1993, c. 98 (Act). The Act directs the Division of Developmental Disabilities (Division) to coordinate with the New Jersey Council on Developmental Disabilities (NJCDD) to provide supports to families that care for individuals with disabilities in the family home. The family support system permits individuals and their families to define their own needs and select their services within available resources.

Subchapter 1 of the rules sets forth the purpose and scope of the rules, which is to provide a system of family support that is flexible and designed to strengthen and promote families that provide care at home for a family member with a developmental disability. Subchapter 1 also provides the definitions for the words and terms used in the rules.

Subchapter 2 sets forth the eligibility criteria applicable to family support system services. An individual determined eligible for Division services pursuant to N.J.A.C. 10:46A is eligible for family support services if the individual either lives with a family member or an uncompensated caregiver, and other publicly funded agency services are unavailable for the family support sought.

Subchapter 3 provides that the Division will implement the family support service system in conjunction with a Family Support Coordinator who is under the direction of the New Jersey Council on Developmental Disabilities. Subchapter 3 also sets forth the role of the Family Support Coordinator to facilitate and collaborate with the efforts of Regional Family Support Planning Councils and the Statewide Council to assess needs, establish goals, and set priorities for the provision of family supports.

Subchapter 4 provides the membership requirements and responsibilities for the Regional and Statewide Family Support Planning Councils.

While the Division is readopting these rules, it recognizes that further rulemaking may be necessary to update these rules in the future. Thus, the Division will continue to review the rules and may consider making substantial amendments prior to the next scheduled readoption.

The Division has reviewed the rules and determined that they are necessary and proper for the purpose for which they were originally promulgated. Therefore, pursuant to N.J.S.A. 52:14B-5.1.c(1), N.J.A.C. 10:46A is readopted and shall continue in effect for seven years.

(a)

DIVISION OF DEVELOPMENTAL DISABILITIES

Notice of Readoption
Placement
Readoption: N.J.A.C. 10:46B

Authorized By: Sarah Adelman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4-25.4 and 30:4-165.2.

Effective Date: September 30, 2024.
New Expiration Date: September 30, 2031.

Take notice that pursuant to N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 10:46B were scheduled to expire on November 17, 2024. N.J.A.C. 10:46B establishes the standards and criteria for placements for eligible individuals. Pursuant to statute, the Division of Developmental Disabilities (Division) assists eligible individuals with appropriate functional services. See N.J.S.A. 30:4-25.4. Functional services include those services that are provided through a residential placement. See N.J.S.A. 30:4-25.1. The Division determines placements based upon each individual's unique needs and situation.

Subchapter 1 of the rules sets forth the purpose of the rules, authority, as well as establishes the standards and criteria for the placement of eligible persons. The subchapter also sets forth the scope of the rules providing that the chapter applies to eligible individuals and provides the definitions for the words and terms used in the chapter.

Subchapter 2 sets forth the general standards for the administration of placements.

Subchapter 3 provides guidelines and parameters regarding the availability of placements, as well as addresses residential placement and waiting lists. The subchapter also describes the process for determining whether an individual is in need of emergency services.

Subchapter 4 sets forth general standards for placement decisions, sets forth guidelines for placements in private institutions, and provides guidelines for private out-of-State placements.

Subchapter 5 sets forth the provisions for filing an appeal of a placement decision.

While the Division is readopting these rules, it recognizes that further rulemaking may be necessary to update these rules in the future. Thus, the Division will continue to review the rules and may consider making substantial amendments prior to the next scheduled readoption.

The Division has reviewed the rules and determined that they are necessary and proper for the purpose for which they were originally promulgated. Therefore, pursuant to N.J.S.A. 52:14B-5.1.c(1), N.J.A.C. 10:46B is readopted and shall continue in effect for seven years.

(b)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Notice of Readoption
Prosthetic and Orthotic Services
Readoption with Technical Changes: N.J.A.C. 10:55

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Authorized By: Sarah Adelman, Commissioner, Department of Human Services.

Effective Dates: September 30, 2024, Readoption;
November 4, 2024, Technical Changes.
New Expiration Date: September 30, 2031.

Take notice that pursuant to N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 10:55, Prosthetic and Orthotic Services, were scheduled to expire on November 20, 2024. N.J.A.C. 10:55 provides provider participation requirements and related information for the provision of prosthetic and orthotic services pursuant to the New Jersey Medicaid/NJ FamilyCare fee-for-service program. The rules also identify covered and non-covered prosthetic and orthotic devices and services.

