



New Jersey.

Dept. of Institutions and Agencies.

Division of Medical Assistance and Health Services.

Proposed home health services manual of the New Jersey
Health Services Program.

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FOREWORD

The New Jersey Medical Assistance and Health Services Act (Chapter 413, Laws of 1968) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. This is the New Jersey version of a program commonly known as "Medicaid" or "Title XIX". In identifying persons eligible for such assistance and services this will be known as the New Jersey Health Services Program.

This manual is designed for use by providers billing for services furnished under the Program. It contains informational and procedural material needed to assist the provider in prompt and efficient payment of claims and to answer questions which patients may ask about the program. The procedures described in this manual have been devised to achieve the goals of the Program with due consideration to the needs of the covered persons and effective relationships with providers.

A careful effort has been made to insure that the provisions of the law and the regulations are accurately reflected. This issuance should help to assure that the law is uniformly applied without regard to where covered services are furnished.

The manual is designed to accommodate new pages as administrative changes in procedure are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

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CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Aid to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

GENERAL INFORMATION

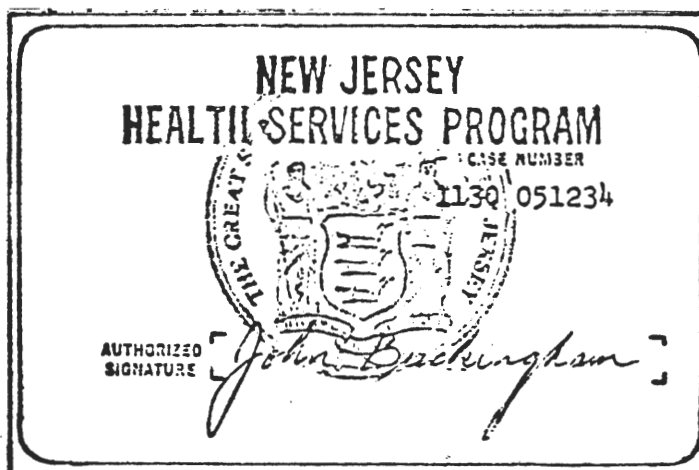
101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

This card identifies an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies. It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OR THE STATE OF NEW JERSEY (SEE SECTION 101.2).

Exhibit I



101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: THIS FORM IS THE SOLE INDICATOR OF ELIGIBILITY. THE PLASTIC IDENTIFICATION CARD ALONE IS NOT SUFFICIENT.

The sample shown contains all of the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, H.S.P. Case Number, and Person Number, EXACTLY as it appears on the Validation form on all Requests for Authorization and claim forms.

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102. AUTHORIZED SERVICES FOR COVERED PERSONS

The items and services provided to covered persons will not normally be limited in duration or amount. Any limitations imposed will be consistent with the medical necessity of the patient's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the Division of Medical Assistance and Health Services. The following items and services, more specifically defined in subsequent sections of the appropriate manual, are authorized under the Program:

- (a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;
- (b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;
- (c) Outpatient hospital services;
- (d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;
- (e) Laboratory and x-ray services;
- (f) Skilled nursing home services;
- (g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;
- (h) Other practitioners' services, limited by State law to podiatrists and optometrists;
- (i) Dental services, including dentures;
- (j) Home health care services;
- (k) Pharmaceutical services - prescribed drugs (legend and non-legend)
- (l) Prosthetic devices and appliances, medical supplies and equipment; eyeglasses and hearing aids;
- (m) Rehabilitation services;
- (n) Transportation, i.e., ambulance service to and from a medical facility when the patient's condition precludes the use of other means of transportation.

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103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, institution, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;

Certified Independent Clinical laboratories;

Dentists;

Hearing Aid Dealers;

Home Health Agencies;

Hospitals;

Skilled Nursing Homes;

Opticians;

Optometrists;

Approved Clinics (Independent Outpatient Health Facilities);

Certified Orthotists;

Pharmacies;

Physicians;

Podiatrists;

Certified Prosthetists; (excluding dental)

Providers of Medical Transportation.

