readily accessible location a minimum of 10 feet from the burner. For electrically driven equipment, an identified switch in the burner supply circuit shall be provided at the entrance to the room or area where the appliance is located or, for equipment located in basements, the switch is required to be located at the top of stairs leading to the basement. An identifiable valve in the oil supply line, operable from a location a minimum of 10 feet from the burner, shall be used for other than electrically driven or controlled equipment.

13. Chapter 14, Heating and Cooling Equipment, shall be amended as follows:

i. Section M1401.3, Equipment and appliance sizing, "When provided" shall be inserted at the beginning of the sentence.

ii.-viii. (No change.)

14.-15. (No change.)

16. Chapter 21, Hydronic Piping, shall be amended as follows:

i. (No change.)

ii. In Sections M2101.3, Protection of potable water, M2101.25, Protection of potable water, and M2105.18, Protection of potable water, "Section P2902" shall be deleted and "the plumbing subcode (N.J.A.C. 5:23-3.15)" shall be inserted.

iii. In Sections M2101.16 and M2105.9, both entitled CPVC plastic pipe, "Section P2906.9.1.2" shall be deleted and "the plumbing subcode (N.J.A.C. 5:23-3.15)" shall be inserted. In addition, in Sections M2101.21 and M2105.14, both entitled PVC plastic pipe, "Section P2906.9.1.4" shall be deleted and "the plumbing subcode (N.J.A.C. 5:23-3.15)" shall be inserted.

iv. (No change in text.)

v. In Sections M2101.26, Pipe penetrations, and M2105.19, Pipe penetrations, "Section P2606.1" shall be deleted and "the plumbing subcode (N.J.A.C. 5:23-3.15)" shall be inserted.

17.-18. (No change.)

19. Chapter 24, Fuel Gas, shall be amended as follows:

i.-vi. (No change.)

vii. Section G2412.2, Liquefied petroleum gas storage, shall be amended to add the following: "Notwithstanding the provisions contained in NFPA 58, the installation of LP-Gas containers on roofs of buildings shall be strictly prohibited."

viii.-x. (No change.)

Recodify existing xii.-xv. as xi.-xiv. (No change in text.)

20. (No change.)

21. Chapter 29, Water Supply and Distribution, shall be deleted except P2904, Dwelling unit fire sprinkler systems. The deleted sections shall have "Plumbing requirements under the scope of this subcode shall be regulated by the plumbing subcode, N.J.A.C. 5:23-3.15." inserted.

i. (No change.)

22.-23. (No change.)

24. The Appendices shall be amended as follows:

i. Appendix *[A]* ***AA***, Sizing and Capacities of Gas Piping; Appendix *[B]* ***AB***, Sizing of Venting Systems Serving Appliances Equipped with Draft Hoods, Category I Appliances, and Appliances Listed for Use with Type B Vents; and Appendix *[C]* ***AC***, Exit Terminals of Mechanical Draft and Direct-Vent Venting Systems are informative and are not part of the one- and two-family dwelling subcode.

ii. Appendix *[D]* ***AD***, Recommended Procedure for Safety Inspection of an Existing Appliance Installation; Appendix *[E]* ***AE***, Manufactured Housing Used as Dwellings; Appendix *[F]* ***AF***, Radon Control Methods; and Appendix *[G]* ***AG***, Piping Standards for Various Applications, are deleted in their entirety.

iii. Appendix *[H]* ***AH***, Patio Covers, and Appendix *[K]* ***AK***, Sound Transmission, shall be adopted as part of this subcode.

iv. Appendix *[I]* ***AI***, Private Sewage Disposal; Appendix *[J]* ***AJ***, Existing Buildings and Structures; Appendix *[L]* ***AL***, Permit Fees; Appendix *[M]* ***AM***, Home Day Care—R-3 Occupancy; Appendix *[N]* ***AN***, Venting Methods; Appendix *[O]* ***AO***, Automatic Vehicular Gates; and Appendix *[P]* ***AP***, Sizing of Water Piping Systems, shall be deleted.

v. Appendix *[Q]* ***AQ***, Tiny Houses; Appendix *[R]* ***AR***, Light Straw-Clay Construction; and Appendix *[S]* ***AS***, Strawbale Construction, shall be adopted as part of this subcode.

vi. Appendix *[T]* ***AT***, Solar-Ready Provisions—Detached One- And Two-Family Dwellings, Multiple Single-Family Dwellings (Townhouses), shall be optional at the discretion of the permit applicant.

vii. Appendix *[V]* ***AV***, Board of Appeals, shall be deleted in its entirety.

viii. Appendix *[W]* ***AW***, 3D-Printed Construction, shall be adopted as part of this subcode. The Appendix shall be amended as follows:

(1) In Section AW103.2, Design approval, in the last line, "Section 104.11" shall be deleted, and "the administrative provisions of the Uniform Construction Code" shall be inserted in its place.