N.J.A.C. 10:55 provides provider enrollment and participation requirements and related information for the provision of prosthetic and orthotic services pursuant to the Medicaid/NJ FamilyCare fee-for-service programs. The chapter consists of two subchapters and a chapter appendix.

N.J.A.C. 10:55-1 includes the general provisions of the chapter, including an overview of services, pertinent definitions, requirements for participation in the program for providers, policy on footwear, prior authorization requirements, prescription policies, and reimbursement policies.

N.J.A.C. 10:55-2 describes and sets forth the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codes and the maximum fee allowances for the covered services.

N.J.A.C. 10:55 Appendix A sets forth information regarding the Fiscal Agent Billing Supplement.

While the Department is readopting these rules with technical changes, it recognizes that further rulemaking may be necessary to update these rules. Therefore, the Department will continue to review the rules and may consider making substantial amendments prior to the next scheduled readoption.

An administrative review of the rules has been conducted, and a determination has been made that N.J.A.C. 10:55 should be readopted, with technical changes, because the rules are necessary, reasonable, adequate, efficient, understandable, and responsive to the purposes for which they were originally promulgated. Therefore, pursuant to N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq., and in accordance with N.J.S.A. 52:14B-5.1.c(1), these rules are readopted and shall continue in effect for a seven-year period.

Throughout the chapter, technical changes replace references to "Medicaid" with "Medicaid/NJ FamilyCare" to be consistent with the current program terminology.

At N.J.A.C. 10:55 Appendix A, a technical change changes the name of the Medicaid/NJ FamilyCare fiscal agent to reflect the current fiscal agent, Gainwell Technologies and removes the "A" codification from the appendix as there is only one appendix.

Full text of the technical changes follows (additions indicated in boldface **thus**; deletion indicated in brackets [thus]):

SUBCHAPTER 1. GENERAL PROVISIONS

10:55-1.1 Introduction

(a) This chapter of the manual N.J.A.C. 10:55 outlines the rules of the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare programs relevant to the provision of prosthetic and orthotic services to [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service beneficiaries. It also lists the specific requirements which must be followed in order to be approved and to participate as a New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare provider of prosthetic and orthotic services.

(b) The Prosthetic and Orthotic Services Manual, N.J.A.C. 10:55, does not include rules for the provision to [Medicaid and NJ] **Medicaid/NJ** FamilyCare beneficiaries of dentures, artificial eyes, or hearing aids. These services are covered in the New Jersey [Medicaid and NJ] **Medicaid/NJ FamilyCare** programs' Dental Services Manual, N.J.A.C. 10:56, Vision Care Services Manual, N.J.A.C. 10:62, and the Hearing Aid Services Manual, N.J.A.C. 10:64, respectively.

(c) Unless otherwise stated, the rules of this chapter apply to [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plan A fee-for-service beneficiaries. Prosthetic and orthotic services provided to [Medicaid and NJ] **Medicaid/NJ** FamilyCare beneficiaries enrolled in a managed care organization (MCO) are governed and administered by that MCO.

1. (No change.)

10:55-1.3 Requirements for approval as a provider of prosthetic and orthotic services

(a) In order to be a fully approved New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service provider of prosthetic and orthotic services, the applicant shall:

1.-2. (No change.)

(b) In order to be granted "provisional" approval by the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service programs, facilities and/or personnel whose application for accreditation/certification is pending with the American Board for Certification in Orthotics, Prosthetics and Pedorthics, Incorporated, the applicant shall:

1.-2. (No change.)

(c) (No change.)

(d) If a certified facility loses its certified prosthetist(s), orthotist(s)**,** and/or pedorthist(s), the fiscal agent shall be notified within five working days of the loss. A grace period of 180 days from the date of such loss shall be granted for demonstrating recertification before provider eligibility is terminated. In the interval between the loss and recertification of personnel, the minimum requirement for continuing acceptable [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service provider eligibility is that fabricated appliances must be fabricated by personnel whose board eligibility is established.

10:55-1.4 Requirements for program participation as prosthetic and orthotic services provider

(a) An approved [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service provider of prosthetic and orthotic services shall be responsible for the following:

1.-3. (No change.)

