.R. v. United Healthcare, OAL DKT. NO. HMA 20718-15, 2016 N.J. AGEN LEXIS 901*, Final Administrative Determination (June 22, 2016).

Elderly woman who was diagnosed with arthritis, spinal stenosis, hyperthyroidism, chronic pain and right-side weakness from a stroke prevailed on her challenge to her health care provider's decision to reduce her Personal Care Assistance (PCA) hours from 56 to 35. Though the assessment tool that was used presumably supported the reduction, it was only a "jumping off point" for a determination of patient need and the evidence showed that the services needed by the woman were exactly the kind contemplated by law including assistance with hygiene, grooming, bathing, toileting, transfer, ambulation, dressing, meal preparation and cleanliness. Because the woman demonstrated a need for assistance well beyond the PCA hours yielded via strict application of the tool, the provider's reduction was improper. *B.R. v. United Healthcare, OAL DKT. NO. HMA 20718-15, 2016 N.J. AGEN LEXIS 219*, Initial Decision (April 25, 2016).

Challenge to a reduction in the personal care assistant (PCA) service hours allocated to an 84 year old women who suffered from advanced Alzheimer's dementia, coronary artery disease, diabetes, kidney failure, congestive heart failure, renal failure, blindness and low vision, generalized weakness, sleep apnea, psoriasis, and bladder incontinence was successful. The patient met the criteria for "severely impaired" and her needs, when fairly assessed, were such that she required "extensive" support to perform ADLs. Nor did the assessment allocate any time for other needs such as shopping and food preparation. On balance, there was insufficient evidence supporting the reduction of PCA hours. *P.R.-P. v. United Healthcare, OAL DKT. NO. HMA 04703-15, 2016 N.J. AGEN LEXIS 199*, Initial Decision (April 13, 2016).

Health care plan failed to carry its burden to show that the number of Personal Care Assistant (PCA) hours which were reasonably needed by an 88-year old member who had severe glaucoma in both eyes, thyroid cancer, only one functioning kidney and mental deficits was properly reduced from the 23 hours provided weekly by a prior health care plan to the 16 hours that the current plan had proposed. The plan was not entitled to impose a reduction in the number of PCA hours without some evidence relating to and justification as to how the member's circumstances had changed since the prior assessment. *F.V. v. Horizon NJ Health, OAL DKT. NO. HMA 16988-14, 2015 N.J. AGEN LEXIS 693*, Initial Decision (October 9, 2015).

Though a disabled Medicaid recipient was not entitled to 40 hours of personal care assistance (PCA), the recipient did establish an entitlement to 30 hours of such assistance. The difference between the 40 hours of PCA sought by the recipient and the 30 hours of PCA recommended by an ALJ included a disallowance of recreation and volunteer activities, food preparation relating to the recipient's preference for a vegetarian diet, and additional time needed for laundering the recipient's clothing separate from the clothing of other family members. *A.V. v. Horizon N.J. Health, OAL DKT. NO. HMA 04469-15, 2015 N.J. AGEN LEXIS 508*, Initial Decision (July 23, 2015).

Number of hours of Personal Care Assistant services (PCA) received by a patient were properly reduced from 40 to 25 hours a week. An ALJ had found that the patient, who had Down Syndrome, needed the additional hours because she needed a skilled level of care, but skilled nursing care was beyond the scope of PCA services. Nor was there any evidence that the needed services could not be performed within 25 hours a week. In fact, the evidence tended to show that any additional hours would be used for supervision or companionship, neither of which were authorized PCA services. *D.W. v. DMAHS and Div. of Disability Servs., OAL DKT. NO. HMA 2324-12, 2014 N.J. AGEN LEXIS 1287*, Final Administrative Determination (December 19, 2014).

Personal Care Assistant (PCA) services were not available where the purpose was to supervise an applicant who suffered from intermittent tics and seizures. The possibility that the applicant may experience a tic or have a seizure existed regardless of how many PCA hours were provided, and since there was no way to predict when one might occur, PCA benefits were not available. *J.R. v. DMAHS and Div. of Disability Servs., OAL DKT. NO. HMA 2179-14, 2014 N.J. AGEN LEXIS 918*, Final Administrative Determination (August 18, 2014).

N.J.A.C. 10:60-3.9

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§ 10:60-3.9 Prior authorization for personal care assistant (PCA) services

(a) All personal care assistant (PCA) services shall be prior authorized, regardless of the number of hours requested per week.

(b) Prior approval for PCA services shall be obtained in accordance with the following procedures:

1. For fee-for-service cases, a registered nurse employed by the PCA provider agency shall complete a face-to-face evaluation of the beneficiary, at the beneficiary's home, and shall complete the State-approved PCA Assessment form, including information regarding the beneficiary's:

i. Supportive service/living environment needs;

ii. Cognitive/mental status;

iii. Ambulation/mobility;

iv. Ability to transfer (for example, from wheelchair to bed);

v. Ability to feed himself or herself;

vi. Ability to bathe himself or herself;

vii. Ability to toilet himself or herself;

viii. Ability to perform grooming and dressing tasks;

ix. Ability to perform housekeeping and shopping tasks; and

x. Ability to perform laundry tasks.

2. The provider agency shall total the numerical elements related to the need areas in (b)1 above;

3. The provider agency shall submit the State-approved PCA Assessment form, in electronic or paper format, and the prior authorization request form (FD-365) to the Division of Disability Services; and

4. Upon completion of the review of a prior authorization request, Division of Disability Services staff shall make a determination regarding the hours of PCA services to be authorized.

(c) Failure to comply with the prior authorization requirements shall result in denial of Medicaid/NJ FamilyCare reimbursement and recoupment of funds for any services provided without documented prior authorization.

History

HISTORY:

New Rule, R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

§ 10:60-3.9 Prior authorization for personal care assistant (PCA) services

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the introductory paragraph of (b)1; in (b)1ix, inserted "housekeeping and"; in (b)3, inserted "State-approved", and deleted "(FD-410)" following the first occurrence of "form"; and in (c), substituted "Medicaid/NJ FamilyCare" for "Medicaid".

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Twenty-seven year old man with autism and profound mental retardation who resided full time in a residential health care facility where he received continuous supervision was not entitled to receive personal care assistance (PCA) hours for the three or four days each month that his mother brought him to the family home for an overnight visit. That was because, inter alia, the patient was already receiving such services in the facility and they were available to him whether or not he was in the facility to utilize them so an allocation of PCA to cover time when he was visiting his family home would represent an improper duplication of services. Nor were there inadequacies in the notices received by the patient relative to the PCA determination. *C.J. v. Horizon NJ Health, OAL DKT. NO. HMA 06301-2016, 2017 N.J. AGEN LEXIS 607*, Initial Decision (August 14, 2017).

Challenge by a recipient of Personal Care Assistant (PCA) services to an order terminating those services was rejected because while the evidence showed that the recipient derived a significant degree of comfort and emotional well-being from the presence of an aide, the recipient in fact was able to perform the activities of daily living without hands-on assistance and thus did not qualify for PCA services at that time. *D.F. v. United Healthcare, OAL DKT. NO. HMA 02584-17, 2017 N.J. AGEN LEXIS 312*, Initial Decision (May 10, 2017).

Fifty-eight year old woman with cognitive impairments, schizophrenia, bipolar disorder and depression was entitled to a continuation of her allocation of 25 hours of personal care assistance (PCA) weekly and a determination of the insurer reducing that entitlement was rejected by an ALJ because there was no evidence of a change in the woman's medical condition justifying a reduction in the number of hours allocated for all assessment cycles over the past decade. *M.B. v. United Healthcare, OAL DKT. NO. HMA 03925-16, 2017 N.J. AGEN LEXIS 218*, Initial Decision (April 18, 2017).

Applicant who was diagnosed with renal failure, gout, hypertension and debility was properly denied continued personal care assistant (PCA) services. The applicant's testimony regarding his ability to perform activities of daily living was in conflict with information that he provided to a representative of the insurer who had visited the applicant to assess his needs in the context of his actual household. Another factor was that while his wife was present when the representative visited the applicant's household, the applicant testified that he lived alone. *C.G. v. Horizon NJ Health, OAL DKT. NO. HMA 12890-16, 2016 N.J. AGEN LEXIS 1271*, Initial Decision (December 27, 2016).

Modifying the initial decision of an ALJ, the Director of DMAHS found that a new assessment was required to determine the needs of an elderly recipient whose personal care assistant (PCA) hours had been reduced from 28 to 13 because there was insufficient information in the assessment reports to justify the substantial reduction. *D.B. v. Horizon NJ Health, OAL DKT. NO. HMA 00902-16, 2016 N.J. AGEN LEXIS 1143*, Final Administrative Determination (September 7, 2016).

§ 10:60-3.9 Prior authorization for personal care assistant (PCA) services

Determination that a Medicaid recipient was entitled only to 20 Personal Care Assistant (PCA) hours rather than the 35 that she previously received was sustained on review because credible evidence supported the determination, using the State Assessment Tool, that she actually needed only 13 hours a week of PCA and the insurer exercised its discretion to increase that number to 20. *B.F. v. United Healthcare, OAL DKT. NO. HMA 01507-15, 2016 N.J. AGEN LEXIS 707*, Initial Decision (August 2, 2016).

Young adult who was diagnosed with autism and epilepsy was entitled to retain her allowance of nine hours per week of Personal Care Assistant (PCA) services, not increased hours as sought by her. The request for an increase in hours was based on the mother's claim that the adult needed constant supervision but PCA hours were for care, not for supervision, and there was sufficient evidence that the number of hours allocated for each covered activity was consistent with the patient's assistance requirements. *E.B. v. Horizon NJ Health, OAL DKT. NO. HMA 04645-16, 2016 N.J. AGEN LEXIS 649*, Initial Decision (July 26, 2016).

Challenge by an elderly man to the reduction of his Personal Care Assistant hours from 20 to zero each week was rebuffed by the DMAHS. Though the man suffered from diabetes and needed to have lotion applied to his feet three times each day, he did not need assistance with *ADLs. D.B. v. United Healthcare, OAL DKT. NO. HMA 03233-16, 2016 N.J. AGEN LEXIS 565*, Initial Decision (July 11, 2016).

Determination that a Medicaid recipient was entitled only to 22 Personal Care Assistant (PCA) hours per week rather than the 38 that he previously received was sustained on review because the recipient's proof relative to his need did not take into account the services that he was receiving at an adult day care facility, which hours were not taken into consideration in the prior assessment and now necessarily reduced the total number of PCA hours available. *J.Y. v. Horizon NJ Health, OAL DKT. NO. HMA 18143-15, 2016 N.J. AGEN LEXIS 355*, Initial Decision (May 19, 2016).