5:23-3.22 Fuel gas subcode

(a) Rules concerning the fuel gas subcode adopted are as follows:

1. Pursuant to authority of P.L. 1975, c. 217, the Commissioner hereby adopts the model code of the International Code Council, Inc., known as the International Fuel Gas Code/2021. This code is hereby adopted by reference as the fuel gas subcode for the State of New Jersey subject to the modifications at (b) below.

i. (No change.)

ii. The International Fuel Gas Code/2021 may be known and cited as the "fuel gas subcode."

2.-3. (No change.)

(b) The following chapters, sections or pages of the International Fuel Gas Code/2021 shall be amended as follows:

1.-3. (No change.)

4. Chapter 4 of the fuel gas subcode, entitled "Gas Piping Installation," shall be amended as follows:

i.-iii. (No change.)

5. Chapter 5 of the fuel gas code, entitled "Chimneys and vents," shall be amended as follows:

i.-ii. (No change.)

6. Chapter 6 of the fuel gas code, entitled "Specific Appliances," shall be amended as follows:

i. In Section 614.11, Common exhaust systems for clothes dryers located in multistory structures, item 7, insert ", if provided," after the word "and".

ii.-iii. (No change.)

7. Chapter 7 of the fuel gas code, entitled "Gaseous Hydrogen Systems," shall be amended as follows:

i. In Section 701.2, Permits, "Section 106" shall be deleted, and "the administrative provisions of the Uniform Construction Code" shall be inserted in its place.

8. Chapter 8 of the fuel gas code, entitled "Referenced Standards," shall be amended as follows:

i. Under the heading "ICC," amend the following titles:

(1) Delete " IPC—21, International Plumbing Code."

Recodify existing 8.-9. as 9.-10. (No change in text.)

11. Appendix E of the fuel gas subcode, entitled "Board of Appeals," is deleted in its entirety.

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services

Adopted New Rules with Amendments: N.J.A.C. 10:60

Proposed: August 16, 2021, at 53 N.J.R. 1327(a).

Adopted: July 20, 2022, by Sarah Adelman, Commissioner, Department of Human Services.

Filed: August 3, 2022, as R.2022 d.107, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

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

Agency Control Number: 21-A-03.

Effective Date: September 6, 2022.
Expiration Date: September 6, 2029.

Summary of Public Comments and Agency Responses:

Comments were received from the American Association of Nurse Practitioners (AANP), the Alliance for the Betterment of Citizens with Disabilities (ABCD), the Home Care & Hospice Association of NJ (HCHANJ), and Leading Age New Jersey and Delaware (LA-NJDE).

1. COMMENT: **General**. A commenter submitted a letter expressing full support of the rules proposed for readoption with amendments.

RESPONSE: The Department of Human Services (Department) thanks the commenter for their support.

2. COMMENT: **N.J.A.C. 10:60-1.6**. The commenter expressed support for the inclusion of Practitioner Orders for Life Sustaining Treatment (POLST) forms, but maintains that the proposed language is ambiguous regarding what duties would be required of the home health agencies other than acknowledging the POLST, adding it to the patient's chart, and answering questions about the form. The commenter requests clarification as to their responsibilities concerning this form.

RESPONSE: The POLST form is meant to be used alone or in conjunction with other forms of advance directives. As such, the Federal requirements referenced at N.J.A.C. 10:60-1.6 apply. As with other documents addressing an individual's preferences regarding end-of-life care directives, providers are required, at a minimum, to offer information regarding the forms, maintain a copy of all forms with the patient's chart, and respect the patient's wishes as indicated on the form. After review of the Federal requirements, the Department maintains that the language at N.J.A.C. 10:60-1.6 is consistent with the Federal requirements and that no clarification or change is needed. Additionally, the Department of Health has issued rules relating to licensing standards for home health agencies that address the use of POLST forms; the commenter may wish to consult those rules for further detail. See N.J.A.C. 8:42-6.5.