4. Warranting against defective material and workmanship (except for parts normally worn from natural use) for a period of one year from date of delivery to and acceptance by the beneficiary. If it is found that either the material or the workmanship is defective, the provider shall be allowed a reasonable opportunity to make such adjustment and/or corrections or replacement without additional charge to the [Medicaid and NJ] **Medicaid/NJ** FamilyCare program, or the beneficiary.

i.-ii. (No change.)

10:55-1.7 Policy on footwear

(a) For purposes of the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare programs policies, an "orthopedic shoe" means footwear, with or without accompanying appliances, used to prevent or correct gross deformities of the feet, which is properly fitted as to length and width, and consists of the following basic parts:

1.-8. (No change.)

(b)-(c) (No change.)

10:55-1.8 Reimbursement for prosthetic and orthotic appliances

(a) (No change.)

(b) Providers of prosthetic and orthotic appliances shall be reimbursed on a fee-for-service basis not to exceed the maximum fee schedule allowance [in] **at** N.J.A.C. 10:55-2. Generally, the reimbursement policy for the purchase or repair of any appliance or footwear is in accordance with the lower of the [Medicaid and NJ] **Medicaid/NJ** FamilyCare maximum fee allowance or the provider's usual and customary charge. In certain instances, a maximum fee allowance cannot easily be established because of the variety of items that can be provided under the same HCPCS. In those instances, the notation "B.R.," by report, is listed in the fee schedule. In those cases, [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service reimbursement will be established by the Division after a review of the additional material submitted by the provider.

1.-2. (No change.)

(c) - (d) (No change.)

(e) For any [Medicaid and NJ] **Medicaid/NJ** FamilyCare beneficiary who is covered under Medicare, responsibility for payments by the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare program for non-hospital based, Medicare Part B services shall be limited to the unsatisfied deductible and/or coinsurance amount to the extent that the combined total of these payments does not exceed the maximum fee allowance for the same or similar service provided by the [Medicaid and NJ] **Medicaid/NJ** FamilyCare program in the absence of other coverage. This limitation shall apply for claims with dates of service on or after July 20, 1998.

SUBCHAPTER 2. CENTERS FOR MEDICARE AND MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:55-2.1 Introduction

(a) (No change.)

(b) The New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service programs utilize the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Code System (HCPCS) for 2009, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, and incorporated herein by reference, as amended and supplemented, and as 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 subchapter 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. HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT numeric design, the CMS-assigned codes and modifiers contain alphabetic characters.

1.-2. (No change.)

10:55-2.2 Elements of HCPCS Coding System

(a)-(b) (No change.)

(c) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the HCPCS procedure code. The [Medicaid and NJ] **Medicaid/NJ**

FamilyCare fee-for-service program's recognized modifier codes for prosthetic and orthotic services are as follows:

1.-2. (No change.)

APPENDIX [A]

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, an updated copy will be posted on www.njmmis.com and a copy will be filed with the Office of Administrative Law. If you do not have access to the internet and would like to request a copy of the Fiscal Agent Billing Supplement, write to:

[Molina Medicaid Solutions] **Gainwell Technologies**
PO Box 4801
Trenton, New Jersey 08619-4801
or contact:
Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Notice of Readoption
Advanced Practice Nurse Services
Readoption with Technical Changes: N.J.A.C. 10:58A

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Authorized By: Sarah Adelman, Commissioner, Department of Human Services.

Effective Dates: October 1, 2024, Readoption;
November 4, 2024, Technical Changes.

Expiration Date: October 1, 2031.

Take notice that pursuant to N.J.S.A. 52:14B-5.1, N.J.A.C. 10:58A, Advanced Practice Nurse Services, was scheduled to expire on November 20, 2024. The Department of Human Services (Department) is issuing this notice of readoption with technical changes in order to avoid expiration of the rules at N.J.A.C. 10:58A. The chapter sets forth enrollment and participation requirements for advanced practice nurses (APNs) enrolled as Medicaid/NJ FamilyCare providers and rules related to the provision of those services to Medicaid/NJ FamilyCare beneficiaries.