Challenge to a reduction in the personal care assistant (PCA) service hours allocated to an 84 year old women who suffered from advanced Alzheimer's dementia, coronary artery disease, diabetes, kidney failure, congestive heart failure, renal failure, blindness and low vision, generalized weakness, sleep apnea, psoriasis, and bladder incontinence was successful. The patient met the criteria for "severely impaired" and her needs, when fairly assessed, were such that she required "extensive" support to perform ADLs. Nor did the assessment allocate any time for other needs such as shopping and food preparation. On balance, there was insufficient evidence supporting the reduction of PCA hours. *P.R.-P. v. United Healthcare, OAL DKT. NO. HMA 04703-15, 2016 N.J. AGEN LEXIS 199*, Initial Decision (April 13, 2016).

ALJ rejected a determination by a health care provider that reduced the personal care assistant hours allowed to a care recipient because there was no evidence of a change in the recipient's medical condition. That being so, there was insufficient evidence in the record to determination whether the reduction was appropriate and the matter was properly remanded. *L.S. v. Amerigroup, OAL DKT. NO. HMA 18655-15, 2016 N.J. AGEN LEXIS 80*, Decision Remanding for New Assessment (February 22, 2016).

ALJ found that a community health plan acted improperly when it reduced a member's personal care assistant (PCA) hours below the 33 hours weekly on which she had been previously maintained and that the health plan had not provided the member with an opportunity to fully explore the ostensible grounds for the reduction because the key witness who had performed the assessment on which the health plan had relied in reducing the PCA hours was not presented as a witness who could testify on the contents of her report. *B.G. v. United Healthcare, OAL DKT. NO. HMA 10992-15, 2015 N.J. AGEN LEXIS 708*, Initial Decision (October 13, 2015).

Though a disabled Medicaid recipient was not entitled to 40 hours of personal care assistance (PCA), the recipient did establish an entitlement to 30 hours of such assistance. The difference between the 40 hours of PCA sought by the recipient and the 30 hours of PCA recommended by an ALJ included a disallowance of recreation and volunteer activities, food preparation relating to the recipient's preference for a vegetarian diet, and additional time needed for laundering the recipient's clothing separate from the clothing of other family members. *A.V. v. Horizon N.J. Health, OAL DKT. NO. HMA 04469-15, 2015 N.J. AGEN LEXIS 508*, Initial Decision (July 23, 2015).

§ 10:60-3.9 Prior authorization for personal care assistant (PCA) services

Reduction in personal care assistant (PCA) hours granted to an 82-year old Medicaid recipient was sustained by an ALJ on findings that the recipient did not demonstrate why the assessment on which his PCA hours were reduced was incorrect or why he could not function on 19 hours of PCA per week. The recipient did not dispute the basic findings in the assessment but simply claimed he needed more time to complete some of those tasks. *W.S., Jr. v. United Healthcare, OAL DKT. NO. HMA 2044-15, 2015 N.J. AGEN LEXIS 454*, Initial Decision (July 16, 2015).

End of Document

N.J.A.C. 10:60-3.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 3. PERSONAL CARE ASSISTANT (PCA) SERVICES

§ 10:60-3.10 Transfer of beneficiary to a different service agency provider

(a) Beneficiaries may be approved for a transfer of service agency provider for good cause situations, including, but not limited to:

1. The current provider agency is unable to staff the case at the level of care approved by the Division; that is, staffing shortages, staffing cases with multiple home health aides when it is determined to be inappropriate;

2. The current provider agency is unable to staff the case due to a beneficiary change of residence; or

3. The current provider agency is unable to staff the case due to language or cultural barrier.

(b) Beneficiaries shall be awarded the same level of services previously approved upon approval of a transfer pursuant to (a) above until the completion of a recertification by the new provider agency.

(c) If a beneficiary is approved to transfer his or her PCA services to another provider agency, an entirely new physician's/practitioner's certification process is required of the new provider. A physician/practitioner certification is not transferable from one provider agency to another.

History

HISTORY:

New Rule, R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (c), substituted "physician's/practitioner's" for "physician's" and "physician/practitioner" for "physician".

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N.J.A.C. 10:60-4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 4. (RESERVED)

Title 10, Chapter 60, Subchapter 4. (Reserved)

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N.J.A.C. 10:60-5.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.1 Purpose and scope

(a) Private duty nursing (PDN) services shall be provided by a licensed certified home health agency, licensed hospice agency or an accredited healthcare services firm approved by DMAHS. The healthcare services firm shall be accredited, initially and on an ongoing basis, by an accreditation organization approved by the Department.

1. A healthcare services firm shall contract with an accreditation organization to complete a comprehensive on-site organizational audit a minimum of once every three years.

(b) The purpose of private duty nursing services is to provide individual and continuous nursing care, as different from part-time intermittent care, to beneficiaries who exhibit a severity of illness that requires complex skilled nursing interventions on a continuous ongoing basis. PDN services are provided by licensed nurses in the home to beneficiaries receiving managed long-term support services (MLTSS), as well as eligible EPSDT beneficiaries.

(c) Private duty nursing services exceed normal parental and/or familial responsibilities; therefore, family members of beneficiaries who are receiving PDN services, who are licensed as an RN or an LPN in the State of New Jersey, may be employed by the agency authorized to provide PDN services to the beneficiary, up to eight hours per day, 40 hours per week. The family member of the beneficiary may not serve as the supervising RN responsible for developing the treatment plan for the beneficiary. The agency employing the family member is responsible to ensure that the PDN services are properly provided and meet all agency standards and regulatory requirements.

History

HISTORY:

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

In (a), substituted "DMAHS" for "the Division" and added the last sentence; and in (b) substituted "Community Resources for People with Disabilities (CRPD)" for "Model Waiver 3".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote the section.

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DMAHS rejected an Initial Decision that allowed a patient to in essence renounce hours of Private Duty Nursing (PDN) services to which she was found to be entitled in favor of Personal Care Assistance (PCA) hours which she had been granted under the state's Personal Preference Program. PDN and PCA hours are not interchangeable as the former services must be performed by a licensed nurse. The patient failed to demonstrate that the 70 weekly PCA hours that she was granted were insufficient to meet her needs so the agency ruling was properly approved and the Initial Decision rejected. A.L. v. Horizon, OAL DKT. NO. HMA 9357-18, 2019 N.J. AGEN LEXIS 348, Final Agency Determination (May 17, 2019).

Patient who had medical conditions including muscular dystrophy, dysphagia, scoliosis and asthma did not establish that she met the requirements for skilled nursing care because she was not ventilator dependent and did not have either an active tracheostomy or a seizure disorder. Moreover, her use of a nebulizer was occasional or periodic. That being so, she did not exhibit a severity of illness that required complex skilled nursing interventions on an ongoing basis. H.W. v. United Healthcare, OAL DKT. NO. HMA 18602-2017, 2018 N.J. AGEN LEXIS 738, Final Agency Determination (August 16, 2018).

Agency director adopted and approved a ruling terminating the provision of private duty nursing services to a 26 year-old recipient who was a wheelchair-bound quadriplegic due to Duchenne muscular dystrophy. The recipient did not exhibit a severity of illness that required complex skilled nursing interventions on an ongoing basis. Moreover, use of a BiPaP machine did not constitute "mechanical ventilation" for such purposes, and the possibility that the recipient may need his mask adjusted or occasional suctioning during the night did not in and of itself satisfy the threshold eligibility requirement for PDN services. L.V. v. United Healthcare, OAL DKT. NO. HMA 08512-15, 2017 N.J. AGEN LEXIS 1159, Final Agency Determination (October 3, 2017).

Decision by an insurer that 35 of the 112 hours of private duty nursing that were authorized to be provided to a 17 year old girl who suffered from congenital cytomegalovirus infection, developmental delays and intractable epilepsy were to be allocated to the hours when she attended school was a "proposed action to terminate, reduce or suspend assistance" within the meaning of N.J.A.C. 10:49-10.4 and the girl's parents were entitled to adequate notice of that proposed action. That being so, the insurer was not permitted to make that allocation but was required to provide all 112 hours at the girl's home pending a hearing on the proposed action. N.P. v. United Healthcare, OAL DKT. NO. HMA 433-17, 2017 N.J. AGEN LEXIS 495, Initial Decision (June 28, 2017).

DMAHS approved of an ALJ's ruling rejecting an insurer's determination finding that a benefit recipient did not demonstrate that private duty nursing (PDN) was medically necessary. The recipient, who was cognitively impaired, had been receiving experimental anti-seizure medication but had suffered a breakthrough seizure when the dosage was lowered. Because the recipient was at risk for Sudden Unexpected Death in Epilepsy Patients, PDN benefits were properly continued for another six month period pending the next assessment. A.D. v. United Healthcare, OAL DKT. NO. HMA 19558-15, 2017 N.J. AGEN LEXIS 529, Final Administrative Determination (February 15, 2017).

Initial Decision (2006 N.J. AGEN LEXIS 350) adopted, which found that the staff at a Pennsylvania university offering a specialized on-campus program to assist resident students with all activities of daily living qualified under N.J.A.C. 10:60-5.3 as adult primary caregivers residing with petitioner who had accepted 24-hour responsibility for her care; thus, petitioner, a 19-year-old student suffering from nemaline myopathy, a form of muscular dystrophy, was eligible for eight hours of private duty nursing services under the Early and Periodic Screening, Diagnosis and Treatment program. A.G. v. DMAHS, OAL Dkt. No. HMA 10133-05, 2006 N.J. AGEN LEXIS 678, Final Decision (June 22, 2006).

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which explained that in attempting to meet the declared purpose of New Jersey's Private Duty Nursing services under *N.J.A.C. 10:60-5.1* et seq., which is to provide individual and continuous care, the provision of these services may be, consistent with federal regulations, limited by medical necessity and utilization control procedures that ensure the fiscal solvency of the Medicaid program. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

End of Document

N.J.A.C. 10:60-5.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.2 Basis for reimbursement for EPSDT/PDN

(a) To be considered for EPSDT/PDN services, the beneficiary shall be under 21 years of age, enrolled in the Medicaid/NJ FamilyCare program and referred by a parent, primary physician/practitioner, hospital discharge planner, Special Child Health Services case manager, Division of Disability Services (DDS), Child Protection and Permanency (CP&P), Division of Mental Health and Addiction Services (DMHAS), or current PDN provider. Requests for services shall be submitted to the Division of Medical Assistance and Health Services (DMAHS) using a "Request for EPSDT Private Duty Nursing Services (FD-389)" form, incorporated herein by reference (see *N.J.A.C. 10:60* Appendix C). The Request shall be completed and signed by the referring physician/practitioner and agreed to and signed by a parent or guardian. All sections of the Request shall be completed and a current comprehensive medical history and current treatment plan, completed by the referring physician/practitioner, shall be attached. The comprehensive medical history, current treatment plan, and other documents submitted with the request shall reflect the current medical status of the beneficiary and shall document the need for ongoing (not intermittent) complex skilled nursing interventions by a licensed nurse. Incomplete requests shall be returned to the referral source for completion prior to further action by DMAHS.

