APSSD's Department-approved program of virtual or remote instruction.

(b) The APSSD may apply one or more days of virtual or remote instruction to qualify as a day of instruction for the purposes of calculating tuition pursuant to N.J.S.A. 18A:46-21.1.a, under the following conditions:

1. Virtual or remote instruction is provided to students on the day(s) that some or all of the programs of instruction of the APSSD were closed to in-person instruction;

2. The virtual or remote instruction meets the Commissioner-established criteria for the occurrence of one of the events at (a) above; and

3. The APSSD submitted a proposed program of virtual or remote instruction to the Commissioner and the sending district board(s) of education within 30 days of the effective date of P.L. 2020, c. 27 and, thereafter, by July 31 annually.

i. If the APSSD is unable to complete and submit a proposed program by July 31 annually, and the APSSD is required to close for a declared state of emergency, declared public health emergency, or a directive by the appropriate health agency or officer to institute a public health-related closure, the Commissioner may retroactively approve the program.

(c) If provided under a Commissioner-approved program, student attendance for a day of virtual or remote instruction shall be accounted for in accordance with N.J.A.C. 6A:32-8.4 for the purposes of meeting State and local graduation requirements, the awarding of course credit, and other matters as determined by the Commissioner.

(d) The virtual or remote instruction shall be consistent with the student's individualized education program (IEP) to the extent appropriate and practicable and shall meet the New Jersey Student Learning Standards.

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services

Proposed Readoption with Amendments: N.J.A.C. 10:60

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

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

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Agency Control Number: 21-P-03.

Proposal Number: PRN 2021-074.

Submit comments by October 15, 2021, to:

Margaret M. Rose Attn: 21-P-03
Division of Medical Assistance and Health Services
PO Box 712
Mail Code #26
Trenton, NJ 08625-0712
Fax: (609) 588-7343
Email: Margaret.Rose@dhs.state.nj.us
Delivery: 6 Quakerbridge Plaza
Mercerville, NJ 08619

The agency proposal follows:

Summary

Take notice that pursuant to N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 10:60, Home Care Services, were scheduled to expire on April 21, 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.

The Home Care Services chapter regulates the provision of home care services under the Medicaid/NJ FamilyCare program. The rules set forth the requirements necessary for participation as a provider of these services. The rules also identify covered and non-covered services and specify the fee-for-service rates for covered services.

The Department of Human Services (Department) has reviewed these rules and has determined them to be necessary, reasonable, and proper for the purpose for which they were originally promulgated and is proposing to readopt the chapter, with amendments, as described below.

Summary of Subchapter Provisions

Subchapter 1, General Provisions, contains the purpose and scope, definitions, provider eligibility information, and out-of-State agency information applicable to general home care services. It also addresses limitations on home care services, advance directives, relationship of the home care provider with the Medical Assistance Customer Center, quality assurance, on-site monitoring visits, and provisions for fair hearings.

Subchapter 2, Home Health Agency (HHA) Skilled Services, describes the requirements for covered home health agency services, certification of need for services, plans of care, clinical records, basis of payment for home health services, and limitations on home health services.

Subchapter 3, Personal Care Assistant (PCA) Services, contains the purpose and scope, basis for reimbursement for PCA services, description of covered services and requirements for the certification of need for PCA services. The subchapter also describes the duties of the registered professional nurse, standards for clinical recordkeeping, basis of payment for PCA services, limitations on PCA services, prior authorization requirements, and procedures for the transfer of a beneficiary from one PCA agency to another.

Subchapter 4 is reserved.

Subchapter 5, Private Duty Nursing (PDN) Services, contains a description of the purpose and scope of the program and services, and requirements for: the basis for reimbursement for eligibility for early and periodic screening diagnosis and treatment/private duty nursing (EPSDT/PDN) services, eligibility for EPSDT/PDN services, limitation, duration and location of EPSDT/PDN services, nursing assessment for the determination of medical necessity for EPSDT/PDN services, clinical records and personnel files, payment for EPSDT/PDN services, eligibility for managed long-term supports and services (MLTSS)/private duty nursing (PDN) services, limitation, duration and location of MLTSS/PDN services, basis for reimbursement of MLTSS/PDN services, and prior authorization requirements for MLTSS/PDN services.