104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the Local Medical Assistance Unit may assist in obtaining an appropriate practitioner or health resource.

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105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical services claims (i.e., legend and non-legend drugs), and claims for out of state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to the Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the program.

106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.

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2. When it is customary for persons in the area generally to use medical care resources and facilities outside the State of New Jersey.
3. When out of state care was provided in an emergency.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;
2. Any services or items furnished in connection with elective cosmetic procedures;

Note: There are certain exceptions to this rule.

A written certification of medical necessity and a treatment plan must be submitted by the practitioner to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;
4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;
5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;
6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy, any other private or governmental health benefit system, or through any similar third party liability;
7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage;

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8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;
9. Any services or items furnished for which the Provider does not normally charge;
10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person's household.

109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which covered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

1. Title XVIII

The Program, in most instances, shall cover the amount of any deductible or co-insurance liability under Title XVIII of the Social Security Act for all covered persons 65 years of age or older.

2. Workmen's Compensation

No Program payments shall be made for a patient covered by workmen's compensation.

3. Other Health Insurance

When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

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111. MEDICAL REVIEW AND EVALUATION (by Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

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CHAPTER II

COVERAGE OF HOME HEALTH SERVICES

200. DEFINITIONS

200.1 Home Health Care Services

The provision of skilled nursing care, ^{person} (and other therapeutic services), on recommendation of a licensed physician, to a homebound patient confined to his place of residence, but not including as a residence a hospital or a skilled nursing home.

200.2 Home Health Agency

A public or private agency or organization, or a subdivision of such an agency or organization, which is certified to participate as a Home Health Agency under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

200.3 Physical Therapist

A physical therapist is a graduate of a program in physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, or its equivalent, and when applicable, is licensed or registered by the State.

200.4 Speech Therapist

A speech therapist is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

200.5 Occupational Therapist

An occupational therapist is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and engaged in the required supervised clinical experience period prerequisite to registration by the American Occupational Therapy Association.

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200.6 Home Health Aide

An individual who has successfully completed an approved training program and meets the criteria of a homemaker-home health aide established by the State Department of Health and is assigned and supervised by a Home Health Agency, to give personal care services to patients, in accordance with the plan of treatment outlined by the attending physician.

200.7 Definition of Homebound Patient

A patient will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated.

201. COVERED HOME HEALTH SERVICES

The scope of services described in this section is limited to those home health care services furnished directly by a Home Health Agency or under arrangements with others.

The patient must be certified as needing skilled nursing care on an intermittent basis, or physical or speech therapy in order to qualify for home health benefits. Payment may be made for other home health services only so long as the provision of skilled nursing care or physical or speech therapy is an essential element of the patient's plan of treatment.

Subject to the limitations and exclusions set forth below, and to the extent home health care services are necessary for and consistent with the treatment of the condition for which the care is required, home health care services shall include:

201.1 Intermittent or Part-Time Nursing Services

Nursing care is covered when provided on a part-time or intermittent basis. Nursing care is defined as those services which must be furnished by or under the direct supervision of a trained nurse if the safety of the patient is to be assured and the medically desired result is to be achieved. If a service is such that it can be safely and adequately performed (or self-administered) by the average non-medical person, without the direct supervision of a trained nurse,

COVERAGE OF HOME HEALTH SERVICES

the service cannot be regarded as a skilled nursing service without regard to who actually provides the service. On the other hand, certain skilled nursing services which a patient may need on a regular and frequent basis are on occasion taught to the beneficiary or a nonmedical person to perform in order to conserve the limited time of skilled nurses, e.g., the injection of insulin. The fact that this skill can be taught to a nonmedical person does not negate the skilled aspect of the service when performed by a nurse in those instances in which the patient cannot be taught these skills, e.g., the patient is blind.