(b) Upon receipt of the fully completed Request (FD-389), a DMAHS Regional Staff Nurse shall conduct an assessment of the need for PDN services, as well as the level (LPN or RN) and amount of service required. A letter notifying the family and the person who referred the individual of the decision following the assessment shall be issued by DMAHS. When the child is found to be eligible for EPSDT/PDN services, the number of hours approved, the level of services, and the length of time of the approval (up to a maximum of six months) shall be noted.

(c) The PDN provider agency, selected by the family, shall submit a request to DMAHS 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.

(d) Requests for continuation, or modification of PDN services during the treatment period, shall be submitted by the PDN agency, in writing, to DMAHS 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.

History

HISTORY:

Recodified from *N.J.A.C. 10:60-5.5* and amended by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Rewrote the section. Former *N.J.A.C. 10:60-5.2*, Clinical records and personnel files, recodified to *N.J.A.C. 10:60-5.6*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "DMAHS" for "the Division" throughout; rewrote (a); and in (b), substituted "a DMAHS" for "the Division's" in (b).

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote (a).

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (a), substituted "physician/practitioner" for "physician" three times; and inserted a comma following "treatment plan".

Annotations

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N.J.A.C. 10:60-5.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.3 Eligibility for Early and Periodic Screening Diagnosis and Treatment/Private Duty Nursing (PDN) Services

(a) Individuals under 21 years of age who are enrolled in the Medicaid/NJ FamilyCare programs, 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 EPSDT services, in accordance with *N.J.A.C. 10:49-5.3(a)*2.

2. For individuals who are enrolled in Medicaid/NJ FamilyCare managed care, private duty nursing is authorized and provided by the MCO.

(b) An individual must exhibit a severity of illness that requires complex skilled nursing interventions on an ongoing basis, to be considered in need of EPSDT/PDN services.

1. "Ongoing" means that the beneficiary needs skilled nursing intervention 24 hours per day/seven days per week.

2. "Complexity" means the degree of difficulty and/or intensity of treatment/procedures.

3. "Skilled nursing interventions" means procedures that require the knowledge and experience of licensed nursing personnel, or a trained primary caregiver.

(c) EPSDT/PDN services are only appropriate when the following requirements are satisfied:

1. There is a capable adult primary caregiver residing with the individual who accepts ongoing 24-hour responsibility for the health and welfare of the beneficiary;

2. The adult primary caregiver agrees to be trained or has been trained in the care of the beneficiary and agrees to receive additional training for new procedures and treatments, if directed to do so by a State agency; and

3. The home environment can accommodate the required equipment and licensed PDN personnel.

History

HISTORY:

Amended by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Rewrote the section.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Added new (c)2, recodified former (c)2 and (c)3 as present (c)3 and (c)4; in present (c)3 substituted "during every" for "in any".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

In the introductory paragraph of (a), deleted "FFS" following "FamilyCare"; in (a)2, substituted "Medicaid/NJ FamilyCare" for "Medicaid" and "MCO" for "HMO"; in (c)2, substituted "beneficiary" for "individual", and inserted "and" at the end; deleted former (c)3; and recodified (c)4 as (c)3.

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Division of Medical Assistance and Health Services reversed the ALJ's decision and reinstated the insurer's termination of Private Duty Nursing (PDN) services for a 22-year-old member, who had been receiving PDN services since 2015. The member's gastronomy feedings had not been complicated by either aspiration or regurgitation, and the member had remained free of any infection. The member's activities of daily living needs did not satisfy the threshold eligibility requirements for PDN and could be addressed by personal care assistance services. *B.L. v. United Healthcare, OAL DKT. NO. HMA 04270-20, 2021 N.J. AGEN LEXIS 253*, Final Agency Determination (June 29, 2021).

DMAHS rejected an Initial Decision that allowed a patient to in essence renounce hours of Private Duty Nursing (PDN) services to which she was found to be entitled in favor of Personal Care Assistance (PCA) hours which she had been granted under the state's Personal Preference Program. PDN and PCA hours are not interchangeable as the former services must be performed by a licensed nurse. The patient failed to demonstrate that the 70 weekly PCA hours that she was granted were insufficient to meet her needs so the agency ruling was properly approved and the Initial Decision rejected. *A.L. v. Horizon, OAL DKT. NO. HMA 9357-18, 2019 N.J. AGEN LEXIS 348*, Final Agency Determination (May 17, 2019).

Patient who had medical conditions including muscular dystrophy, dysphagia, scoliosis and asthma did not establish that she met the requirements for skilled nursing care because she was not ventilator dependent and did not have either an active tracheostomy or a seizure disorder. Moreover, her use of a nebulizer was occasional or periodic. That being so, she did not exhibit a severity of illness that required complex skilled nursing interventions on an ongoing basis. *H.W. v. United Healthcare, OAL DKT. NO. HMA 18602-2017, 2018 N.J. AGEN LEXIS 738*, Final Agency Determination (August 16, 2018).

Agency director adopted and approved a ruling terminating the provision of private duty nursing services to a 26 year-old recipient who was a wheelchair-bound quadriplegic due to Duchenne muscular dystrophy. The recipient did not exhibit a severity of illness that required complex skilled nursing interventions on an ongoing basis. Moreover, use of a BiPaP machine did not constitute "mechanical ventilation" for such purposes, and the possibility that the recipient may need his mask adjusted or occasional suctioning during the night did not in and of itself satisfy the threshold eligibility requirement for PDN services. *L.V. v. United Healthcare, OAL DKT. NO. HMA 08512-15, 2017 N.J. AGEN LEXIS 1159*, Final Agency Determination (October 3, 2017).

Decision by an insurer that 35 of the 112 hours of private duty nursing that were authorized to be provided to a 17 year old girl who suffered from congenital cytomegalovirus infection, developmental delays and intractable epilepsy were to be allocated to the hours when she attended school was a "proposed action to terminate, reduce or suspend assistance" within the meaning of *N.J.A.C. 10:49-10.4* and the girl's parents were entitled to adequate notice of that proposed action. That being so, the insurer was not permitted to make that allocation but was required to provide all 112 hours at the girl's home pending a hearing on the proposed action. *N.P. v. United Healthcare, OAL DKT. NO. HMA 433-17, 2017 N.J. AGEN LEXIS 495*, Initial Decision (June 28, 2017).

Director of DMAHS rejected the Initial Decision of an ALJ finding that the maximum number of private duty nursing (PDN) hours that could be provided by an insurer to a medically fragile 12-year old girl was 16 in any 24-hour period. That conclusion was legally incorrect because that standard did not pertain to children under the age of 21 who were eligible to receive Early and Periodic Screening, Diagnostic and Treatment services. Rather, such children were entitled to receive any medically necessary service. That being so, this matter was properly returned to the insurer for the purpose of an assessment to determine the amount of medically necessary PDN services that were required. *J.M. v. United Health Care, OAL DKT. NO. HMA 14778-2015, 2017 N.J. AGEN LEXIS 1072*, Order of Remand (May 3, 2017).

DMAHS approved of an ALJ's ruling rejecting an insurer's determination finding that a benefit recipient did not demonstrate that private duty nursing (PDN) was medically necessary. The recipient, who was cognitively impaired, had been receiving experimental anti-seizure medication but had suffered a breakthrough seizure when the dosage was lowered. Because the recipient was at risk for Sudden Unexpected Death in Epilepsy Patients, PDN benefits were properly continued for another six month period pending the next assessment. *A.D. v. United Healthcare, OAL DKT. NO. HMA 19558-15, 2017 N.J. AGEN LEXIS 529*, Final Administrative Determination (February 15, 2017).

Agency adopted and approved an ALJ's determination that the maximum number of hours of PDN services available to a patient was 16 and that the 16-hour cap could be exceeded only in the event of an emergency situation as when the patient's sole caregiver was hospitalized. On this record, the provider was ordered to determine whether such an emergency situation existed. *J.C. v. Horizon-NJ Health, OAL DKT. NO. HMA 04995-16, 2016 N.J. AGEN LEXIS 1355*, Final Administrative Determination (December 21, 2016).

Medical needs of a 23 year old who was diagnosed with Dravets Syndrome, including medical evidence tending to show that she was at risk of sudden death, were such that an insurer's decision to terminate private-duty nursing services under the Managed Long Term Services and Supports Program was unsupported and such services were properly required to be provided. *A.D. v. United Healthcare, OAL DKT. NO. HMA 19558-15, 2016 N.J. AGEN LEXIS 1005*, Initial Decision (December 5, 2016).

ALJ rejected an agency decision allowing a provider to terminate private duty nursing (PDN) services provided to a 13-year old Medicaid recipient who had a complex, chronic medical history that included hydrocephalus; chronic migraines; gastroesophageal reflux disease; and gastrostomy/jejunostomy tube placement. The evaluation on which termination was premised was incorrect in that it did not reflect that the child had both a jejunostomy tube and a gastrostomy tube, which was unusual. Moreover, the child had been receiving the same number of hours of PDN care for 12.5 years and nowhere in the evaluation on which the termination was based did the assessor identify any changes in his medical condition on which the termination properly was premised. *J.O'N. v. Amerigroup, OAL DKT. NO. HMA 17414-15, 2016 N.J. AGEN LEXIS 669*, Initial Decision (August 5, 2016).

Agency agreed with a determination of an ALJ that a health insurer might properly reduce private duty nursing (PDN) services being provided to a nine year old girl with muscular dystrophy and myasthenia gravis with global hypotonia from 12 hours daily to eight hours daily. *G.G. v. United Healthcare Community Plan, OAL DKT. NO. HMA 08582-15, 2016 N.J. AGEN LEXIS 505*, Final Administrative Determination (April 12, 2016).