Subchapter 6, Managed Long-Term Services and Supports (MLTSS) Provided Under the New Jersey 1115 Comprehensive Medical Waiver, contains a description of MLTSS and beneficiary eligibility requirements.

Subchapters 7 through 10 are reserved.

Subchapter 11, Healthcare Common Procedure Coding System (HCPCS), describes the procedure codes used by home care providers when requesting reimbursement.

Appendix A, which is not reproduced in the New Jersey Administrative Code, contains the Fiscal Agent Billing Supplement applicable to this chapter.

Appendix B contains the Rancho Los Amigos Levels of Cognitive Functioning Scale, which is used in determining eligibility for the TBI program.

Appendix C contains the Request for Early and Periodic Screening, Diagnosis, and Treatment/Private Duty Nursing (EPSDT/PDN) Services form.

Summary of General Changes

Throughout the chapter the terms "Medicaid or NJ FamilyCare" and "Medicaid and NJ FamilyCare" are replaced with the term "Medicaid/NJ FamilyCare" to reflect the current nomenclature used by the Department.

Throughout the chapter all references to the "Department of Health and Senior Services" are replaced with references to the "Department of Health" to reflect the correct name of the department.

Throughout the chapter all references to "physician" are revised to read "physician/practitioner" because home health services can be prescribed by medical professionals other than a physician within the scope of their license.

Summary of Specific Changes

At N.J.A.C. 10:60-1.2, the following definitions are being added: "National Plan and Provider Enumeration System (NPPES)," "National Provider Identifier (NPI)," "practitioner," "Practitioner Orders for Life Sustaining Treatment (POLST)," "taxonomy code," "Type 1 NPI," and "Type 2 NPI." The definitions are being added because the terms are proposed to be used in this chapter, as described elsewhere in this Summary.

At N.J.A.C. 10:60-1.2, the definition of "health care service firm" is being amended to indicate that such a firm can be operated by a person or an entity and the definition of "legally responsible relative" is being amended to indicate that the legal guardian of an adult is considered a legally responsible relative.

Proposed new N.J.A.C. 10:60-1.3(b) requires providers to have a valid National Provider Identifier to be approved as a Medicaid/NJ FamilyCare participating provider. Proposed new N.J.A.C. 10:60-1.3(c) requires the provider to remain a provider in good standing by completing a revalidation when requested by the Division of Medical Assistance and Health Services (DMAHS).

N.J.A.C. 10:60-1.4(a), which addresses the reimbursement of out-of-State home health agency claims for dates of service prior to January 1, 1999, is proposed to be deleted because the rule is now obsolete.

At N.J.A.C. 10:60-1.6, a reference to Practitioner Orders for Life Sustaining Treatment (POLST) forms is proposed to be added to indicate that agencies providing home health services shall be subject to the provisions of such a document, if one has been executed by the beneficiary.

N.J.A.C. 10:60-1.7(b) is proposed for deletion because the "HSDP," which refers to a "Health Service Delivery Plan" is no longer utilized, and no assessments are done by the State for individuals referred for home care services outside the pre-admission screening (PAS) process.

At N.J.A.C. 10:60-1.8(d)2, a proposed amendment requires the agency to be as consistent as possible when assigning staff to beneficiaries and removes the requirement that the same aide must be assigned. This wording allows for more flexibility for the agency regarding the assignment of staff while still helping to ensure consistency of care for the beneficiary.

At N.J.A.C. 10:60-2.1(e), a proposed amendment changes the reference to a "physician" to read "physician/practitioner" since other medical practitioners can prescribe medical equipment if allowed within their scope of practice. An additional proposed amendment changes the reference to "HMO" to read "MCO" because that is the preferred terminology of the Medicaid/NJ FamilyCare program.

