i. When a recipient requires more than one month of medical supplies, prior authorization for the supplies shall be requested and received from the appropriate Medicaid District Office. 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. If a recipient is an enrollee of the Garden State Health Plan or a private HMO, prior authorization shall be obtained from the GSHP physician case manager or private HMO.

ii. When a recipient 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 recipient and billed to the Medicaid program by the medical supplier.

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

9. Personal care assistant services shall be as described in N.J.A.C. 10:60–1.10.

(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 recipient, a request for authorization for the equipment shall be made by an approved medical supplier. The request for authorization shall be submitted to the Medicaid District Office and shall include a personally signed, legible prescription from the attending physician, as well as a personally signed legible prescription from the GSHP physician case manager (if not the prescriber) and private HMO, if applicable. Durable medical equipment, either rented or owned by the home health agency, shall not be billed to the New Jersey Medicaid program (see Medical Supplier Services Manual, N.J.A.C. 10:59–1.5 and 1.7).

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Administrative Correction.
See: 26 N.J.R. 2285(a).
Amended by R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).
Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).
See: 30 N.J.R. 3198(a), 30 N.J.R. 4377(a).
In (d), inserted new 2 and 3, and recodified former 2 through 7 as 4 through 9.

Case Notes

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

10:60–1.5 Certification of need for services

To qualify for payment of home health services by the New Jersey Medicaid and NJ KidCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the home health agency by the attending physician. The nurse or therapist shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).
See: 30 N.J.R. 3198(a), 30 N.J.R. 4377(a).
Inserted a reference to NJ KidCare fee-for-service and substituted a reference to beneficiaries for a reference to recipients in the first sentence.

10:60–1.6 Plan of care

(a) The plan of care shall be developed by the attending physician in cooperation with agency personnel. It shall include, but not be limited to, medical, nursing, and social care information. The plan shall be re-evaluated by the nursing staff at least every two months and revised as necessary, appropriate to the recipient's condition. The following shall be part of the plan of care:

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

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

3. The period covered by the plan;

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

5. Additional health related services supplied by other providers;

6. A copy of physician's orders and their updates;

7. Medications, treatments and personnel involved;

8. Equipment and supplies required;

9. Goals, long and short-term;

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

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

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

New Jersey State Library

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

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

(b) The plan of care shall include the recipient'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.

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

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

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

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–1.7 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 recipient receiving home health care services. The clinical record shall include, at a minimum, the following:

1. A plan of care as described in N.J.A.C. 10:60–1.6;
2. Appropriate identifying information;
3. The name, address and telephone number of recipient's physician;
4. Clinical notes by nurses, social workers, and special therapists, which shall be written, signed and dated on the day each service is provided;
5. Clinical notes to evaluate a recipient's response to service on a regular, periodic basis, which shall be written, signed and dated by each discipline providing services;
6. Summary reports of pertinent factors from the clinical notes of the nurses, social workers, and special therapists providing services, which shall be submitted to the attending physician at least every two months; and
7. When applicable, transfer of the recipient to alternative health care, which shall include transfer of appropriate information from the recipient's record.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).

10:60–1.8 Basis of payment of home health services

(a) For home health services provided before January 1, 1999, the New Jersey Medicaid and the NJ KidCare fee-for-service programs follow the Medicare principles of reimbursement which are based upon the lowest of:

1. 100 percent of reasonable covered costs; or
2. The published cost limits; or
3. Covered charges.

(b) For services provided prior to January 1, 1999, interim reimbursement shall be made on the basis of 100 percent or less (if reasonable allowable cost is anticipated to be less) of covered charges.

(c) For services provided prior to January 1, 1999, retroactive settlement and final reimbursement shall be based on Medicare principles of reimbursement.

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

Revenue Code	Description	Base Amount Per Unit
420	Physical Therapy	$23.31
430	Occupational Therapy	$23.07
440	Speech Therapy	$19.64
550	Skilled Nursing	$28.24
560	Medical Social Services and Dietary/ Nutritional Services	$25.10
570	Home Health Aide	$ 6.03

(e) Effective for services rendered on or after January 1, 1999 through December 31, 1999, home health agencies shall be reimbursed 90 percent to 100 percent of allowable cost, which is based on Medicare principles of reimbursement as defined in (a) above. To assure appropriate cash flow, the service-specific unit rates shall be modified by the Division to reflect provider-specific rates for each unit of service provided to Medicaid and NJ KidCare fee-for-service beneficiaries. The provider-specific unit rates shall be calculated by adjusting the base unit rates in (d) above to approximate the reimbursable cost the home health agency is incurring in providing covered services to Medicaid and NJ KidCare fee-for-service beneficiaries. A final reconciliation shall be completed for the first 12–month period after the date of adoption. The final reconciliation shall be calculated by subtracting interim payments from reimbursable cost. Reimbursable cost, which represents the 90 percent to 100 percent range of allowable cost, is calculated as follows:

1. If the Medicaid/NJ KidCare fee-for-service payment under the proposed rates described in (d) above is greater than the allowable cost, reimbursable cost is equal to the allowable cost, which is defined at (a) above.