Reduction of the private duty nursing (PDN) services being provided by a health insurer to a nine year old girl with muscular dystrophy and myasthenia gravis with global hypotonia from 12 hours daily to eight hours daily was appropriate. The child did not depend on mechanical ventilation, have an active tracheostomy or require deep

suctioning. Also, though the parents were available for some extended periods during the day and evening, they were not providing any care to their daughter and instead were relying completely on the PDN services when they could be providing themselves. Because the child's condition and needs did not meet the medical necessity criteria in governing rules, the reduction of PDN services was consistent with the rules. *G.G. v. United Healthcare Community Plan, OAL DKT. NO. HMA 08582-15, 2016 N.J. AGEN LEXIS 118*, Initial Decision (March 8, 2016).

Initial Decision (2006 N.J. AGEN LEXIS 350) adopted, which found that the staff at a Pennsylvania university offering a specialized on-campus program to assist resident students with all activities of daily living qualified under *N.J.A.C. 10:60-5.3* as adult primary caregivers residing with petitioner who had accepted 24-hour responsibility for her care; thus, petitioner, a 19-year-old student suffering from nemaline myopathy, a form of muscular dystrophy, was eligible for eight hours of private duty nursing services under the Early and Periodic Screening, Diagnosis and Treatment program. *A.G. v. DMAHS, OAL Dkt. No. HMA 10133-05, 2006 N.J. AGEN LEXIS 678*, Final Decision (June 22, 2006).

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which concluded that one justification for the 16-hour private duty nursing limitation of *N.J.A.C. 10:60-5.4*, i.e., balancing the costs of home care and institutional care, can be seen as an utilization control procedure that is rationally related to the legitimate interest in the fiscal solvency of the Medicaid program; this basis for restricting service is allowable as long as it does not impede the reasonable achievement of the purpose of the service, which is continuous care. Continuous care is achieved by placing a burden on the recipient to cover at least 8 hours of care per day. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

N.J.A.C. 10:60-5.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

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

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

1. Private duty nursing shall be provided for eligible FFS beneficiaries in the community only and not in hospital inpatient or nursing facility settings.

2. DMAHS shall determine and approve the total PDN hours for reimbursement, in accordance with *N.J.A.C. 10:60-5.2(b)*.

3. The determination of the total EPSDT/PDN hours approved shall take into account the primary caretaker's ability to provide care, as well as alternative sources of PDN care available to the caregiver, such as medical day care or a school program.

4. In emergency situations, for example, when the sole caregiver has been hospitalized, DMAHS may authorize, for a limited time, additional hours beyond the authorized amount.

5. DMAHS may also approve, for a limited time, additional hours when a change in the child's medical condition requires additional training for the primary caregiver to address changes in the care needs of the beneficiary.

(b) Medical necessity for EPSDT/PDN services shall be based upon, but may not be limited to, the following criteria in (b)1 or 2 below:

1. A requirement for all of the following medical interventions:

i. Dependence on mechanical ventilation;

ii. The presence of an active tracheostomy; and

iii. The need for deep suctioning; or

2. A requirement for any of the following medical interventions:

i. The need for around-the-clock nebulizer treatments, with chest physiotherapy;

ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or

iii. A seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anti-convulsants.

(c) The following situational criteria shall be considered, once medical necessity has been established in accordance with (b) above, when determining the extent of the need for EPSDT/PDN services and the authorized hours of service:

1. Available primary care provider support.

i. Determining the level of support should take into account any additional work related or sibling care responsibilities, as well as increased physical or mental demands related to the care of the beneficiary;

2. Additional adult care support within the household; and

3. Alternative sources of nursing care.

(d) Services that shall not, in and of themselves, constitute a need for PDN services, in the absence of the skilled nursing interventions listed in (b) above, shall include, but shall not be limited to:

1. Patient observation, monitoring, recording or assessment;

2. Occasional suctioning;

3. Gastrostomy feedings, unless complicated as described in (b)1 above; and

4. Seizure disorders controlled with medication and/or seizure disorders manifested by frequent minor seizures not occurring in clusters or associated with status epilepticus.

(e) Private duty nursing shall be a covered service only for those beneficiaries covered under EPSDT/PDN.

(f) Private duty nursing services shall not include respite or supervision, or serve as a substitution for routine parenting tasks.

(g) In the event that two Medicaid/NJ FamilyCare beneficiaries are receiving PDN services in the same household, the family may elect to have one nurse provide services for both children. The agency providing the nursing services shall document that having one nurse does not pose a health risk to either beneficiary in the plan of care which shall be signed by the physician/practitioner. At no time shall a nurse provide care for more than two beneficiaries at the same time in a single household.

History

HISTORY:

Amended by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Rewrote the section.

Amended by R.2004 d.92, effective March 1, 2004.

See: *35 N.J.R. 4424(a)*, *36 N.J.R. 1206(b)*.

In (a), amended the N.J.A.C. reference in 2 and inserted "PDN" preceding "care available to the caregiver" in 3.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "DMAHS" for "the Division" throughout; in (a)2, substituted a period for a semi-colon; in (a)4, substituted "16-hour" for "16 hour"; in (b)1, inserted "of"; and rewrote (f).

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Section was "Limitation, duration and location of EPSDT/PDN". Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (g), substituted "physician/practitioner" for "physician".

Annotations

Notes

Chapter Notes

Case Notes

Division of Medical Assistance and Health Services reversed the ALJ's decision and reinstated the insurer's termination of Private Duty Nursing (PDN) services for a 22-year-old member, who had been receiving PDN services since 2015. The member's gastronomy feedings had not been complicated by either aspiration or regurgitation, and the member had remained free of any infection. The member's activities of daily living needs did not satisfy the threshold eligibility requirements for PDN and could be addressed by personal care assistance services. *B.L. v. United Healthcare, OAL DKT. NO. HMA 04270-20, 2021 N.J. AGEN LEXIS 253*, Final Agency Determination (June 29, 2021).

Patient who had medical conditions including muscular dystrophy, dysphagia, scoliosis and asthma did not establish that she met the requirements for skilled nursing care because she was not ventilator dependent and did not have either an active tracheostomy or a seizure disorder. Moreover, her use of a nebulizer was occasional or periodic. That being so, she did not exhibit a severity of illness that required complex skilled nursing interventions on an ongoing basis. *H.W. v. United Healthcare, OAL DKT. NO. HMA 18602-2017, 2018 N.J. AGEN LEXIS 738*, Final Agency Determination (August 16, 2018).

Agency director adopted and approved a ruling terminating the provision of private duty nursing services to a 26 year-old recipient who was a wheelchair-bound quadriplegic due to Duchenne muscular dystrophy. The recipient did not exhibit a severity of illness that required complex skilled nursing interventions on an ongoing basis. Moreover, use of a BiPaP machine did not constitute "mechanical ventilation" for such purposes, and the possibility that the recipient may need his mask adjusted or occasional suctioning during the night did not in and of itself satisfy the threshold eligibility requirement for PDN services. *L.V. v. United Healthcare, OAL DKT. NO. HMA 08512-15, 2017 N.J. AGEN LEXIS 1159*, Final Agency Determination (October 3, 2017).

Private Duty Nursing services that were being provided to a 26 year old recipient who was a wheelchair-bound quadriplegic due to Duchenne muscular dystrophy were properly terminated because there was no showing of medical necessity within the meaning of governing law. Use of a BiPaP machine did not constitute "mechanical ventilation" for such purposes, and the fact that the recipient's mother adequately assisted the patient when the private duty nurse was not on duty was further evidence that the services being rendered by the private duty nurse were those of an overnight monitor rather than skilled nursing services. *L.V. v. United Healthcare Cmty. Plan, OAL DKT. NO. HMA 08512-15, 2017 N.J. AGEN LEXIS 575*, Initial Decision (July 27, 2017).

Director of DMAHS rejected the Initial Decision of an ALJ finding that the maximum number of private duty nursing (PDN) hours that could be provided by an insurer to a medically fragile 12-year old girl was 16 in any 24-hour period. That conclusion was legally incorrect because that standard did not pertain to children under the age of 21 who were eligible to receive Early and Periodic Screening, Diagnostic and Treatment services. Rather, such children were entitled to receive any medically necessary service. That being so, this matter was properly returned to the insurer for the purpose of an assessment to determine the amount of medically necessary PDN services that were required. *J.M. v. United Health Care, OAL DKT. NO. HMA 14778-2015, 2017 N.J. AGEN LEXIS 1072*, Order of Remand (May 3, 2017).

The maximum number of private duty nursing (PDN) hours that could be provided by an insurer to a medically fragile 12-year old girl who was comatose was 16 hours per day and the insurer was not permitted by governing law to provide more than 16 PDN hours in any 24 hour period. The only exception was during such times that the primary caregiver who, in this case, was the child's mother, was rendered incapable of caring for her daughter due

to the mother's illness. *J.M. v. United Health Care, OAL DKT. NO. HMA 14778-2015, 2017 N.J. AGEN LEXIS 198*, Initial Decision (March 30, 2017).

DMAHS approved of an ALJ's ruling rejecting an insurer's determination finding that a benefit recipient did not demonstrate that private duty nursing (PDN) was medically necessary. The recipient, who was cognitively impaired, had been receiving experimental anti-seizure medication but had suffered a breakthrough seizure when the dosage was lowered. Because the recipient was at risk for Sudden Unexpected Death in Epilepsy Patients, PDN benefits were properly continued for another six month period pending the next assessment. *A.D. v. United Healthcare, OAL DKT. NO. HMA 19558-15, 2017 N.J. AGEN LEXIS 529*, Final Administrative Determination (February 15, 2017).

Agency adopted and approved an ALJ's determination that the maximum number of hours of PDN services available to a patient was 16 and that the 16-hour cap could be exceeded only in the event of an emergency situation as when the patient's sole caregiver was hospitalized. On this record, the provider was ordered to determine whether such an emergency situation existed. *J.C. v. Horizon-NJ Health, OAL DKT. NO. HMA 04995-16, 2016 N.J. AGEN LEXIS 1355*, Final Administrative Determination (December 21, 2016).

Medical needs of a 23 year old who was diagnosed with Dravets Syndrome, including medical evidence tending to show that she was at risk of sudden death, were such that an insurer's decision to terminate private-duty nursing services under the Managed Long Term Services and Supports Program was unsupported and such services were properly required to be provided. *A.D. v. United Healthcare, OAL DKT. NO. HMA 19558-15, 2016 N.J. AGEN LEXIS 1005*, Initial Decision (December 5, 2016).

An insurer's determination that the maximum number of private duty nursing (PDN) hours properly authorized for a Medicaid recipient who had Amyotrophic Lateral Sclerosis was 18 hours out of every 24 hour cycle, the expectation being that the recipient's wife would provide the other 8 hours of care. Here, however, given the wife's deteriorating medical condition, the case was remanded so that the wife could provide evidence of her physical inability to provide such care, possibly triggering the medical necessity exception. *J.C. v. Horizon NJ Health, OAL DKT. NO. HMA 04995-16, 2016 N.J. AGEN LEXIS 822*, Remand Order (October 5, 2016).