At N.J.A.C. 10:60-2.3(a), proposed amendments specify that the plan of care for the beneficiary shall be an interdisciplinary plan of care, changes the reference to "physician" to read "physician/practitioner" since other medical professionals can authorize care within the scope of their licenses, and adds therapies, nutrition, and home health aide services to the list of topics to be included in the plan. At N.J.A.C. 10:60-2.3(a)6, a proposed amendment requires that the physician/practitioner's initial orders and any subsequent orders be part of the plan of care. At N.J.A.C. 10:60-2.3(a)11, a proposed amendment changes the word "persons" to "person's" to correct a grammatical error. N.J.A.C. 10:60-2.3(b) is proposed for deletion because a separate nursing plan of care is no longer required, as all services are contained in the interdisciplinary plan of care.

At N.J.A.C. 10:60-2.4(a)6, the reference to "two months" for submission of reports is being changed to "60 days" because that description allows for more specific timeframes based on the actual date the plan was developed. Additionally, the reference to "physician" is being changed to "physician/practitioner" since other medical professionals can certify the need for care within the scope of their licenses.

At N.J.A.C. 10:60-2.5(c)1, a proposed amendment adds a nutrition visit to the list of visits for which home health agencies are allowed to bill. An additional amendment corrects an incorrect cross reference.

At N.J.A.C. 10:60-3.5(a)1, proposed amendments change the reference to "physician" to read "physician/practitioner" since other medical practitioners can certify the need for care in accordance with their scope of practice.

N.J.A.C. 10:60-3.6(a)2i is proposed to be amended to require that any nursing assessment completed be included in the beneficiary's clinical record. N.J.A.C. 10:60-3.6(a)2ii is proposed for deletion.

Proposed new N.J.A.C. 10:60-3.7(a)1 requires that when PCA services are provided to the same beneficiary on the same date that the total number of minutes shall be added together for billing purposes and rounded up or down to a total number of billable units of service. Beyond the initial unit, service times less than half of the unit shall be rounded down, while service time equal to or greater than half shall be rounded up. For example, if PCA services are provided in the morning and then again in the afternoon on the same date, with a break between during which the provider leaves the site of services, the number of minutes should be added together and billed instead of two bills being submitted. Once added together, the total number of minutes should be rounded up or down as described above. For example, if services were provided from 9:00 A.M. through 10:30 A.M. (1.5 hours) and again on the same date from 2:00 P.M. through 3:45 P.M. (1.75 hours) for a total of 3.25 hours, the billable units of service would be rounded down to three hours. This new paragraph also clarifies that one unit of service is 0 minutes.

At N.J.A.C. 10:60-3.8(b), a proposed amendment revises the description of what is meant by legally responsible relative to be consistent with the proposed amendments to the definition at N.J.A.C. 10:60-1.2. At N.J.A.C. 10:60-3.8(c)4, the term "baby sitting" is replaced with "babysitting" to correct the spelling error.

At N.J.A.C. 10:60-5.2(a), the reference to a "physician" is changed to "physician/practitioner" since other medical practitioners can certify the need for care in accordance with their scope of practice.

At N.J.A.C. 10:60-5.5(a), a proposed amendment clarifies that the assessment shall be completed by a registered nurse.

At N.J.A.C 10:60-11.2(a), the hourly reimbursement rate for PCA services was increased to $20.00.

At N.J.A.C 10:60-11.2(b), the hourly reimbursement rate for PDN services provided by an RN is proposed to be increased to $60.00 and the reimbursement for PDN services provided by an LPN is proposed to be increased to $48.00.

At N.J.A.C. 10:60 Appendix A, the reference to "Molina Medicaid Systems" was replaced with "Gainwell Technologies," which is the name of the current fiscal agent for the Medicaid/NJ FamilyCare program.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

During State Fiscal Year (SFY) 2020, a monthly average of 1,381 Medicaid/NJ FamilyCare fee-for-service beneficiaries received various home care services each month under the Medicaid/NJ FamilyCare fee-for-service programs. During SFY 2020, there was a monthly average of 32,993 individuals receiving various managed long-term services and supports (MLTSS) under managed care.