The chapter sets forth four subchapters, as described below:

Subchapter 1, General Provisions, includes an overview of services that may be provided by an APN. Definitions of words and terms used in the rules are provided. Requirements for provider participation are identified and addressed, documentation requirements are explained, and the basis of reimbursement is provided. Personal contribution to care requirements for NJ FamilyCare Plan C beneficiaries and copayments for Plan D beneficiaries are specified.

Subchapter 2, Provision of Services, describes the general policies and procedures for the provision of Medicaid and NJ FamilyCare fee-for-service services provided by APNs. Services (medical services, surgical procedures, pharmaceutical services, clinical laboratory services, family planning, mental health, and obstetrical and gynecological services) are separately identified and discussed when unique characteristics or requirements exist. Evaluation and management services and codes for specialty areas and specialty programs, such as the New Jersey Vaccines for Children program and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, are described. The medical exception process and pre-admission screening requirements are also included at Subchapter 2.

Subchapter 3, HealthStart, sets forth HealthStart program requirements, including: a description of the services; purpose and scope of the services; provider participation criteria; termination of a HealthStart provider certificate; documentation, confidentiality, and informed consent requirements for HealthStart maternity care providers; health support services; standards for the pediatric HealthStart certificate; professional requirements for HealthStart pediatric care providers; preventive care services by HealthStart pediatric care providers; referral services by HealthStart pediatric care providers; documentation, confidentiality, and informed consent requirements for HealthStart pediatric care providers; and a delineation of specific pediatric services provided by an APN who has a HealthStart certificate.

Subchapter 4, Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), addresses how HCPCS codes and assigned modifiers are utilized by Medicaid and NJ FamilyCare fee-for-service providers for payment for services rendered. The subchapter assists providers in determining the appropriate procedure code to be used for the service rendered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

N.J.A.C. 10:58A Appendix sets forth the Fiscal Agent Billing Supplement.

In addition to readopting the existing rules, the Department is making technical changes throughout N.J.A.C. 10:58A. The changes correct nomenclature and terminology, correct cross-references, update contact information, and make grammatical changes. They do not change the purpose or intent of the rule.

Throughout the chapter, references to "Medicaid" are being replaced with "Medicaid/NJ FamilyCare" to be consistent with the current program terminology.

Throughout the chapter, including the appendix, references to "Molina Medicaid Solutions" are being replaced with references either to "the DMAHS fiscal agent" for a general reference, or "Gainwell Technologies" for a specific reference, to the DMAHS fiscal agent, depending on the context of the language.

Throughout the chapter, references to the "New Jersey Department of Health and Senior Services" are being replaced with references to the "New Jersey Department of Health" to reflect the current name of the department. In addition, the acronym "DHSS" is being changed to "DOH," where applicable.

Throughout the chapter, references to the "Division of Mental Health Services" are being replaced with references to the "Division of Mental Health and Addiction Services" to reflect the current name of the Division. In addition, the acronym "DMHS" is being changed to "DMHAS," where applicable.

At N.J.A.C. 10:58A-1.1(a), a grammatical correction that does not change the purpose or intent of the rule is being made.

New N.J.A.C. 10:58A-1.3(a)2 adds a website address to the contact information for Gainwell Technologies, the DMAHS fiscal agent.

At N.J.A.C. 10:58A-1.4(e), a reference at N.J.A.C. 10:49-9.9 is deleted. N.J.A.C. 10:49-9.9 was repealed, effective February 6, 2012, and this reference was inadvertently not deleted at that time.

At N.J.A.C. 10:58A-1.5(c), a grammatical correction reorganizes the sentence but that does not change the purpose or intent of the rule.

At N.J.A.C. 10:58A-2.5(d)4, a cross-reference at N.J.A.C. 10:49 is corrected.

At N.J.A.C. 10:58A-2.10(a), a change spells out the acronym "MI/MR" to read "mental illness (MI) and/or intellectual disabilities (ID)" with "ID" replacing the outdated term "MR," which referred to mental retardation.

At N.J.A.C. 10:58A-2.10(c), a change replaces the outdated term "mental retardation" with the term "intellectual disabilities."

At N.J.A.C. 10:58A-2.10(e)2, a change replaces the reference to the 1987 edition of the "Diagnostic and Statistical Manual of Mental Disorders (DSM-III)" with a requirement that the provider refer to the most recent version of the DSM, as is standard practice within the provider community. An additional change updates a reference to "being diagnosed as mentally retarded" to "being diagnosed as having intellectual disabilities."