

CHAPTER 60
HOME CARE SERVICES

Authority

N.J.S.A. 30:4D-6b(2), 7, 7a, 7b, and 7c; 30:4D-12,
30:4E; 42 CFR 440.70, 170, 180, and 181.

Source and Effective Date

R.1996 d.18, effective December 7, 1995.
See: 27 N.J.R. 3667(a), 28 N.J.R. 184(a).

Executive Order No. 66(1978) Expiration Date

Chapter 60, Home Care Services, expires on December 7, 2000.

Chapter Historical Note

Chapter 60, Home Health Services Manual, was adopted as R.1971 d.56, effective April 21, 1971. See: 3 N.J.R. 42(a), 3 N.J.R. 83(a).

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services Manual, was readopted as R.1985 d.488, effective August 27, 1985. See: 17 N.J.R. 28(a), 17 N.J.R. 2433(a). Pursuant to Executive Order No. 66(1978), Chapter 60 was readopted as R.1990 d.458, effective August 15, 1990. See: 22 N.J.R. 1663(a), 22 N.J.R. 2966(c). Subchapter 4, Home Care Expansion Program, was adopted as new rules by R.1990 d.466, effective September 17, 1990. See: 22 N.J.R. 597(a), 22 N.J.R. 2967(a).

Chapter 60, Home Care Services Manual, was repealed and Chapter 60, Home Care Services, was adopted as new rules by R.1991 d.65, effective February 19, 1991 (operative March 1, 1991). See: 22 N.J.R. 3116(a), 23 N.J.R. 420(b). Subchapter 2, Covered Home Care Services (Home Health Care Services and Personal Care Assistant Services), was repealed; Subchapter 3, Home and Community-Based Services Waiver Programs, was recodified as Subchapter 2; Subchapter 4, Home Care Extension Program was recodified as Subchapter 3; and Subchapter 5, HCFA Common Procedure Coding System (HCPCS) was recodified as Subchapter 4 by R.1994 d.41, effective January 18, 1994. See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c). Subchapter 5, Traumatic Brain Injury Program, was adopted as new rules by R.1994 d.426, effective August 15, 1994. See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

Pursuant to Executive Order No. 66(1978), Chapter 60, Home Care Services, was readopted as R.1996 d.18, effective December 7, 1995. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 Purpose and scope

(a) The purpose of the home care services program, as delineated in this chapter, is to provide home care services to those individuals determined eligible.

(b) This chapter provides requirements for, and information about, the following programs:

1. Home health services;
2. Personal care assistant services;
3. Home and Community-Based Services Waiver programs, which include the following:
 - i. Home and Community-Based Services Waiver for the Elderly and Disabled, known as the Community Care Program for the Elderly and Disabled (CCPED);
 - ii. Home and Community-Based Services Waiver for Blind or Disabled Children and Adults (Model Waivers I, II, and III); and
 - iii. Home and Community-Based Services Waiver for Persons with AIDS and Children under five who are HIV Positive, known as AIDS Community Care Alternatives Program (ACCAP);
4. Home Care Expansion Program (HCEP); and
5. Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing (EPSDT/PDN) Services.

(c) Home health agencies, homemaker agencies, hospice agencies, and private duty nursing agencies are eligible to participate as Medicaid home care services providers. The services which each type of agency may provide and the qualifications required to participate as a Medicaid provider are listed in N.J.A.C. 10:60-1.2.

(d) General information about the home health services program and the personal care assistant services program are outlined in this subchapter. Specific program requirements are provided in N.J.A.C. 10:60-2.

(e) Requirements of the Home and Community-Based Services Waiver Programs and the Home Care Expansion Program are provided in N.J.A.C. 10:60-2 and 3, respectively.

(f) N.J.A.C. 10:60-4 HCFA Common Procedure Coding System—HCPCS, outlines the procedure codes used to submit a claim for services provided under the personal care assistant services program, Home and Community-Based Services Waiver programs, the Home Care Expansion Program, and Early and Periodic Screening, Diagnosis and Treatment/Private Duty Nursing Services.

Repeal and 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.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

10:60-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Calendar work week” means the time parameters which constitute a work week for personal care assistant services. These time parameters are from Sunday at 12:00 A.M. to Saturday at 11:59 P.M.