Nursing care, as defined above, must be performed by a:

- (a) Registered professional nurse (R.N.) within the scope of her (his) license, and/or
- (b) Practical Nurse when such services are supervised by a registered professional nurse, and/or
- (c) Student nurse, when the Home Health Agency is participating in a training program approved by the National League for Nursing, when such services are supervised by a registered professional nurse.

201.2 Rehabilitation Services - (See Section 204.)

201.3 Intermittent or Part-Time Services of a Home Health Aide

Intermittent or part-time services of a home health aide employed by or under contract to an approved Home Health Agency when such services are performed in accordance with a physician's orders and are supervised by a registered professional nurse.

The primary function of a home health aide is to render personal care to a patient.

Personal care duties which may be performed by a home health aide include assistance in the activities of daily living, e.g., helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise, and to take medications specifically ordered by a physician which are ordinarily self-administered, and retraining the patient in necessary self-help skills.

201.4 Medical Supplies

Medical supplies (other than drugs and biologicals) essential to enable the Home Health Agency to carry out the plan of treatment

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established by the physician, and normally supplied by the Home Health Agency, including, but not limited to, gauze, cotton, bandages, surgical dressings, catheters, surgical gloves, irrigating solutions and rubbing alcohol.

201.5 Medical Equipment

Medical equipment which is eligible under Title XVIII of the Social Security Act and which is essential in enabling the Home Health Agency to carry out the plan of treatment established by the physician and which is owned by the Home Health Agency and loaned to the patient, including, but not limited to, bed pans, wheelchairs, walkers, crutches, hospital beds, trapeze bars, oxygen tanks, intermittent positive pressure machines, and alternating air pressure mattresses.
(See Section 202.5)

202. NON-REIMBURSABLE HOME HEALTH SERVICES

In addition to those general exclusions outlined in Section 108, Chapter I, the following also are excluded:

202.1 Ambulance Transportation

202.2 Items and Services Not Covered by Title XVIII

Any item or service excluded from Home Health Agency care under Title XVIII of the Social Security Act, unless specifically included herein.

202.3 Domestic or Housekeeping Services

Domestic or housekeeping services unrelated to patient care to the full extent they are excluded under Title XVIII of the Social Security Act.

202.4 Services Which Are Not Part of an Approved Treatment Plan

202.5 Equipment Rented By the Home Health Agency From a Third Party

The Supplier must bill the program directly.

203. SPECIAL PROVISIONS

Home health care services must be performed pursuant to a licensed physician's orders and in accordance with a plan of treatment.

203.1 Treatment Plan

The plan of treatment, which must be established and periodically reviewed by a physician, should indicate the types of skilled services required to treat the patient's illness or injury. If the plan of treatment does not indicate a need for skilled nursing care or physical or speech therapy but prescribes only the provision of supportive services, such as personal care services which are rendered by a home health aide, the patient cannot be considered as meeting the certification requirements and is, therefore, ineligible for home health benefits.

A plan of treatment shall include:

- (a) Patient's major and minor impairments.
- (b) Period covered by the plan.
- (c) Number of visits to be provided.
- (d) Treatments by type and personnel involved.
- (e) Equipment required.
- (f) Copy of physician's orders.
- (g) Summary of case history.
- (h) Certification that patient is confined to his place of residence and requires skilled nursing care on an intermittent basis, or physical or speech therapy.
- (i) Signature of the authorized representative of the Home Health Agency.

The treatment plan form shall be the Home Health Agency form used to satisfy Title XVIII (Medicare) plan content requirements.

203.2 Prior Authorization

Prior authorization is required for all persons not covered under Medicare. A plan of treatment must be submitted to the Local Medical

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Assistance Unit for approval and authorization. Such authorization shall not exceed sixty (60) calendar days, but is renewable upon submission of a progress report including recommendation for extension of such treatment plan.