Insurer erred in not obtaining and reviewing nursing care notes reflecting the nature of care needed by a patient prior to rejecting the application for private-duty nursing care. It was also erred to measure the patient's needs by using the PDN Acuity Grid, so a reassessment that complied with governing regulations was required. *JO'N v. Amerigroup, OAL DKT. NO. HMA 17414-15, 2016 N.J. AGEN LEXIS 1318*, Final Administrative Determination (September 13, 2016).

ALJ rejected an agency decision allowing a provider to terminate private duty nursing (PDN) services provided to a 13-year old Medicaid recipient who had a complex, chronic medical history that included hydrocephalus; chronic migraines; gastroesophageal reflux disease; and gastrostomy/jejunostomy tube placement. The evaluation on which termination was premised was incorrect in that it did not reflect that the child had both a jejunostomy tube and a gastrostomy tube, which was unusual. Moreover, the child had been receiving the same number of hours of PDN care for 12.5 years and nowhere in the evaluation on which the termination was based did the assessor identify any changes in his medical condition on which the termination properly was premised. *J.O'N. v. Amerigroup, OAL DKT. NO. HMA 17414-15, 2016 N.J. AGEN LEXIS 669*, Initial Decision (August 5, 2016).

Agency agreed with a determination of an ALJ that a health insurer might properly reduce private duty nursing (PDN) services being provided to a nine year old girl with muscular dystrophy and myasthenia gravis with global hypotonia from 12 hours daily to eight hours daily. *G.G. v. United Healthcare Community Plan, OAL DKT. NO. HMA 08582-15, 2016 N.J. AGEN LEXIS 505*, Final Administrative Determination (April 12, 2016).

Reduction of the private duty nursing (PDN) services being provided by a health insurer to a nine year old girl with muscular dystrophy and myasthenia gravis with global hypotonia from 12 hours daily to eight hours daily was appropriate. The child did not depend on mechanical ventilation, have an active tracheostomy or require deep suctioning. Also, though the parents were available for some extended periods during the day and evening, they were not providing any care to their daughter and instead were relying completely on the PDN services when they

could be providing themselves. Because the child's condition and needs did not meet the medical necessity criteria in governing rules, the reduction of PDN services was consistent with the rules. *G.G. v. United Healthcare Community Plan, OAL DKT. NO. HMA 08582-15, 2016 N.J. AGEN LEXIS 118*, Initial Decision (March 8, 2016).

ALJ rejected a challenge, by the guardian of a 7-year old child, to a reduction of private duty nursing (PDN) hours because the patient, a 9 year old blind child with encephalopathy, cerebral palsy and seizure disorder, did not meet the medical necessity criteria for PDN services for daytime feeding or monitoring. *J.A. v. United Healthcare Comm. Plan, OAL DKT. NO. HMA 01855-15, 2015 N.J. AGEN LEXIS 586*, Final Agency Determination (August 5, 2015).

Health care provider acted improperly when it reduced the weekly home nursing service provided to an adult who had cerebral palsy from 120 hours to 70 hours a week. The recipient was fed by a gastrostomy tube and his primary need for private duty nursing was to oversee and regulate that process. The evidence showed that the recipient suffered from seizures and airway compromise and was at risk for aspiration pneumonia and that those and other risks only could be reduced or eliminated if his care was supervised by a private duty nurse. That being so, the provider's suggestion that such tasks could be undertaken by a home health aide was contrary to regulations detailing the nature of services properly performed by such lesser trained personnel. *A.B. v. United Health Care, OAL DKT. NO. HMA15133-14, 2015 N.J. AGEN LEXIS 511*, Initial Decision (July 17, 2015).

Initial Decision (2006 N.J. AGEN LEXIS 350) adopted, which found that the staff at a Pennsylvania university offering a specialized on-campus program to assist resident students with all activities of daily living qualified under *N.J.A.C. 10:60-5.3* as adult primary caregivers residing with petitioner who had accepted 24-hour responsibility for her care; thus, petitioner, a 19-year-old student suffering from nemaline myopathy, a form of muscular dystrophy, was eligible for eight hours of private duty nursing services under the Early and Periodic Screening, Diagnosis and Treatment program. *A.G. v. DMAHS, OAL Dkt. No. HMA 10133-05, 2006 N.J. AGEN LEXIS 678*, Final Decision (June 22, 2006).

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which explained that in attempting to meet the declared purpose of New Jersey's Private Duty Nursing services under *N.J.A.C. 10:60-5.1* et seq., which is to provide individual and continuous care, the provision of these services may be, consistent with federal regulations, limited by medical necessity and utilization control procedures that ensure the fiscal solvency of the Medicaid program. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which concluded that one justification for the 16-hour private duty nursing limitation of *N.J.A.C. 10:60-5.4*, i.e., balancing the costs of home care and institutional care, can be seen as an utilization control procedure that is rationally related to the legitimate interest in the fiscal solvency of the Medicaid program; this basis for restricting service is allowable as long as it does not impede the reasonable achievement of the purpose of the service, which is continuous care. Continuous care is achieved by placing a burden on the recipient to cover at least 8 hours of care per day. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which concluded that where there were multiple children in the same household in need of services under the Early and Periodic Screening Diagnosis and Treatment/Private Duty Nursing (EPSDT/PDN) Medicaid program, petitioners failed to establish a basis for providing 24-hour private duty nursing care over and above the maximum amount of 16 hours of PDN services per child in any 24-hour period, as specifically set forth in *N.J.A.C. 10:60-5.4(a)*2; the services were still accomplished in such a way as to ensure continuous care, and by satisfying this goal of the PDN services, federal law was also satisfied. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which concluded that no deprivation of due process had resulted from deficiencies in the notice informing petitioners of a reduction in private duty nursing service hours provided by Medicaid, because petitioners had constructive notice of the grounds of denial at the time the appeal

was initiated, the hearing before the ALJ provided due process, and the services had not been terminated but had been maintained pending the outcome of the hearing. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which concluded that petitioners' Americans with Disabilities Act (ADA) claim lacked merit because the asserted basis of discrimination--that petitioners were triplets--was not a disability protected by the ADA. In addition, the Office of Administrative Law lacks jurisdiction to address ADA claims, as ADA cases are federal cases, public agencies are required to adopt procedures to handle ADA claims, the New Jersey Supreme Court has stated that the filing of a complaint with the appropriate federal agency is probably required before a New Jersey "court" may hear a case that raises ADA claims, and subject-matter jurisdiction has not been granted to the OAL by legislation. *N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112*, Final Decision (December 8, 2005).

N.J.A.C. 10:60-5.5

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.5 Determination of medical necessity for EPSDT/PDN Services

(a) An initial on-site nursing assessment is necessary in order to review the complexity of the child's care. A hands-on examination of the child is not included in the assessment. The nursing assessment shall include an hour-by-hour inventory of all care-related activities over a 24-hour period, which accurately describes the child's current care. The assessment shall be completed by a registered nurse employed by a licensed certified home health agency, an accredited healthcare services firm, or licensed hospice agency approved by DMAHS.

(b) The assessor shall describe the specific elements of care, and the individual who rendered the service. Frequency of skilled nursing interventions shall be noted, for example, indicating whether suctioning is occasional, or frequently required or regularly scheduled with chest PT, such as twice a day or every six hours.

(c) Activities that constitute skilled nursing interventions shall be identified by the assessor, separate from non-skilled nursing activities. The presence and intensity of skilled nursing interventions shall determine whether EPSDT/PDN hours should be authorized.

(d) The presence or absence of alternative care, such as medical day care, private duty nursing services provided by private insurance, or private duty nursing services provided by the child's school, shall be identified and recorded, and those hours shall be deducted from the total hours of EPSDT/PDN services to be authorized in accordance with *N.J.A.C. 10:60-5.4*.

(e) If EPSDT/PDN hours are authorized, the assessor shall indicate the duration of the prior authorization (PA) period (not to exceed six months) and the time frame for reassessment.

(f) A nursing reassessment shall be conducted by the nurse assessor prior to the end of the PDN authorization period, in accordance with the following:

1. The reassessment will be conducted in the beneficiary's home, in order to determine the on-going medical necessity of EPSDT/PDN services, and shall include a 24-hour inventory of needed services.

2. The nurse assessor shall utilize the reports from the provider agency for documentation of specific functions performed by the provider agency nurse(s).

3. Any changes in the child's status or circumstances, including the frequency and type of interventions required, shall be noted. These changes shall be clearly identified in the reassessment summary, and shall be used to support any decision to continue, reduce or increase PDN hours.

History

HISTORY:

New Rule, R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Former N.J.A.C. 10:60-5.5, Basis for reimbursement for EPSDT/PDN, recodified to N.J.A.C. 10:60-5.2.

Amended by R.2018 d.172, effective September 17, 2018.

See: 49 N.J.R. 2698(a), 50 N.J.R. 1992(b).

Section was "Nursing assessment for the determination of medical necessity for EPSDT/PDN Services". Rewrote (a), in (b), (c), and (e), deleted "nurse" preceding "assessor"; in (b), deleted "(EPSDT/PDN)" following "occasional"; and in (d), inserted ", private duty nursing services provided by private insurance, or private duty".

Amended by R.2022 d.107, effective September 6, 2022.

See: 53 N.J.R. 1327(a), 54 N.J.R. 1721(a).

In (a), inserted "registered".

Annotations

Notes

Chapter Notes

Case Notes

Division of Medical Assistance and Health Services reversed the ALJ's decision and reinstated the insurer's termination of Private Duty Nursing (PDN) services for a 22-year-old member, who had been receiving PDN services since 2015. The member's gastronomy feedings had not been complicated by either aspiration or regurgitation, and the member had remained free of any infection. The member's activities of daily living needs did not satisfy the threshold eligibility requirements for PDN and could be addressed by personal care assistance services. B.L. v. United Healthcare, OAL DKT. NO. HMA 04270-20, 2021 N.J. AGEN LEXIS 253, Final Agency Determination (June 29, 2021).