“Case Management” is defined as the process of on-going monitoring by the Medicaid District Office staff, of the delivery and quality of home care services, as well as the recipient/caregiver’s satisfaction with the services. Such case management does not include the case management services provided under the waiver programs and HCEP (N.J.A.C. 10:60-2.3(b)1, 2.9(b)1 and 3.3(a)1). Case management ensures timely and appropriate provider responses to changes in care needs and assures delivery of coordinated services which promote maximum restoration and prevents unnecessary deterioration.

“Class C boarding home” means a boarding home which offers personal assistance as well as room and board, as defined by the Department of Community Affairs (see N.J.A.C. 5:27).

“Dietitian” means a person who is a graduate of an accredited college or university with courses meeting the academic standards of the American Dietetic Association, plus a dietetic internship or dietetic traineeship or master’s degree plus six months experience. A registered dietitian is one who has met current requirements for registration.

“Discharge planning” means that component part of a total individualized plan of care formulated by all members of the agency’s health care team, together with the recipient and/or his or her family or interested person which anticipates the health care needs of the recipient in order to provide for continuity of care after the services of the home care agency have terminated. Such planning aims to provide humane and psychological preparation to enable the recipient to adjust to his changing needs and circumstances.

“Division” means the Division of Medical Assistance and Health Services.

“Early and periodic screening, diagnosis and treatment/private duty nursing (EPSDT/PDN)” means the private duty nursing services provided to Early and Periodic Screening, Diagnosis and Treatment Program recipients under 21 years of age who live in the community and whose medical condition and treatment plan justify that need.

“Health services delivery plan (HSDP)” means an initial plan of care prepared by the Division’s Regional Staff Nurse (RSN) during the preadmission screening (PAS) assessment process. The HSDP reflects individual problems and required care needs. The HSDP is to be forwarded to the authorized care setting and is to be attached to the recipient’s medical record upon admission to a nursing facility or when the recipient receives services from home care agencies. The HSDP may be updated as required to reflect changes in the recipient’s condition.

“Home health agency” means a public or private agency or organization, either proprietary or non-profit, or a subdivision of such an agency or organization, which qualifies as follows:

1. Is approved by the New Jersey State Department of Health, including requirements for Certificate of Need and licensure when applicable;
2. Is certified as a home health agency under Title XVIII (Medicare) Program; and
3. Is approved for participation as a home health agency provider by the Division of Medical Assistance and Health Services.

“Homemaker agency” means a proprietary or voluntary non-profit agency approved by the Department of Human Services, Division of Medical Assistance and Health Services to provide Personal Care Assistant Services, and homemaker services under the Community Care Program for the Elderly and Disabled (CCEPD) and the Home Care Expansion Program (HCEP), and accredited, initially and on an on-going basis, by the Commission on Accreditation for Home Care Inc., the National HomeCaring Council, a Division of the Foundation for Hospice and Homecare or the Community Health Accreditation Program (CHAP).

“Homemaker-home health aide” means a person who:

1. Successfully completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division is retained in the agency’s personnel file.
2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and
3. Is supervised by a registered professional nurse employed by a Medicaid approved home health agency provider.

“Hospice agency” means a public agency or private organization (or subdivision of such organization) that is Medicare certified for hospice care in accordance with N.J.A.C. 10:53A, and has a valid provider agreement with the Division to provide hospice services.

“Hospice service” means a service package provided by a Medicaid approved hospice agency to recipients enrolled in the AIDS Community Care Alternatives Program (ACCAP) who are certified by an attending physician as terminally ill, with a life expectancy of up to six months. The service package supports a philosophy and method for caring for the terminally ill emphasizing supportive and palliative, rather than curative care, and includes services such as home care, bereavement counseling, and pain control. (For information regarding hospice services to regular Medicaid

recipients under Title XIX, see Hospice Services Manual N.J.A.C. 10:53A).

“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 recipients, upon request of the attending physician.

1. “Acute home health care” means concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required.
2. “Chronic home health care” means either long or short-term uncomplicated, professional and non-professional services, where there is no anticipated change in condition and services required.

“Licensed practical nurse” means a person who is licensed by the State of New Jersey as a practical nurse, pursuant to N.J.S.A. 45:11-27 et seq., having completed formal accredited nursing education programs.

“Medicaid District Office” (MDO) means one of the Division’s offices located throughout the State, which, for purposes of this manual, administers a home care quality assurance program through its case management staff via post-payment review.

“Nutritionist” means a person who has graduated from an accredited college or university, with a major in foods or nutrition or the equivalent course work for a major in the subject area, and two years of full-time professional experience in nutrition. Successful completion of a dietetic internship of traineeship in hospital or community nutrition approved by the American Dietetic Association, or completion of a master’s degree in the subject area may be substituted for the two years of full-time experience.