3. COMMENT: **N.J.A.C. 10:60-2.1(d)5i**. A commenter expressed support for the change of all references to "physician" being changed to "physician/practitioner" as home health services can be prescribed by medical professionals other than physicians within the scope of their licensure, but noted that this change was not made in the second sentence of this subparagraph.

RESPONSE: The Department will correct this oversight upon adoption.

4. COMMENT: **N.J.A.C. 10:54-5.17**. A commenter requested that the reference to "physician" be changed to "physician/practitioner" at this cite to be consistent with the proposed amendments.

RESPONSE: The proposed rulemaking readopted, with amendments, is N.J.A.C. 10:60, Home Care Services. N.J.A.C. 10:54-5.17 is part of the Physician Services Manual and, therefore, is outside the scope of this rulemaking, so the requested change will not be made as part of this rulemaking.

5. COMMENT: **N.J.A.C. 10:60-3.5**. A commenter recommended that the current regulation be changed regarding the supervision of certified home health aides (CHHA) by registered nurses (RN) to allow remote supervisory visits. The commenter noted that the State allowed supervisory visits to be done remotely using telehealth as part of the response to the COVID-19 pandemic. The commenter maintains that allowing the use of remote supervision will be more efficient, particularly for those clients who receive services from multiple CHHAs.

RESPONSE: Telehealth supervisory visits were authorized as part of the response to the recent COVID-19 public health emergency (PHE) as a temporary measure to make sure that some level of supervision was provided. The Department's rules regarding the supervision of a CHHA by a RN are consistent with Board of Nursing rules at N.J.A.C. 13:37-6.2 and 14.3. The use of remote supervisory visits should be determined by the licensing board when they address telehealth regulation changes.

6 COMMENT: **N.J.A.C. 10:60-3.6**. A commenter recommends removing the word "any" when referring to nursing assessments and instead require agencies to keep the records for three years in the active chart or available onsite at the agency location to be consistent with the requirements of the accrediting bodies in New Jersey.

RESPONSE: The Department agrees with the commenter that consistency with the accrediting bodies in New Jersey should be maintained whenever feasible. Accordingly, the above suggestion will be implemented upon adoption. This will not cause a burden on the regulated public, as they are already required to keep these records pursuant to the licensing authority.

7. COMMENT: **N.J.A.C. 10:60-5.6(c)**. The commenter maintains that this regulation, which requires direct supervision of a private duty nurse be provided by a registered nurse in the resident's home every 30 days, "exceeds the Federal Medicare Condition of Participation as well as many if not all regulations in other states for the supervision of nursing services." The commenter maintains that this level of supervision "does not consider the scope of practice of licensed professionals or all components of case oversight that include clinical documentation, review of orders obtained and changes to the plan of care, physician directed plan of care under which all nurses must work, care coordination and technology such as electronic health records." The commenter recommends revising the regulation to align more closely with the Medicare Condition of Participation, with a focus on case management, care coordination, and oversight of services, while only requiring physical observation of the private duty nurse once per year.

RESPONSE: The Department appreciates the comment and will take the recommended changes under advisement; however, no change will be made upon adoption. The Department will review the Medicare Condition of Participation and if it is determined that changes are needed to the existing rule, additional amendments will be proposed in a future rulemaking, as any amendments designed to implement the suggested amendments would be too substantive to include upon adoption, and are not necessary at this point in time.

Federal Standards Statement

Sections 1902(a)(10) and 1905(a) of the Social Security Act, 42 U.S.C. §§ 1396a(a)(10) and 1396d(a), respectively, specify who may receive services through a Title XIX Medicaid program and which services may be provided under the program, including home health services.

Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n, and 42 CFR 440, 441, and 484 allow a state Medicaid program to provide in-home community-based waiver services. Home and community-based services, provided under federally approved waivers, and home care services, are governed by 42 CFR 440.70 and 440.180, which list services eligible for reimbursement as home care services.

Title XXI of the Social Security Act allows a state, at its option, to provide a state child health insurance plan (SCHIP). New Jersey has elected this option with the development of the NJ FamilyCare Program. Sections 2103 and 2110 of the Social Security Act, 42 U.S.C. §§ 1397cc and 1397jj, respectively, describe services that a state may provide to targeted, low-income children.