ALJ rejected an agency decision allowing a provider to terminate private duty nursing (PDN) services provided to a 13-year old Medicaid recipient who had a complex, chronic medical history that included hydrocephalus; chronic migraines; gastroesophageal reflux disease; and gastrostomy/jejunostomy tube placement. The evaluation on which termination was premised was incorrect in that it did not reflect that the child had both a jejunostomy tube and a gastrostomy tube, which was unusual. Moreover, the child had been receiving the same number of hours of PDN care for 12.5 years and nowhere in the evaluation on which the termination was based did the assessor identify any changes in his medical condition on which the termination properly was premised. J.O'N. v. Amerigroup, OAL DKT. NO. HMA 17414-15, 2016 N.J. AGEN LEXIS 669, Initial Decision (August 5, 2016).

End of Document

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

§ 10:60-5.6 Clinical records and personnel files

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

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

1. A referral source;

2. Diagnoses;

3. A physician's/practitioner's treatment plan and renewal of treatment plan every 90 days;

4. Interim physician/practitioner orders, as necessary, for medications and/or treatment;

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

6. A six-month nursing reassessment;

7. A nursing care plan;

8. Signed and dated progress notes describing beneficiary's condition; and

9. Evidence that beneficiary was given information regarding advance directives.

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

1. The visit to provide direct in-home supervision must occur during a nurse's scheduled shift to allow face-to-face supervision for that individual.

2. The direct in-home supervision shall be rotated among each private duty nurse until each staff member has been assessed.

3. The direct in-home supervision shall consist of a review of all documentation from each nurse assigned to the case, as well as a review of any concerns raised by the beneficiary or primary caretaker.

4. Concerns involving staff not present during the on-site visit shall be addressed with that staff member before they provide any care.

5. If required, follow-up interventions with the assessed staff may be by telephone or provided off-site.

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

1. Diagnoses;

2. A physician/practitioner treatment plan and interim orders;

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

4. A nursing care plan;

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

6. A record of medication administered.

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

1. A completed application for employment;

2. Evidence of a personal interview;

3. Evidence of a current license to practice nursing;

4. Satisfactory employment references;

5. Evidence of a physical examination; and

6. Ongoing performance evaluation.

(f) On-site monitoring visits shall be made periodically by DMAHS staff, or a designated agency as approved by DHS, to the private duty nursing agency to review compliance with personnel, recordkeeping, and service delivery requirements.

History

HISTORY:

Recodified from *N.J.A.C. 10:60-5.2* by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Former *N.J.A.C. 10:60-5.6*, Payment for EPSDT/PDN, recodified to *N.J.A.C. 10:60-5.7*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "DMAHS" for "Division" in (f).

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Rewrote (c); and in (f), inserted ", or a designated agency as approved by DHS," and inserted a comma following "recordkeeping".

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (b), inserted a comma twice; in (b)3, substituted "physician's/practitioner's" for "physician's"; in (b)4, substituted "physician/practitioner" for "physician" and inserted a comma twice; in (d), inserted a comma twice; and in (d)2, substituted "physician/practitioner" for "physician".

Annotations

Notes

Chapter Notes

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N.J.A.C. 10:60-5.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.7 Payment for EPSDT/PDN

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

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

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

History

HISTORY:

Recodified from *N.J.A.C. 10:60-5.6* by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Former *N.J.A.C. 10:60-5.7*, Eligibility for home and community-based services waiver/private duty nursing (PDN) services, recodified to *N.J.A.C. 10:60-5.8*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "DMAHS" for "Division" and "the Division" throughout; and in (a), substituted "CMS" for "HCFA".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

In (b), substituted "with each prior authorization request," for "every two months".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:60-5.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.8 Eligibility for managed long-term supports and services (MLTSS)/private duty nursing (PDN) services

(a) MLTSS/private duty nursing is available only to a beneficiary who meets nursing facility level of care criteria (see N.J.A.C. 10:60-6.2), is based on medical necessity, and is prior approved by the NJ FamilyCare MCO in a plan of care prepared by a MLTSS care manager. Private duty nursing is individual, continuous nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS.

(b) MLTSS/PDN services are only appropriate when the following requirements are satisfied:

1. An individual must exhibit a severity of illness that requires complex skilled nursing interventions on a continuous ongoing basis.

i. "Ongoing" means that the beneficiary requires the provision of skilled nursing intervention on an ongoing basis, up to 24 hours per day/seven days per week.

ii. "Complex" means the degree of difficulty and/or intensity of treatment/procedures.

iii. "Skilled nursing interventions" means procedures that require the knowledge and experience of licensed nursing personnel, or a trained primary caregiver.

2. There must be a capable adult primary caregiver residing with the individual who accepts ongoing 24-hour responsibility for the health and welfare of the beneficiary;

3. The adult primary caregiver must agree to be trained, or have been trained, in the care of the individual and must agree to receive additional training for new procedures and treatments if directed to do so by a State agency;

4. The adult primary caregiver must agree to provide a minimum of eight hours of care to the individual during every 24-hour period; and

5. The home environment must accommodate the required equipment and licensed PDN personnel.

History

HISTORY:

Recodified from N.J.A.C. 10:60-5.7 by R.2003 d.103, effective March 3, 2003.

See: 34 N.J.R. 2705(a), 35 N.J.R. 1279(a).

Former N.J.A.C. 10:60-5.8, Limitation, duration and location of home and community-based services waiver/private duty nursing (waiver/ PDN) services, recodified to N.J.A.C. 10:60-5.9.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "DMAHS/DDS/DDD" for "the Division" and "Community Resources for People with Disabilities (CRPD)" for "Model Waiver 3".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Section was "Eligibility for home and community-based services waiver/private duty nursing (PDN) services". Rewrote the section.

Annotations

Notes

Chapter Notes

Case Notes

Medical needs of a 23 year old who was diagnosed with Dravets Syndrome, including medical evidence tending to show that she was at risk of sudden death, were such that an insurer's decision to terminate private-duty nursing services under the Managed Long Term Services and Supports Program was unsupported and such services were properly required to be provided. *A.D. v. United Healthcare, OAL DKT. NO. HMA 19558-15, 2016 N.J. AGEN LEXIS 1005*, Initial Decision (December 5, 2016).

End of Document

N.J.A.C. 10:60-5.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.9 Limitation, duration, and location of MLTSS/PDN services

(a) MLTSS/PDN services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN).

1. Private duty nursing services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain MLTSS/PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing MLTSS/PDN services. Only those MLTSS/PDN beneficiaries who require, and are authorized by the MCO and the MLTSS care manager to receive, private duty nursing services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home.

2. Due to safety concerns, the nurse shall not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle.

(b) Private duty nursing shall be a covered service only for those beneficiaries enrolled in MLTSS. Under MLTSS, when payment for private duty nursing services is being provided or paid for by another source (that is, insurance), MLTSS shall supplement payment up to a maximum of 16 hours per 24-hour period. The hours approved shall supplement alternative sources of PDN care available, such as medical day care or a school program, including services provided or paid for by the other sources or other insurance available to the beneficiary; shall be medically necessary; and, shall comply with the annual cost threshold.

(c) Private duty nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person in MLTSS. There shall be a live-in primary adult caregiver who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy.

1. The MLTSS care manager or DMAHS shall conduct an assessment to determine the need for MLTSS/PDN services, the required provider skill level (LPN or RN), and the amount of service required. The number of hours approved and the skill level of services shall be noted in the individual's service plan and be reviewed by the care manager and/or designated DMAHS staff person every six months.

2. The adult primary caregiver must be trained in the care of the individual and agree to meet the beneficiary's skilled needs during a minimum of eight hours of care to the individual during every 24-hour period.

3. In emergency circumstances, for example, when the sole caregiver has been hospitalized or brief post-hospital periods while the caregiver(s) adjust(s) to the new responsibilities of caring for the discharged beneficiary, the MCO or DMAHS may authorize, for a limited time, additional hours beyond the 16-hour limit.

(d) Medical necessity for MLTSS/PDN services shall be based upon the following criteria:

1. A requirement for all of the following medical interventions:

i. Dependence on mechanical ventilation;

ii. The presence of an active tracheostomy; and

iii. The need for deep suctioning; or

2. A requirement for any of the following medical interventions:

i. The need for around-the-clock nebulizer treatments, with chest physiotherapy;

ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration;

iii. A seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anti-convulsants; or

iv. The need for other skilled nursing interventions on an ongoing basis.

(e) Medical interventions that shall not, in and of themselves, constitute a need for MLTSS/PDN services, in the absence of the skilled nursing interventions listed in (d) above, shall include, but shall not be limited to:

1. Beneficiary observation, monitoring, recording, or assessment;

2. Occasional suctioning;

3. Gastrostomy feedings, unless complicated as described in (d)2ii above; and

4. Seizure disorders controlled with medication and/or seizure disorders manifested by frequent minor seizures not occurring in clusters or associated with status epilepticus.

(f) The following situational criteria shall be considered, once medical necessity has been established in accordance with (d) above, when determining the extent of the need for MLTSS/PDN services in addition to the primary caregiver(s) eight-hour responsibility and the authorized hours of service:

1. Available primary care provider support.

i. Determining the level of support should take into account any additional work related or dependent(s) care responsibilities, as well as increased physical or mental demands related to the care of the individual;

2. Additional adult care support within the household; and

3. Alternative sources of nursing care.

(g) In the event that two Medicaid/NJ FamilyCare MLTSS beneficiaries are receiving PDN services in the same household, the beneficiary or legal guardian may elect to have one nurse provide services for both beneficiaries. The agency providing the nursing services shall document that having one nurse does not pose a health risk to either beneficiary in the plan of care, which shall be signed by the physician/practitioner. At no time, shall a nurse provide care for more than two beneficiaries at the same time in a single household.

History

HISTORY:

Recodified from *N.J.A.C. 10:60-5.8* by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Former *N.J.A.C. 10:60-5.9*, Basis for reimbursement for home and community-based services waiver/PDN, recodified to *N.J.A.C. 10:60-5.10*.

Amended by R.2004 d.92, effective March 1, 2004.

See: *35 N.J.R. 4424(a)*, *36 N.J.R. 1206(b)*.

Rewrote (a); in (b) and (c), substituted references to CRPD/PDN for references to Model Waiver 3.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

In (a)1, substituted "DMAHS/DDD/DDS" for "the Division"; and in (b), substituted "Community Resources for People with Disabilities (CRPD)," for the first occurrence of "CRPD/PDN", "CRPD," for the second occurrence of "CRPD/PDN" and "DDS or DMAHS" for "the Division" and inserted "or paid for" following "provided" two times; and in (c), inserted "including services provided or paid for by other sources" and substituted "CRPD," for "CRPD/PDN".

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Section was "Limitation, duration and location of home and services waiver/private duty nursing (waiver/PDN)". Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (g), substituted "physician/practitioner" for "physician".