“Occupational therapist” means a person, who is registered by the American Occupational Therapy Association, or a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association. If treatment and/or services are provided in a state other than New Jersey, the occupational therapist shall meet the practice requirements of that state including licensure, if applicable, and shall also meet all applicable federal requirements.

“On-site monitoring” means a visit by Division staff to a homemaker agency, private duty nursing agency, or hospice agency to monitor compliance with this Manual.

“Performance standards” for the purpose of this manual means the criteria established by this Division in order to measure the recipient/caregiver’s satisfaction with the quality, quantity and appropriateness of the services delivered.

“Personal care assistant” means a person who:

1. Successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate or other documentation issued by the New Jersey Department of Law and Public Safety, Board of Nursing is retained in the agency's personnel file.

2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and

3. Is supervised by a registered professional nurse employed by a Medicaid approved homemaker/personal care assistant provider agency.

"Personal care assistant services" means health related tasks performed by a qualified individual in a recipient's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a recipient's written plan of care.

"Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent; and

1. If practicing in the State of New Jersey, is licensed by the State of New Jersey; or

2. If treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable. The practitioner shall also meet all applicable Federal requirements.

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

"Plan of care" means the individualized and documented program of health care services provided by all members of the home health or homemaker agency involved in the delivery of home care services to a recipient. The plan includes short-term and long-term goals for rehabilitation, restoration or maintenance made in cooperation with the recipient and/or responsible family member or interested person. Appropriate instruction of recipient, and/or the family or interested person as well as a plan for discharge are also essential components of the treatment plan. The plan shall be reviewed periodically and revised appropriately according to the observed changes in the recipient's condition.

"Preadmission screening (PAS)" means that process by which all eligible Medicaid recipients, and individuals who may become Medicaid eligible within 180 days following admission to a Medicaid certified nursing facility, and who are seeking admission to a Medicaid certified nursing facility receive a preadmission screening by the Medicaid District Office professional staff to determine appropriate placement prior to admission to a nursing facility pursuant to N.J.S.A. 30:4D-17.10 (P.L. 1988, c.97).

"Primary caregiver" means an adult relative or significant other adult who accepts 24 hour responsibility for the health and welfare of the recipient. For the recipient to receive private duty nursing services in the Home and Community-Based Services Waiver Programs, the primary caregiver must reside with the recipient and provide a minimum of 8 hours of hands-on care to the recipient in any 24 hour period.

"Prior authorization" means the process of approval by the MDO for certain services prior to the provision of these services. Prior authorization also may be applied in other service areas in situations of an agency's continued non-compliance with program requirements. In accordance with N.J.A.C. 10:60-1.4, if a patient is enrolled in the Garden State Health Plan or a private HMO, authorization for reimbursement is required by the GSHP physician case manager or private HMO prior to rendering any service.

"Private duty nursing" means individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to recipients under Model Waiver III and the AIDS Community Care Alternatives Program, as well as eligible Early and Periodic Screening Diagnosis and Treatment (EPSDT) recipients.

"Private duty nursing agency" means a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by the Division to provide private duty nursing services under Model Waiver III, and the AIDS Community Care Alternatives Program (ACCAP) and EPSDT. The private duty nursing agency shall be located/have an office in New Jersey and shall have been in operation and actively engaged in home health care services in New Jersey for a period of not less than one year prior to application.

"Public health nurse" means a person licensed as a registered professional nurse, who has completed a baccalaureate degree program approved by the National League for Nursing for public health preparation, or post-baccalaureate study which includes content approved by the National League for Nursing for public health nursing preparation.

"Quality assurance", for the purpose of this manual, means a system by which the Medicaid District Office staff shall conduct post-payment reviews to determine the recipient/caregiver's satisfaction with the quality, quantity and appropriateness of home care services provided to Medicaid recipients.

"Registered professional nurse" means a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.S.A. 45:11-26 et seq.

"Social worker" means a person who has a master's degree from a graduate school of social work accredited by the Council on Social Work Education, has one year of post-masters social work experience in a health care setting and is licensed to practice social work in the State of New Jersey.

“Social work assistant” means a person who has a baccalaureate degree in social work, or psychology, or sociology or other field related to social work and has had at least one year of social work experience in a health care setting.

“Speech-language pathologist” means a person who has a certificate of clinical competence from the American Speech-Language-Hearing Association; has completed the equivalent education requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate; and

1. If practicing in the State of New Jersey, is licensed by the State of New Jersey; or
2. If treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable. The practitioner shall also meet all applicable Federal requirements.