203.3 Visits

When two or more persons are present simultaneously to provide a single service for which one supervises or instructs the other, payment is allowed for only one visit.

When two or more persons visit the patient during a 24-hour period for the purpose of providing different and distinct types of service, payment is allowed for each visit.

204. REHABILITATION SERVICES

204.1 Definition

"Rehabilitation Services" means physical therapy, occupational therapy, speech therapy and hearing services, and the use of such supplies and equipment as are necessary in the provision of such services.

204.2 Scope of Services

This section is concerned with rehabilitation service which includes care in the fields of physical therapy, occupational therapy, speech therapy and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best functional level. It does not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form, massage, routine calisthenics or group exercises, assistance in any activity or use of a simple mechanical device not requiring the special skill of a qualified physical therapist.

Rehabilitation services shall be made available to covered persons as an integral part of a comprehensive medical care program. Such services include not only intermittent or part-time service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

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204.3 General Policies

(a) Providers of Service

Rehabilitation services shall be provided by qualified therapists employed by or under contract to:

1. An approved Home Health Agency; or,
2. A hospital out-patient department; or,
3. An approved clinic or independent out-patient health facility.

(b) Where Care May Be Provided

Rehabilitation services may be provided by a Home Health Agency in the patient's home or other place of residence, including inpatients in a skilled nursing home.

(c) Prior Authorization

Prior approval of the Local Medical Assistance Unit is required for rehabilitation services which involve an extended course of treatment; e.g., 60 calendar days or more. Authorization for all rehabilitation services shall be granted only when the following conditions are met:

1. All rehabilitation services of any type shall be supported by a written recommendation of a licensed physician.
2. Such recommendation shall include a statement including the medical reason pertaining to the need for therapy, the objective of treatment, a therapy prescription, and the estimated number of treatments.
3. Therapy prescriptions must be definitive as to type and scope of procedures to be rendered. Prescriptions such as, "Physical therapy 3X a week," will not be accepted.

(d) Duration of Authorization

Initial or subsequent authorization shall not exceed sixty (60) calendar days.

The Local Medical Assistance Unit shall review the progress of the treatment at least as often as the term of the authorized plan, or as needed in the judgment of the Unit's professional staff.

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AUTHORIZATION AND BILLING PROCEDURES

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CHAPTER III

AUTHORIZATION AND BILLING PROCEDURES

300. PRIOR AUTHORIZATION

Prior authorization means approval by the Local Medical Assistance Unit for Home Health services.

Prior authorization is required for all persons not covered under Medicare. A plan of treatment must be submitted to the Local Medical Assistance Unit for approval and authorization shall not exceed sixty (60) calendar days, but is renewable upon submission of a progress report including recommendation for extension of such treatment plan.

300.1 How to Obtain Prior Authorization

A Plan of Treatment should be promptly obtained from the Attending Physician, and submitted to the Local Medical Assistance Unit with a Request for Authorization.

300.2 Submission of Authorization to Contractor

When the Request for Authorization has been approved it should be submitted to the proper Contractor for reimbursement of the services provided. An approved authorization form must accompany each billing form.

300.3 Period Covered by Authorization

An approved Request for Authorization will only be valid for the period of sixty days beginning with the date care starts.

300.4 Renewing or Extending a Treatment Plan

If Home Health Care is needed beyond the period authorized, the Agency should prepare a progress report and send it to the attending physician for his review and recommendations. The attending physician will decide if the plan of treatment should be continued on the same basis or whether changes in frequency of services, etc., are needed. All renewals or extensions of treatment plans should indicate the length of time the treatment will be required. The Agency will submit a copy of the progress report, the new Plan of Treatment, and the new Request for Authorization to the Local Medical Assistance Unit.

AUTHORIZATION AND BILLING PROCEDURES

301. BILLING PROCEDURES

301.1 Submission of Home Health Claim Form (MC-3)

A fully completed Home Health Claim Form (MC-3) should be submitted to the appropriate Contractor. A copy of the approved authorization should be attached to the Contractor's copy of the Home Health Claim. The Provider copy should be retained by the Agency.