Annotations

Notes

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Case Notes

DMAHS director reversed the ruling of an ALJ who had found that a patient was entitled to PCA services each week even though he was already receiving the maximum number of hours of private duty nursing (PDN) hours weekly. Though there was no explicit regulatory prohibition disallowing the concurrent provision of PCA services, the termination of such services was warranted where, as here, the patient already was receiving more than the maximum 16 hours of daily hands-on services permitted by law and contract. Under these facts, moreover, there was no prohibition against a private duty nurse performing nonmedical tasks. *T.M. v. United Healthcare, OAL DKT. NO. HMA 18965-16, 2017 N.J. AGEN LEXIS 1144*, Final Agency Determination (August 16, 2017).

Determination of a health care provider that a 23 year old spinal muscular atrophy patient who was paralyzed and ventilator-dependent did not qualify for personal care assistant services (PCA services) was reversed by an ALJ on findings that the provider's own assessment tool showed that the patient needed nearly 38 hours of PCA services each week. The ALJ rejected the provider's suggestion that the patient was receiving PCA-type services from personnel who were providing private duty nursing (PDN) because PDN and PCA were mutually exclusive services and the allowance of one did not limit eligibility for the other. More importantly, personnel providing PDN services were prohibited from performing non-medical services of the type provided by *PCA. T.M. v. United Healthcare, OAL DKT. NO. HMA 18965-16, 2017 N.J. AGEN LEXIS 378*, Initial Decision (June 8, 2017).

Initial Decision (2006 N.J. AGEN LEXIS 350) adopted, which found that the staff at a Pennsylvania university offering a specialized on-campus program to assist resident students with all activities of daily living qualified under *N.J.A.C. 10:60-5.3* as adult primary caregivers residing with petitioner who had accepted 24-hour responsibility for her care; thus, petitioner, a 19-year-old student suffering from nemaline myopathy, a form of muscular dystrophy, was eligible for eight hours of private duty nursing services under the Early and Periodic Screening, Diagnosis and Treatment program. *A.G. v. DMAHS, OAL Dkt. No. HMA 10133-05, 2006 N.J. AGEN LEXIS 678*, Final Decision (June 22, 2006).

End of Document

N.J.A.C. 10:60-5.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.10 Basis for reimbursement for MLTSS/PDN services

(a) A provider of private duty nursing services shall be reimbursed by the New Jersey Medicaid/NJ FamilyCare program on a fee-for-service basis for services provided as authorized by the individual's service plan prepared by the waiver case manager. Providers shall be precluded from receiving additional reimbursement for the cost of these services above the fee established by the Medicaid/NJ FamilyCare program.

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

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

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

(c) Home health services are billed on the institutional claim form (see Fiscal Agent Billing Supplement).

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

History

HISTORY:

Recodified from *N.J.A.C. 10:60-5.9* by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Former *N.J.A.C. 10:60-5.10*, Prior authorization of home and community-based services waiver/PDN, recodified to *N.J.A.C. 10:60-5.11*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "CMS" for "HCFA" throughout.

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Section was "Basis for reimbursement for home and community-based services waiver/PDN". Rewrote the introductory paragraph of (a); and in (c), substituted "institutional claim" for "UB-92 CMS-1450".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:60-5.11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 5. PRIVATE DUTY NURSING (PDN) SERVICES

§ 10:60-5.11 Prior authorization of MLTSS/PDN services

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

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

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

History

HISTORY:

Recodified from *N.J.A.C. 10:60-5.10* by R.2003 d.103, effective March 3, 2003.

See: *34 N.J.R. 2705(a)*, *35 N.J.R. 1279(a)*.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Substituted "Office" for "Bureau" in (a).

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Section was "Prior authorization of home and community-based services waiver/PDN". In the introductory paragraph of (a), substituted "MCO" for "Office of Home and Community Services".

Annotations

Notes

Chapter Notes

Case Notes

The maximum number of private duty nursing (PDN) hours that could be provided by an insurer to a medically fragile 12-year old girl who was comatose was 16 hours per day and the insurer was not permitted by governing law to provide more than 16 PDN hours in any 24 hour period. The only exception was during such times that the primary caregiver who, in this case, was the child's mother, was rendered incapable of caring for her daughter due to the mother's illness. *J.M. v. United Health Care, OAL DKT. NO. HMA 14778-2015, 2017 N.J. AGEN LEXIS 198*, Initial Decision (March 30, 2017).

An insurer's determination that the maximum number of private duty nursing (PDN) hours properly authorized for a Medicaid recipient who had Amyotrophic Lateral Sclerosis was 18 hours out of every 24 hour cycle, the expectation being that the recipient's wife would provide the other 8 hours of care. Here, however, given the wife's deteriorating medical condition, the case was remanded so that the wife could provide evidence of her physical inability to provide such care, possibly triggering the medical necessity exception. *J.C. v. Horizon NJ Health, OAL DKT. NO. HMA 04995-16, 2016 N.J. AGEN LEXIS 822*, Remand Order (October 5, 2016).

N.J.A.C. 10:60-6.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 6. MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS) PROVIDED UNDER THE NEW JERSEY 1115 COMPREHENSIVE MEDICAID WAIVER

§ 10:60-6.1 Managed long-term services and supports (MLTSS)

(a) Managed long-term services and supports (MLTSS) under the New Jersey 1115 Comprehensive Medicaid Waiver expands existing managed care programs to include managed long-term care services and supports and expands home and community-based services. The purpose of MLTSS is to increase the availability and utilization of home and community-based services for seniors and individuals with disabilities, allowing them to remain at home in the community instead of living in a nursing facility.

(b) The beneficiary's annual long-term services and support cost cannot exceed the annual cost threshold, unless he or she is granted an exception due to temporary higher care needs or long-term complex medical needs, as identified in the interdisciplinary team process.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:60-6.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 6. MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS) PROVIDED UNDER THE NEW JERSEY 1115 COMPREHENSIVE MEDICAID WAIVER

§ 10:60-6.2 Eligibility for MLTSS

(a) Individuals qualify for MLTSS by meeting established Medicaid financial requirements and Medicaid clinical and age and/or disability requirements for nursing facility services contained in *N.J.A.C. 10:69*, 70, 71, or 72.

1. For children who meet the nursing home level of care, and who are applying for MLTSS, there is no deeming of parental income or resources in the determination of eligibility.

2. Once qualified to receive MLTSS, the individual must be enrolled with a managed care organization (MCO) in order to receive MLTSS services. Limited MLTSS services may be authorized by DMAHS after the individual has been determined clinically eligible for MLTSS and prior to enrollment into the MCO.

(b) Individuals who were enrolled in the Home and Community-Based Waiver programs listed below with an enrollment date of on or before July 1, 2014, were automatically transferred into MLTSS through their managed care organization (MCO).

1. Global Options (GO);

2. Community Resources for People with Disabilities (CRPD);

3. Traumatic Brain Injury (TBI); and

4. AIDS Community Care Alternatives Program (ACCAP).

(c) Participation in managed long-term services and supports is voluntary. Individuals receiving MLTSS are required to receive care management services including, but not limited to, outreach and face-to-face visits. Failure to cooperate with care management services may result in removal from the MLTSS benefit package. Individuals who have been removed from the MLTSS benefit package may file an appeal of the removal in accordance with N.J.A.C. 10:49-10.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:60-7

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTERS 7 THROUGH 10. (RESERVED)

Title 10, Chapter 60, Subchapters 7 through 10. (Reserved)

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:60-11.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 11. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:60-11.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare programs adopted the Federal Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System codes for 2006, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, *42 U.S.C. §§ 1320d* et seq., and incorporated herein by reference, as amended and supplemented, and published by PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS (code additions, code deletions, and replacement codes) will be reflected in this chapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1* et seq., and *52:14F-1* et seq. The HCPCS codes as listed in this subchapter are relevant to certain Medicaid/NJ FamilyCare Home Care services.

(b) These codes are used when requesting reimbursement for certain Home Care services and when a CMS 1500 Claim Form is required.

History

HISTORY:

Amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

In (a), inserted references to NJ KidCare throughout; and in (b), changed form reference.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Rewrote (a); and in (b), substituted "CMS" for "HCFA".

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Rewrote the section.

Annotations

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Chapter Notes

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N.J.A.C. 10:60-11.2

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 11. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:60-11.2 HCPCS codes and maximum reimbursement rates

(a) PERSONAL CARE ASSISTANT SERVICES

HCPCS Code	Mod	Description	Maximum Rate
S9122		Personal Care Assistant Service (Individual/hourly/weekday)	$ 20.00
S9122	TV	Personal Care Assistant Service (Individual/hourly/weekend/holiday)	$ 20.00

(b) HCPCS CODES FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT/PRIVATE DUTY NURSING:

HCPCS Code	Mod	Description	Maximum Rate
S9123	EP	PDN-RN, EPSDT, Per Hour	$ 60.00
S9124	EP	PDN-LPN, EPSDT, Per Hour	$ 48.00

History

HISTORY:

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

Amended by R.2000 d.46, effective February 7, 2000.

See: *31 N.J.R. 3186(a)*, *32 N.J.R. 472(a)*.

In (a), inserted a reference to NJ KidCare--Plan A in the heading, and increased Maximum Rates for HCPCS Codes Z1600 and Z1611.

Amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Rewrote the section.

Amended by R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Rewrote section.

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

Section was "HCPCS Codes". Rewrote the section.

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

In (a), substituted "20.00" for "19.00" twice; and in (b), subtituted "60.00" for "50.00" and "48.00" for "38.00".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:60-11, Appx. A

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 60. HOME CARE SERVICES > SUBCHAPTER 11. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

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.

The Fiscal Agent Billing Supplement is available on the website of the New Jersey Medicaid/NJ FamilyCare fiscal agent: *www.njmmis.com*

If you do not have internet access and would like to request a copy of the Fiscal Agent Billing Supplement, write to:

Gainwell Technologies
PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

History

HISTORY:

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).

Amended by R.2001 d.14, effective January 2, 2001.

See: *32 N.J.R. 3940(a)*, *33 N.J.R. 66(a)*.

Amended by R.2018 d.172, effective September 17, 2018.

See: *49 N.J.R. 2698(a)*, *50 N.J.R. 1992(b)*.

APPENDIX A

Inserted "The Fiscal Agent Billing Supplement is available on the website of the New Jersey Medicaid/NJ FamilyCare fiscal agent: *www.njmmis.com*", and substituted "If you do not have internet access and would like to request" for "For" and "Molina Medicaid Systems" for "Unisys Corporation".

Amended by R.2022 d.107, effective September 6, 2022.