Amended by R.1993 d.588, effective November 15, 1993.
See: 25 N.J.R. 2803(a), 25 N.J.R. 5167(a).
Amended by R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
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.1997 d.277, effective July 7, 1997.
See: 29 N.J.R. 1454(a), 29 N.J.R. 2831(a).
Added “Calendar work week”.

10:60-1.3 Providers eligible to participate

(a) A home care agency or organization, as described in (a)1 through 4 below, is eligible to participate as a New Jersey Medicaid provider of specified home care services in 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. Out-of-State home health agencies providing services to Medicaid recipients out of State, must meet the requirements of that state, including licensure, if applicable, and must meet all applicable Federal requirements.
2. A homemaker agency, as defined in N.J.A.C. 10:60-1.2;
 - i. A new provider shall be issued a Medicaid Provider Billing Number by the fiscal agent. Those Personal Care Assistance (PCA) providers already enrolled as providers of homemaker services in the CCPED program (see N.J.A.C. 10:60-2) shall use the same Medicaid Provider Billing Number issued for CCPED.
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) The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis, by the

Commission on Accreditation for Home Care, Inc., the Community Health Accreditation Program, or the Foundation for Hospice and Homecare.

1. Exception: A private duty nursing agency currently approved by the Division to provide private duty nursing services (except for the licensed home health agency which is exempt from the accreditation requirement) shall have up to July 1, 1996 to become an accredited agency and meet the Division's requirements for accreditation. New private duty nursing agencies applying to become Medicaid providers after December 19, 1994 shall conform to the accreditation requirement at the time of application.

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.1994 d.623, effective December 19, 1994.
See: 26 N.J.R. 2840(a), 26 N.J.R. 5021(a).
Amended by R.1998 d.16, effective January 5, 1998.
See: 29 N.J.R. 4262(a), 30 N.J.R. 72(a).
In (b)1, amended date.

10:60-1.4 Covered home health services

(a) Home health care services covered by the New Jersey Medicaid program are limited to those services provided directly by a home health agency approved to participate in the New Jersey Medicaid program or through arrangement by that agency for other services.

1. Medicaid reimbursement is available for these services when provided to Medicaid recipients in their place of residence, such as a private home, residential hotel, residential health care facility, rooming house and boarding home.

- i. In residential health care facilities, homemaker-home health aide or personal care assistant services are excluded from Medicaid coverage.
- ii. Home health services shall not be available to Medicaid recipients in a hospital or nursing facility.

(b) Covered home health care services are those services provided according to medical, nursing and other health care related needs, as documented in the individual plan of care, on the basis of medical necessity and on the goals to be achieved and/or maintained.

(c) Home health care services shall be directed toward rehabilitation and/or restoration of the recipient to the optimal level of physical and/or mental functioning, self-care and independence, or directed toward maintaining the present level of functioning and preventing further deterioration, or directed toward providing supportive care in declining health situations.

(d) The types of home health agency services covered include professional nursing by a public health nurse, registered professional nurse, or licensed practical nurse; homemaker-home health aide services; physical therapy; speech-language pathology services; occupational therapy; medical

social services; nutritional services; certain medical supplies; and personal care assistant services, as defined in this section.

1. The home health agency shall provide comprehensive nursing services under the direction of a public health nurse supervisor/director as defined by the New Jersey State Department of Health. These services shall include, but not be limited to, the following:

i. Participating in the development of the plan of care with other health care team members, which includes discharge planning;

ii. Identifying the nursing needs of the recipient through an initial assessment and periodic reassessment;

iii. Planning for management of the plan of care particularly as related to the coordination of other needed health care services;

iv. Skilled observing and monitoring of the recipient's responses to care and treatment;

v. Teaching, supervising and consulting with the recipient and family and/or interested persons involved with his or her care in methods of meeting the nursing care needs in the home and community setting;

vi. Providing direct nursing care services and procedures including, but not limited to:

- (1) Wound care/decubitus care and management;
- (2) Enterostomal care and management;
- (3) Parenteral medication administration; and
- (4) Indwelling catheter care.

vii. Implementing restorative nursing care measures involving all body systems including, but not limited to:

- (1) Maintaining good body alignment with proper positioning of bedfast/chairfast recipients;
- (2) Supervising and/or assisting with range of motion exercises;
- (3) Developing the recipient's independence in all activities of daily living by teaching self-care, including ambulation within the limits of the treatment plan; and
- (4) Evaluating nutritional needs including hydration and skin integrity; observing for obesity and malnutrition;

viii. Teaching and assisting the recipient with practice in the use of prosthetic and orthotic devices and durable medical equipment as ordered;

ix. Providing the recipient and the family or interested persons support in dealing with the mental, emotional, behavioral, and social aspects of illness in the home;

x. Preparing nursing documentation including nursing assessment, nursing history, clinical nursing records and nursing progress notes; and

xi. Supervising and teaching other nursing service personnel.