Section 2110 of the Act (42 U.S.C. § 1397jj) allows a state to provide home care services for the state children's health insurance program.

Federal regulations at 45 CFR 162.402 through 162.414 require the use of standard unique health identifiers for healthcare providers.

The Division has reviewed the Federal statutory and regulatory requirements and has determined that the rules readopted with amendments do not exceed Federal standards.

Full text of the expired rules proposed herein as new rules can be found in the New Jersey Administrative Code at N.J.A.C. 10:60.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 Purpose and scope

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

(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)-(e) (No change.)

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.

. . .

"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.

. . .

"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.-2. (No change.)

. . .

"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).

. . .

"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.

. . .

"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.

. . .

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

. . .

"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.

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. (No change.)

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) (No change in text.)

(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.

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.

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)).

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.

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. (No change.)

(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.-5. (No change.)

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

1. (No change.)

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. (No change.)

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

5.-7. (No change.)

(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.-4. (No change.)

(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.-3. (No change.)

(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.-5. (No change.)

(h) (No change.)

(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.-3. (No change.)

(j) (No change.)

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) (No change.)

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.

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. (No change.)

ii. Home health services shall not be available to Medicaid/NJ FamilyCare fee-for-service beneficiaries in a hospital or nursing facility.

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

(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.-xi. (No change.)

2.-3. (No change.)

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. (No change.)

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]* ***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) (No change.)

(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)-(C) (No change.)

(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)-(B) (No change.)

(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) (No change.)

6.-7. (No change.)

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) (No change.)

9. (No change.)

(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).

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.-5. (No change.)

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.-10. (No change.)

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

12. (No change.)

Recodify existing (c)-(e) as (b)-(d) (No change in text.)

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.-2. (No change.)

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

4.-5. (No change.)

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. (No change.)

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

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

(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.-6. (No change.)

(d)-(i) (No change.)

SUBCHAPTER 3. PERSONAL CARE ASSISTANT (PCA) SERVICES

10:60-3.1 Purpose and scope

(a) (No change.)

(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.-4. (No change.)

(c) (No change.)

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.-ix. (No change.)

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)-(c) (No change.)

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) (No change.)

(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)-(f) (No change.)

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.-3. (No change.)

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. *[Any nursing]* ***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.***

Recodify existing iii.-ix. as ii.-viii. (No change in text.)

3. (No change.)

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)-(c) (No change.)

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.-8. (No change.)

(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.-3. (No change.)

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

1.-3. (No change.)

4. Child care or babysitting;

5.-9. (No change.)

(d)-(i) (No change.)

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

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

(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.

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)-(d) (No change.)

10:60-5.4 Limitation, duration, and location of EPSDT/PDN

(a)-(f) (No change.)

(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.

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)-(f) (No change.)

10:60-5.6 Clinical records and personnel files

(a) (No change.)

(b) Clinical records maintained at the agency shall contain, at a minimum, the following:

1.-2. (No change.)

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.-9. (No change.)

(c) (No change.)

(d) Clinical records maintained in the beneficiary's home by the private duty nurse shall contain, at a minimum, the following:

1. (No change.)

2. A physician/practitioner treatment plan and interim orders;

3.-6. (No change.)

(e)-(f) (No change.)

10:60-5.9 Limitation, duration, and location of MLTSS/PDN services

(a)-(f) (No change.)

(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.

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) (No change.)

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

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

CORRECTIONS

(a)

STATE PAROLE BOARD

State Parole Board Rules

Adopted Amendments: N.J.A.C. 10A:71-3.2, 3.16, 3.18, 3.20, 3.53, 6.4, 6.11, 6.12, 7.9, 7.15, and 7.17

Adopted New Rules: N.J.A.C. 10A:72-16

Proposed: May 2, 2022, at 54 N.J.R. 760(a).

Adopted: July 27, 2022, by the New Jersey State Parole Board, Samuel J. Plumeri, Jr., Chairman.

Filed: August 12, 2022, as R.2022 d.112, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 30:4-123.48.d; and P.L. 2020, c. 106 (N.J.S.A. 30:4-123.51 et seq.), and P.L. 2021, c. 19 (N.J.S.A. 2C:35-5 et seq.).