The rules proposed for readoption with amendments, will have a positive impact on both the providers and the beneficiaries of the Medicaid/NJ FamilyCare program. The providers will continue to receive reimbursement if they provide the services in a manner consistent with the requirements of the chapter and the beneficiaries will continue to have access to services they may otherwise not be able to afford.

Economic Impact

During State Fiscal Year 2020, the fee-for-service annual payments (Federal and State share combined) for specific home care services were:

Home Health Care Services	$856,829
Personal Care Assistant (PCA) Services	$89,542,017
ESPDT/PDN Services	$779,001
Waiver Programs	$4,272,554
TOTAL	$95,450,401

It should be noted that the figure for home health care services includes the costs for physical therapy, occupational therapy, home health aides, medical social services, certain medical supplies, speech-language pathology, and skilled nursing services.

During SFY 2020, there was a monthly average of 32,993 individuals receiving MLTSS under managed care at an annual cost of approximately $1,885,652,175.

There will continue to be a positive fiscal impact on beneficiaries who receive home health services, since they do not currently pay for home health services and the rules proposed for readoption with amendments do not change that policy.

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, 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 proposed for readoption with amendments do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption with amendments will result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

Since the rules proposed for readoption with amendments concern the provision of home care services, the Department anticipates that the rules proposed for readoption with amendments will have no impact on the agriculture industry in the State of New Jersey.

Regulatory Flexibility Analysis

A regulatory flexibility analysis is necessary because some home care providers are considered small businesses, as the term is defined in the Regulatory Flexibility Act at N.J.S.A. 52:14B-17. Providers of home care waiver services are not expected to be adversely affected by the rules proposed for readoption with amendments. The rules proposed for readoption with amendments do not impose recordkeeping, compliance, or reporting requirements on small businesses that currently provide services to beneficiaries, beyond those required for operation of a business.

The new requirements related to the use of a National Provider Identifier (NPI) are not expected to adversely affect the providers since the use of an NPI is required when submitting healthcare claims to any insurance company. The providers have been using the NPI for the past several years with private insurance companies so they are familiar with the requirement, therefore, now requiring them to use their NPI when filing claims with Medicaid/NJ FamilyCare will not be burdensome.

Providers are already required to maintain sufficient records to document the name of the beneficiary, date of service, place of service, and other details regarding the provision of services, as are required by the rules proposed for readoption. See N.J.S.A. 30:4D-12 and N.J.A.C. 10:49. Providers are also currently required to use the Healthcare Common Procedure Coding System (HCPCS) for billing and submission of claims. The requirements of the chapter are uniform and applicable to all providers, regardless of business size. The Department will not differentiate between large and small businesses due to the need for consistent standards for provider reimbursement and quality of beneficiary care.

Housing Affordability Impact Analysis

Since the rules proposed for readoption with amendments concern the provision of home care services, the Department anticipates that the rules proposed for readoption with amendments will have no impact on the affordability of housing, nor will it have an impact on average costs associated with housing.

Smart Growth Development Impact Analysis

Since the rules proposed for readoption with amendments concern the provision of home care services, the rules proposed for readoption with amendments will have no impact on housing production within Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan and will have no impact on smart growth.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:60.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [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 and NJ FamilyCare] **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 [in] **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 or NJ FamilyCare] **Medicaid/NJ FamilyCare** fee-for-service beneficiaries, upon request of the attending [physician] **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 and NJ FamilyCare] **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 and NJ FamilyCare] **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 or NJ FamilyCare] **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 [in] **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[, as defined in N.J.A.C. 10:60-1.2].

i. (No change.)

2. A health care service firm[, as defined in N.J.A.C. 10:60-1.2];

3. A private duty nursing agency[, as defined in N.J.A.C. 10:60-1.2]; and

4. A hospice agency[, as defined in N.J.A.C. 10:60-1.2].

(b) 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.

[(b)] **(d)** (No change in text.)

[(c)] **(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-approved] **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

[(a) For services rendered prior to January 1, 1999, final reimbursement shall be made to out-of-State approved home health agencies on the basis of 80 percent of covered reasonable charges. There is no cost filing required. No retroactive settlement shall be made.]