301.2 Medicare/Medicaid Coverage

When the patient is covered under both programs, only a Medicare form (SSA 1487) should be completed. Item 14 of the Medicare form should show the Health Services Program case and person number. When Medicare benefits are exhausted, a Home Health Claim Form (MC-3) must be completed and prior authorization is required.

302. COMPLETING THE HOME HEALTH CLAIM FORM (MC-3)

All items should be typed or printed clearly.

- Item 1. Patient's Name - Enter patient's last name and first name from the validation form. (Last name first.)
- Item 2. Sex - Enter X in appropriate block.
- Item 3. Birthdate - Enter six position date, i.e. 06/14/39.
- Item 4. Leave Blank.
- Item 5. Start Care Date - Enter a six position date on which the approved Home Health care began.
- Item 6. Claim From Date - Enter the date of the first service in this billing period.
- Item 7. Claim Thru Date - Enter the date of the last service in this billing period.
- Item 8. Visits - Enter the number of visits being billed.
- Item 9. Leave Blank.

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- Item 10. Attending Physician's Name - Enter the attending physician's name.
- Item 11. Medical Record No. - Enter the patient's Medical record number.
- Item 12. Health Services Program Case No. - Enter the patient's Health Service Program number as shown on the identification card or validation form. (See Section 101.)
- Item 13. Patient Person No. - Enter the Patient Person Number shown on the validation form. (See Section 101.)
- Item 14. Provider Name and Address - Enter the Agency's name and address. This information may be pre-printed.
- Item 15. Provider Number - Enter Provider Number. This information may be pre-printed.
- Item 16. Case Name - Enter name shown on the permanent Identification Card.
- Item 17. Patient's Certification - Each claim form must be signed by the patient or his representative. The signature need be legible only on the original. If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf. The statement should be read to a patient who signs by mark, and witnessed by a person who knows the patient. Enter the name and address of the witness. In certain situations, an agency representative may sign on behalf of the patient. If the patient is a minor, a parent or guardian should sign and indicate relationship.
- Item 18. Type of Service - Enter date of each service opposite appropriate code; e.g.,

Skilled Nursing Care.....02
Home Health Aide.....03
Physical Therapy.....10
Speech Therapy.....11
Occupational Therapy.....12

- Item 19. Statement of Charges - Enter the number of visits and charges in the appropriate columns. Lines 26, 27 and 28 should be used to list additional services. The totals should be shown on Line 98.

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Item 20. Other Coverage - Remaining Charges - If a patient is a Medicare/Medicaid patient, see Section 301.2. If patient is non-Medicare, enter charges not covered by other insurance on Line 32 of Item 20. Appropriate information should be entered in Item 25.

NOTE: Item 20 is reserved solely for other insurance coverage. Items 19 and 20 cannot be completed on the same claim form.

Item 21. Patient Status - Check appropriate block. Check "still patient" on all bills until discharged or deceased, including renewed or extended plans.

Item 22. Discharge Date - Enter the date of the last visit under the Plan of Treatment, or the date of admission to the hospital or skilled nursing home.

Item 23. Discharge or Current Diagnoses - Enter all the diagnoses which relate to the condition requiring the current services. The primary diagnosis shown is the illness or condition which was the primary reason for the service. Other diagnoses should be shown under secondary. The diagnoses should be shown in accordance with recognized nomenclature, e.g., "International Classification of Diseases Adapted," "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

Item 24. Employment Related - If the condition is considered to be employment related, the primary diagnosis should always be shown along with the name and address of the employer. No program payments shall be made for a patient covered by Workmen's Compensation. (Any amounts not covered by Workmen's Compensation should be entered in Item 20, Line 32.) (See Section 110.)