Effective Date: September 6, 2022.
Expiration Dates: March 19, 2025, N.J.A.C. 10A:71;
July 23, 2028, N.J.A.C. 10A:72.

Summary of Public Comment and Agency Response:

1. COMMENT: By letter dated June 27, 2022, the Honorable Glenn A. Grant, J.A.D., Administrative Director of the Courts, noted that the State Parole Board's notice of proposal, in part, removed language pertaining to medical parole and inserted language relating to the State Parole Board's role in the statutorily enacted compassionate release process and that the other two components of the rulemaking do not pertain to the Judiciary. Administrative Director Grant advised that the assignment judges and criminal presiding judges had reviewed the State Parole Board's rulemaking and had no comments.

RESPONSE: The State Parole Board appreciates the submission of Administrative Director Grant's letter and the review of the rulemaking by the assignment judges and criminal presiding judges.

Summary of Agency-Initiated Changes Upon Adoption:

At N.J.A.C. 10A:71-6.4(a)13, 6.11(b)13 and 6.12(d)13, the State Parole Board noted the last sentence at subparagraph ii of each respective paragraph is reflected as, "This condition shall not apply to a controlled dangerous substance prescribed by a physician." As situated, the sentence appears to qualify subparagraph ii, which applies to drug paraphernalia. This was not the intent of the State Parole Board. To clarify the matter, the State Parole Board has relocated the sentence from the respective subparagraph ii to the lead-in text of each paragraph.

At N.J.A.C. 10A:71-6.4(l) the phrase "or designated representative of the Commission" was inadvertently included as a proposed amendment. This language was previously removed from the subsection and it was not the intent of the State Parole Board to reinsert the language. The State Parole Board has, therefore, deleted the language.

At N.J.A.C. 10A:72-16.5(l) there is an incorrect reference to District Parole Supervisor. The correct reference should be Director, Division of Parole, and the State Parole Board has elected to delete District Parole Supervisor and insert Director, Division of Parole.

As part of this rulemaking, the State Parole Board proposed new N.J.A.C. 10A:72-16, which contained 10 sections, N.J.A.C. 10:72-16.1 through 16.10. However, due to an inadvertent codification error, the rulemaking was published with two sections codified as N.J.A.C. 10A:72-16.7. The State Parole Board is correcting this error upon adoption by recodifying the second proposed N.J.A.C. 10A:72-16.7, 16.8, and 16.9 as 16.8, 16.9, and 16.10, respectively, without change.

Federal Standards Statement

The amendments and new rules are not adopted under the authority of, or in order to implement, comply with, or participate in any program established under Federal law or under State statute that incorporates or refers to Federal law, standards, or requirements. An analysis of the amendments pursuant to P.L. 1995, c. 65 is, therefore, not required.

Full text of the adoption follows (additions indicated in boldface with asterisks ***thus***; deletions indicated in brackets with asterisks *[thus]*):

CHAPTER 71
PAROLE

SUBCHAPTER 3. PAROLE RELEASE HEARINGS

10A:71-3.2 Calculation of parole eligibility terms

(a)-(k) (No change.)

(l) (No change in text.)

10A:71-3.16 Board member review; adult inmates

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

(c) The Board members certifying parole release shall not impose on any parolee any condition that would prohibit or restrict manufacturing, distributing, or dispensing, or possessing or having under control with intent to manufacture, distribute, or dispense, marijuana or hashish in violation of N.J.S.A. 2C:35-5(b)12, or possession of marijuana or hashish in violation of N.J.S.A. 2C:35-10.a3.

Recodify existing (c)-(e) as (d)-(f) (No change in text.)

10A:71-3.18 Board panel hearing; notice of decision for adult inmates

(a) (No change.)

(b) If the Board panel determines to certify parole release pursuant to (a)1 above, the Board panel shall not impose on any parolee any condition that would prohibit or restrict manufacturing, distributing, or dispensing, or possessing or having under control with intent to manufacture, distribute, or dispense, marijuana or hashish in violation of N.J.S.A. 2C:35-5.b12, or possession of marijuana or hashish in violation of N.J.S.A. 2C:35-10.a3.

Recodify existing (b)-(f) as (c)-(g) (No change in text.)

10A:71-3.20 Board hearing; notice of decision for adult inmates

(a) (No change.)