[(b)] 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, [and] **as well as** communication to and education of staff, community, and interested parties. Detailed information [may be] **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

[(a)] Prior authorization shall be required for all [Medicaid-eligible or NJ FamilyCare-eligible] **Medicaid/NJ FamilyCare-eligible** individuals and [non-Medicaid] **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.

[(b) For the many individuals in the community setting referred for home care services outside the PAS process described in (a) above, an HSDP shall not be provided.]

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 [under] **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 and NJ FamilyCare] **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 [in] **at** (c) through (j) below to conduct a post-payment quality assurance

review of home care services as provided to the [Medicaid or NJ FamilyCare] **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] **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 [same aide shall be assigned on a regular basis,] **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 provide**d** 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] **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] **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] **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 or Medicare and/or NJ FamilyCare] **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 or NJ FamilyCare] **Medicaid/NJ FamilyCare** fee-for-service beneficiary.

(b) (No change.)

10:60-1.10 Provisions for fair hearings

Providers and [Medicaid or NJ FamilyCare] **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 [in] **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 and NJ FamilyCare] **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 or NJ FamilyCare] **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 or NJ FamilyCare] **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 [and Senior Services]. 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] **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] **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] **physician/practitioner** and the professional nursing staff of the home health agency. The attending [physician] **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] **physician/practitioner** shall approve of any changes in the plan of care and delivery of therapy services.

i. The attending [physician] **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 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] **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] **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] **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] **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] **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] **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] **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] **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] **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] **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] **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 or NJ FamilyCare] **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] **physician/practitioner**, as well as a personally signed legible prescription from the [HMO] **MCO**, if applicable. Durable medical equipment, either rented or owned by the home health agency, shall not be billed to the New Jersey [Medicaid or NJ FamilyCare] **Medicaid/NJ FamilyCare** program, as applicable (see Medical Supplier Services [Chapter] **chapter**, N.J.A.C. 10:59**)**.

10:60-2.3 Plan of care

(a) [The] **An interdisciplinary** plan of care shall be developed by agency personnel in cooperation with the attending [physician] **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] **physician's/practitioner's initial** orders and [their updates] **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 [persons] **person's** involvement (for example, teaching); and

12. (No change.)

[(b) The plan of care shall include beneficiary's needs, make a nursing diagnosis, develop a nursing plan of care, provide nursing services and coordinate other therapeutic services to implement the approved medical and nursing plan of care.]

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] **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] **physician/practitioner** at least every [two months] **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 [in] **at** N.J.A.C. 10:60-[1.4(d)]**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] **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 or advanced practice nurse] **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] **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 or advance practice nurse (APN)] **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/APN's] **physician's/practitioner's** counter signature within 30 days.

(b) (No change.)

(c) The [physician's] **physician's/practitioner's** certification as described [in] **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] **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] **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. [An initial] **Any** nursing assessment**s completed by the nursing agency**.

[ii. A six-month nursing reassessment;]

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 or NJ FamilyCare] **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 or NJ FamilyCare] **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] **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 [baby sitting] **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] **physician's/practitioner's** certification process is required of the new provider. A [physician] **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] **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] **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] **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] **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] **physician's/practitioner's** treatment plan and renewal of treatment plan every 90 days;

4. Interim [physician] **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] **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] **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 and NJ FamilyCare] **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] **subchapter** are relevant to

certain [Medicaid and NJ FamilyCare] **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)	$[19.00]**20.00**
S9122	TV	Personal Care Assistant Service (Individual/hourly/weekend/holiday)	$[19.00]**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	$[50.00]**60.00**
S9124	EP	PDN-LPN, EPSDT, Per Hour	$[38.00]**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:

[Molina Medicaid Systems] **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

LABOR AND WORKFORCE DEVELOPMENT

(a)

DIVISION OF WORKERS' COMPENSATION

Pre-Trial Conference; Conduct of Formal Hearings; Pension Offset; Public Employees; Accidental Disability Retirement

Proposed Amendments: N.J.A.C. 12:235-3.11 and 3.12

Proposed New Rule: N.J.A.C. 12:235-3.19

Authorized By: Robert Asaro-Angelo, Commissioner, Department of Labor and Workforce Development.