2. If the Medicaid/NJ KidCare fee-for-service payment under the proposed unit rates described in (d) above is less than or equal to 90 percent of the allowable cost, reimbursable cost is equal to the sum of the following:

i. 90 percent of the allowable cost excluding escorts; and

ii. 95 percent of the Medicaid/NJ KidCare fee-for-service programs' share of field security costs for the period in which the reconciliation is calculated. In order to receive this escort cost adjustment, each home health agency which incurs escort costs shall submit source documentation demonstrating the total amount of field security costs incurred and the Medicaid/NJ KidCare fee-for-service programs' share of such costs. This documentation shall be sent along with the submission of the Medicaid cost report to be used for this reconciliation to the following address:

Office of Provider Rate Setting
Division of Medical Assistance and Health Services
PO Box 712
Mail Code #43
Trenton, New Jersey 08625–0712

3. If the payment under the proposed unit rates described in (d) above is greater than 90 percent but less than or equal to 100 percent of the allowable cost, reimbursable cost is equal to the Medicaid/NJ KidCare fee-for-service payment in accordance with (d) above.

(f) Effective January 1, 2000, and thereafter, the reimbursement rates shall be the service-specific Statewide per unit rates found in (d) above, incrementally adjusted each January 1, beginning on January 1, 2000, using Standard and Poor's DRI Home Health Market Basket Index, and published in the New Jersey Register as a notice of administrative change, in accordance with N.J.A.C. 1:30–2.7. Home health agencies shall maintain both unit and visit statistics for all services provided to Medicaid and NJ KidCare fee-for-service beneficiaries.

(g) Effective January 1, 1999, home health agencies shall bill the Medicaid and NJ KidCare 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, or a medical social service visit, as defined in N.J.A.C. 10:60–1.4(d). A home health agency shall not bill when a Medicaid/NJ KidCare fee-for-service beneficiary is not home or cannot be found, and hands-on medical care was not provided;

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

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

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

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

5. Routine supplies shall be considered visit overhead costs and billed as part of a unit of service. Non-routine supplies shall be billed using Revenue Code 270 on the UB–92 and HCPCS codes in accordance with N.J.A.C. 10:59–2;

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

(h) Home health agencies shall submit a cost report for each fiscal year to the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #42, PO Box 712, Trenton, New Jersey 08625–0712 or the Director's designee. The cost report shall be legible and complete in order to be considered acceptable.

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

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

3. To be granted the extension in (h)2 above, the provider shall submit a written request to, and obtain written approval from, the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #42, PO Box 712, Trenton,

New Jersey 08625–0712 or the Director's designee, at least 30 days before the due date of the cost report.

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

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

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).
See: 30 N.J.R. 3198(a), 30 N.J.R. 4377(a).
Rewrote the section.

10:60–1.9 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. 10:60–1.8(d) and (f). There is no cost filing required. No retroactive settlement shall be made.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Amended by R.1998 d.586, effective December 21, 1998 (operative January 1, 1999).
See: 30 N.J.R. 3198(a), 30 N.J.R. 4377(a).
In (a), added "For services rendered prior to January 1, 1999," at the beginning; and added (b).

10:60–1.10 Personal care assistant services

(a) Personal care assistant services shall be provided by a certified licensed home health agency or by a proprietary or voluntary non-profit accredited homemaker agency.

(b) Personal care assistant services are health related tasks performed by a qualified individual in a recipient's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. These services are available from a home health agency or a homemaker agency.

1. The purpose of personal care is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses.

2. Personal care assistant services shall be reimbursable when provided to Medicaid recipients in their place of residence, including:

i. A private home;

ii. A rooming house;

iii. A boarding home (not Class C);

iv. A Division of Youth and Family Services' (DYFS) foster care home; or

v. A Division of Developmental Disabilities (DDD) foster care home.

(c) Personal care assistant services are described as follows:

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

i. Care of the teeth and mouth;

ii. Grooming such as, care of hair, including shampooing, shaving, and the ordinary care of nails;

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

iv. Using the toilet or bed pan;

v. Changing bed linens with the recipient in bed;

vi. Ambulation indoors and outdoors, when appropriate;

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

viii. Eating and preparing meals, including special therapeutic diets for the recipient;

ix. Dressing;

x. Relearning household skills; and

xi. Accompanying the recipient to clinics, physician office visits, and/or other trips made for the purpose of obtaining medical diagnosis or treatment or to otherwise serve a therapeutic purpose.

2. Household duties that are essential to the recipient's health and comfort, performed by a personal care assistant shall include, but not be limited to:

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

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

iii. Care of bathroom, including maintaining cleanliness of toilet, tub, shower and floor;

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

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

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

vii. Listing food and household supplies needed for the health and maintenance of the recipient;