Item 25. Other Insurance or Liability Coverage - Applies to coverage other than Medicare or Workmen's Compensation. (See Section 110.)

Item 26. Provider Certification - The claim form must be signed and dated by an authorized representative of the Agency. Any pertinent remarks may be entered in the Remarks section. The date forwarded should be the date the bill is actually mailed to the contractor and should not be before the "claim thru" date in Item 7. A stamped signature is acceptable.

REMARKS--This block will be used by the Agency and/or Contractor.

Items 28-37 For Contractor's use only.

303. SUBMITTING CORRECTED BILLS

To correct a previously submitted bill, the Home Health Agency should reproduce a legible copy of the submitted bill. Corrections should be made in red in the appropriate items. The corrected bill should be marked DEBIT-ADJ in the upper right hand margin. If all charges and visits reported on the previously submitted bill are to be deleted mark it Cancel Only. A corrected bill should be submitted if the charges change by more than \$1.00.

PLEASE TYPE OR PRINT



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

HOME HEALTH CLAIM

1. Patient's Last Name		First Name		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Birthdate Mo. / Day / Yr.	4.
5. Start Care Date Mo. / Day / Yr.	6. Claim From-Date Mo. / Day / Yr.	7. Claim Thru-Date Mo. / Day / Yr.	8. Visits	10. Attending Physician's Name (Please Print) Last First M.I.		11. Medical Record No.
12. Health Services Program Case No.			13. Patient Person No.	14. Provider Name and Address		15. Provider Number
16. Case Last Name		First Name				

17. PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

Patient's Signature (Authorized Representative) _____ Date _____

18. TYPE OF SERVICE (Indicate Dates Services Performed)

02	
03	
10	
11	
12	

19. STATEMENT OF CHARGES			21. Patient Status <input type="checkbox"/> Still Patient <input type="checkbox"/> Deceased <input type="checkbox"/> Discharged <input type="checkbox"/> Discharged to other facility	22. Discharge Date Mo. / Day / Year
SERVICE	NO. OF VISITS	CHARGES	23. Discharge or Current Diagnosis Primary: Secondary:	
SKILLED NURSING CARE	02			
HOME HEALTH AIDE	03			
PHYSICAL THERAPY	10			
SPEECH THERAPY	11			
OCCUPATIONAL THERAPY	12			
SUPPLIES - MEDICAL/SURGICAL	23			
EQUIPMENT	25			
OTHER (Describe)	26			
	27			
	28			
TOTAL	98		24. Claim Related to Employment? _____ If yes, give name of employer.	
20. OTHER COVERAGE - REMAINING CHARGES			25. Other Insurance or Liability Coverage Name Policy Number	
MEDICARE - DEDUCTIBLE	29		26. PROVIDER CERTIFICATION: I certify that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the provisions of Title VI of the Federal Civil Rights Act.	
MEDICARE - CO-Insurance	30			
MEDICARE - OTHER	31			
OTHER (Describe)	32			
TOTAL	99		Provider Representative Signature _____ Date Sent _____	
REMARKS:				

DO NOT USE AREA BELOW

28.	29. PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	30. ADJUDICATOR CODE	31. DECLINE CODE
32.	33. OTHER COVERAGE CODE	34. PATIENT STATUS	35. PAYMENT	36. PROCES CODE
	<input type="checkbox"/> 0 - None <input type="checkbox"/> 1 - Medicare A <input type="checkbox"/> 2 - Medicare B <input type="checkbox"/> 3 - Other Insurance <input type="checkbox"/> 4 - Liability <input type="checkbox"/> 5 - Other	<input type="checkbox"/> 1 - Still Patient <input type="checkbox"/> 2 - Discharged <input type="checkbox"/> 3 - Deceased <input type="checkbox"/> 4 - Discharged to other facility		
				37. TRAN. CODE

MC-3A (1-70)

CONTRACTOR'S COPY

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MC-3B (1-70)

PROVIDER COPY

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