Authority: N.J.S.A. 34:1-20, 34:1A-3.e, 34:1A-12(b) and (c), and 34:15-64.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2021-076.

Submit written comments by October 15, 2021, to:

David Fish, Executive Director
Legal and Regulatory Services
New Jersey Department of Labor and Workforce Development
PO Box 110–13th Floor
Trenton, New Jersey 08625-0110
Fax to: (609) 292-8246
Email: david.fish@dol.nj.gov.

The agency proposal follows:

Summary

The Department of Labor and Workforce Development (Department) is proposing amendments at N.J.A.C. 12:235-3.11 and 3.12, and a new rule at N.J.A.C. 12:235-3.19, which would effectuate recommendations of the Office of the State Comptroller (OSC) contained in its report, An Examination Into the Use of Medical Monitoring Settlements by the Division of Workers' Compensation and the Impact on the State's Pension Funds. The report describes a medical monitoring settlement as an arrangement whereby in order to resolve a workers' compensation case, a claim petitioner accepts, in lieu of payment of cash benefits to which he or she would otherwise be entitled by law, the respondent's (employer's/insurer's) commitment to provide "reasonable and necessary" treatment for injuries related to the work accident for the life of the claim petitioner (beyond the two-year statute of limitations for reopening a workers' compensation claim). According to the report, use of continuing medical monitoring settlements to conclude workers' compensation claims where the injury or illness that is the basis for the workers' compensation claim is also the basis for an accidental disability pension application prevents the various public pension funds from calculating and imposing a dollar-for-dollar offset of the workers' compensation award against the accidental disability pension allowance, as is required by law (See, for example, N.J.S.A. 43:15A-25.1.b and 43:16A-15.2.b). The OSC concluded in its report that use of continuing medical monitoring settlements under these circumstances has "exacerbated the underfunded status of the pension funds," because claimants receive the full value of their accidental disability pension allowance, plus the undefined and open-ended value of continuing medical monitoring, without the required pension offset.

The proposed amendments and new rule, written in consultation with the Division of Pensions and Benefits, are designed to ensure that the proper pension offset does, in fact, occur. The proposed amendments at N.J.A.C. 12:235-3.11 and 3.12 would do this by expressly stating that "good cause" for adjournment of either pre-trial conference or formal hearing before a Judge of Compensation, shall not include that the injury or illness upon which the subject claim before the Division of Workers' Compensation is based is also the basis for a pending accidental disability pension application to a pension fund administered by the Division of Pensions and Benefits. In addition, the Department is proposing new N.J.A.C. 12:235-3.19, which would, when the injury or illness upon which a workers' compensation claim is based is also the basis for a pending accidental disability pension application: (1) expressly prohibit the approval by a Judge of Compensation of a continuing medical monitoring settlement (except where the workers' compensation claim petition is for an occupational disease, like asbestosis, under the appropriate circumstances based on the fact presented, and when not used in a way to avoid a pension offset); and (2) require that both the workers' compensation petitioner and workers' compensation respondent notify the Division of Pensions and Benefits of the filing of the claim petition with the Division of Workers' Compensation, and that each also notify the Division of Pensions and Benefits that a Judge of Compensation has granted a judgment, approved a settlement award, or dismissed petitioner's claim before the Division of Workers' Compensation.

As the Department has provided a 60-day comment period for this notice of proposal, this notice is excepted from the rulemaking calendar requirement at N.J.A.C. 1:30-3.3(a)5.

Social Impact

The proposed amendments and new rule seek to restore an appropriate balance between workers' compensation claims and State pension benefits in the wake of the OSC's report citing the burden on New Jersey's underfunded pension funds created by the use of continuing medical monitoring settlements in the manner described in the Summary above. Whereas the only purpose of workers' compensation insurance is to compensate injured workers, the purpose of the State pension system is to provide financial security in retirement to all covered workers based on