See: *53 N.J.R. 1327(a)*, *54 N.J.R. 1721(a)*.

Substituted "Gainwell Technologies" for "Molina Medicaid Systems".

Annotations

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End of Document

N.J.A.C. 10:60, Appx. B

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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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/	Patient appears alert and is able to respond to	

APPENDIX B

	nonagitated	simple commands. Responses are best with familiar routines, people, and structured situations. Distractibility and short attention span lead to difficulty learning new tasks and agitation in response to frustrations. If physically mobile, there may be wandering. Much external structure is needed. Initiation and memory are limited.
VI	Confused, appropriate	Patient shows goal-directed behavior, but still is dependent on external structure and direction. Simple directions are followed consistently and there is carry-over of relearned skills (like dressing), yet new learning progresses very slowly with little carry-over. Orientation is better and there is no longer inappropriate wandering.
VII	Automatic, appropriate	Patient appears appropriate and oriented with familiar settings such as home and hospital, but is confused and often helpless in unfamiliar surroundings. The daily routine can be managed with minimal confusion as long as there are no changes. There is little recall of what has just been done. There is only a superficial understanding of the disability, with lack of insight into the significance of the remaining deficits. Judgment is impaired with inability to plan ahead. New learning is slow and minimal supervision is needed. Driving is unsafe; supervision is needed for safety in the community or in school and workshop settings.
VIII	Purposeful, appropriate	Patient may not function as well as before the injury, but is able to function independently

in home and community skills, including driving. Alert, oriented, and able to integrate past and present events. Vocational rehabilitation is indicated. Difficulties dealing with stressful or unexpected situations can arise, as there may be a decrease in abstract reasoning, judgment, intellectual ability, and tolerance of stress relative to premorbid capabilities.

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N.J.A.C. 10:60 Appx. C

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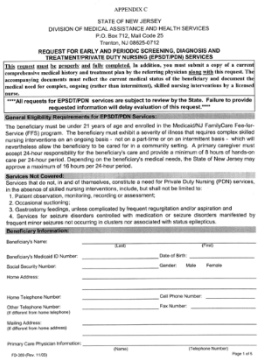

APPENDIX C

STATE OF NEW JERSEY
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712, Mail Code 25
Trenton, NJ 08625-0712

REQUEST FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT/PRIVATE DUTY NURSING (EPSDT/PDN) SERVICES

This request must be accurately and fully completed. In addition, you must submit a copy of a current comprehensive medical history and treatment plan by the referring physician along with this request. The accompanying documents must reflect the current medical status of the beneficiary and document the medical need for complex, ongoing (rather than intermittent), skilled nursing interventions by a licensed nurse.

****All requests for EPSDT/PDN services are subject to review by the State. Failure to provide requested information will delay evaluation of this request.****

General Eligibility Requirements for EPSDT/PDN Services:

The beneficiary must be under 21 years of age and enrolled in the Medicaid/NJ FamilyCare Fee-for-Service (FFS) program. The beneficiary must exhibit a severity of illness that requires complex skilled nursing interventions on an ongoing basis – not on a part-time or on an intermittent basis – which will nevertheless allow the beneficiary to be cared for in a community setting. A primary caregiver must assist 24-hour responsibility for the beneficiary's care and provide a minimum of 8 hours of hands-on care per 24-hour period. Depending on the beneficiary's medical needs, the State of New Jersey may approve a maximum of 16 hours per 24-hour period.

Services Not Covered:

Services that do not, in and of themselves, constitute a need for Private Duty Nursing (PDN) services, in the absence of skilled nursing interventions, include, but shall not be limited to:

1. Patient observation, monitoring, recording or assessment;
2. Occasional suctioning;
3. Gastrostomy feedings, unless complicated by frequent regurgitation and/or aspiration and
4. Services for seizure disorders controlled with medication or seizure disorders manifested by frequent minor seizures not occurring in clusters nor associated with status epilepticus.

Beneficiary Information:

Beneficiary's Name: _____ (Last) _____ (First)

Beneficiary's Medicaid ID Number: _____ Date of Birth: _____

Social Security Number: _____ Gender: Male Female

Home Address: _____

_____

Home Telephone Number: _____ Cell Phone Number: _____

Other Telephone Number (if different from home telephone): _____ Fax Number: _____

Mailing Address (if different from home address): _____

_____

Primary Care Physician Information: _____ (Name) _____ (Telephone Number)

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Referral Information:

Name of Person Referring: _____ (Last) _____ (First)

Organization (If Applicable): _____

Mailing Address: _____

_____

E-Mail Address: _____

Telephone Number: _____ Fax Number: _____

Hospital Information:

Name of Hospital: _____

Discharge Planner's Name: _____

Discharge Planner's Telephone Number: _____ Beeper: _____

Beneficiary's Actual or Anticipated Discharge Date: _____

Attending Physician's Name: _____

Attending Physician's Telephone Number: _____ Beeper: _____

Primary Caregiver Information:

Primary Caregiver's Name: _____ (Last) _____ (First)

Relationship to Beneficiary: _____

Home Address: _____

E-Mail Address: _____

Home Telephone Number: _____ Cell Phone Number: _____

Employer: _____

Work Address: _____

_____

Work Telephone Number: _____ E-Mail Address: _____

Time Spent at Work: _____ Hrs/Day _____ Days/Wk

Physical Limitations: _____

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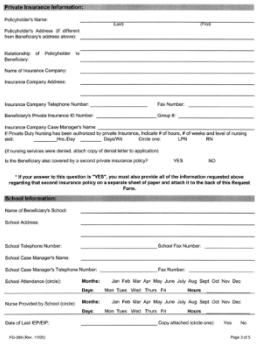

Private Insurance Information:

Policyholder's Name: _____ (Last) _____ (First)

Policyholder's Address (if different from Beneficiary's address above): _____

Relationship of Policyholder to Beneficiary: _____

Name of Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Telephone Number: _____ Fax Number: _____

Beneficiary's Private Insurance ID Number: _____ Group #: _____

Insurance Company Case Manager's Name: _____

If Private Duty Nursing has been authorized by private Insurance, Indicate # of hours, # of weeks and level of nursing skill: _____ Hrs./Day _____ Days/Wk Circle one: LPN RN

(If nursing services were denied, attach copy of denial letter to application)

Is the Beneficiary also covered by a second private insurance policy? YES NO

*** If your answer to this question is "YES", you must also provide all of the information requested above regarding that second insurance policy on a separate sheet of paper and attach it to the back of this Request Form.**

School Information:

Name of Beneficiary's School: _____

School Address: _____

_____

School Telephone Number: _____ School Fax Number: _____

School Case Manager's Name: _____

School Case Manager's Telephone Number: _____ Fax Number: _____

School Attendance (circle): **Months:** Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Days: Mon Tues Wed Thurs Fri **Hours** _____

Nurse Provided by School (circle): **Months:** Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Days: Mon Tues Wed Thurs Fri **Hours** _____

Date of Last IEP/IEP: _____ Copy attached (circle one): Yes No

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APPENDIX C

New Jersey Division of Disability Services (DDS) Information:

Is the beneficiary receiving any services from the DDS? _____ If yes, complete the following:

DDS Case Manager's Name: _____

DDS Case Manager's Telephone Number: _____

DDS Case Manager's Fax Number: _____

Nurses Provided: _____ Hrs./Day _____ Days/Wk.

Personal Care Assistant Provided: _____

Other Agency Information:

Is the beneficiary receiving services from any other agencies? _____ If yes, complete the following:

Agency Name	Contact Person's Name	Telephone Number

Parent/ Primary Caregiver Agreement:

In order for _____ to be maintained at home and receive EPSDT/PDN services, I accept the primary responsibility for his/her care. I have been trained on his/her care needs and have developed the skills to provide for those needs. I agree to receive new training for new procedures and treatments if I am directed to do so by a State agency. I agree to provide a minimum of 8 hours of hands-on care during every 24 hour period and accept the limitations and requirements of the EPSDT/PDN program. I understand that when the State receives this completed Request for EPSDT/PDN Services, it will assess my child's eligibility for those services and will decide the number of hours approved (up to 16 hours per day), the level of service approved (LPN or RN) and the length of the approval (up to a maximum of 6 months). I understand that the State will reassess my child's eligibility and need for continued EPSDT/PDN services prior to the end of the authorization period and may either continue, reduce, stop or increase these services based on any changes in my child's medical status or circumstances.

I understand that the presence or absence of alternative care, such as medical day care or nursing services provided by the child's school or by insurance, will be identified and recorded, and those hours will be deducted from the total hours of EPSDT/PDN that have been authorized. I certify that the statements made above are a true and accurate representation of the facts.

Parent/Primary Caregiver's Name: _____ (Print) _____ (Signature)

Relationship to Beneficiary: _____ Date: _____

Other Parent's Name: _____ (Print) _____ (Signature)

Relationship to Beneficiary: _____ Date: _____

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Diagnosis Information:

Name of Patient: _____

Primary Diagnosis: _____

Other Diagnoses: _____

_____

_____

Medical Necessity Criteria (Check All That Apply):

	Yes	No
Beneficiary is dependent on mechanical ventilation;		
Beneficiary has an active tracheostomy and needs frequent deep suctioning;		
Beneficiary needs around-the-clock nebulizer treatments with chest physiotherapy;		
Beneficiary needs gastrostomy feeding which is complicated by frequent regurgitation and/or aspiration;		
Beneficiary has a seizure disorder manifested by frequent prolonged seizures requiring emergency administration of anti-convulsants.		

Physician Certification (To be completed by Referring Physician):

After careful medical evaluation of _____, I certify that he/she is in medical need of complex, ongoing skilled nursing interventions by a licensed nurse. I agree to provide medical care and referrals and to review the home health agency plan of care and provide the agency with a medical treatment plan. I have discussed the patient's medical condition and required treatments with his/her parents or designated caregiver. I believe that they understand the responsibilities involved with home health care, and that they accept 24 hour responsibility for his/her care.

Referring Physician's Name (Print): _____

Referring Physician's Address: _____

_____

Referring Physician's License #: _____

Medical Specialty: _____ E-Mail Address: _____

Telephone Number: _____ Fax Number: _____

Referring Physician's Signature: _____ Date: _____

THE PHYSICIAN MUST ATTACH A CURRENT COMPREHENSIVE MEDICAL HISTORY AND TREATMENT PLAN TO THIS REQUEST FORM.

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History

HISTORY:

New Rules, R.2006 d.238, effective July 3, 2006.

See: *38 N.J.R. 1136(a)*, *38 N.J.R. 2810(a)*.

Annotations

Notes

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