2. 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 recipient 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 recipient's room, personal laundry, shopping, meal planning and preparation. In contrast, personal care services may include assisting the recipient 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 recipient, as well as the need for physician prescribed personal care and other health services, and not solely the recipient's medical diagnosis.

ii. The registered professional nurse, in accordance with the physician'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 recipient and the resources of the recipient, 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. The registered professional nurse, and other professional staff members, shall make visits to the recipient's residence to observe, supervise and assist, when the homemaker-home health aide is present or when the aide is absent, to assess relationships between the home health aide and the family and recipient and determine whether goals are being met.

3. 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 and the professional nursing staff of the home health agency. The attending physician shall be given an evaluation of the progress of therapies provided as well as the recipient's reaction to treatment and any change in the recipient's condition. The attending physician shall approve of any changes in the plan of care and delivery of therapy services.

i. The attending physician 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 recipient, 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) Evaluating and identifying the recipient's physical therapy needs;

(B) Developing long and short-term goals to meet the individualized needs of the recipient and a treatment plan to meet these goals. Physical therapy orders shall be related to the active treatment program designed by the attending physician to assist the recipient 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 the recipient's reaction to treatment, as well as, any changes in the recipient's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, care provided and the recipient's response to therapy along with the notification and approval received from the physician; 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 or by a physical therapist which are purely palliative; for example, applications of heat in any form, massage, routine and/or group exercises, as-

sistance 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) Evaluating, identifying, and correcting the individualized problems of the communication impaired recipient;

(B) Developing long and short-term goals and applying speech-language pathology service procedures to achieve identified goals;

(C) Coordinating activities with and providing assistance to a certified audiologist, when indicated;

(D) Observing and reporting to the attending physician the recipient's reaction to treatment, as well as, any changes in the recipient's condition; and

(E) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, the care provided, and the recipient's response to therapy, along with the notification and approval received from the physician.

(3) The need for occupational therapy is not a qualifying criterion for initial entitlement to home health services benefits. However, if an individual has otherwise qualified for home health benefits, his or her eligibility for home health services may be continued solely because of his or her need for occupational therapy. Occupational therapy services shall include, but not be limited to, activities of daily living, use of adaptive equipment, and home-making task oriented therapeutic activities. When the agency provides or arranges for occupational therapy services, the services shall be provided by a registered occupational therapist. The duties of an occupational therapist shall include, but not be limited to, the following:

(A) Evaluating and identifying the recipient's occupational therapy needs;

(B) Developing long and short-term goals to meet the individualized needs of the recipient and a treatment plan to achieve these needs;

(C) Observing and reporting to the attending physician the recipient's reaction to treatment as well as any changes in the recipient's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, the care provided, and the recipient's response to

therapy along with the notification and approval received from the physician; and

(E) Occupational therapy services shall include but not be limited to activities of daily living, use of adaptive equipment, and homemaking task oriented therapeutic activities.

4. When the agency provides or arranges for medical social services, the services shall be provided by a social worker, or by a social work assistant under the supervision of a social worker. These shall include, but not be limited to, the following:

i. Identifying the significant social and psychological factors related to the health problems of the recipient and reporting any changes to the home health agency;

ii. Participating in the development of the plan of care, including discharge planning, with other members of the home health agency;

iii. Counseling the recipient and family/interested persons in understanding and accepting the recipient's health care needs, especially the emotional implications of the illness;

iv. Coordinating the utilization of appropriate supportive community resources, including the provision of information and referral services; and

v. Preparing psychosocial histories and clinical notes.

5. When the agency provides or arranges for nutritional services, the services shall be provided by a registered dietitian or nutritionist. These services shall include, but are not limited to, the following:

i. Determining the priority of nutritional care needs and developing long and short-term goals to meet those needs;

ii. Evaluating the recipient's home situation, particularly the physical areas available for food storage and preparation;

iii. Evaluating the role of the family/interested persons in relation to the recipient's diet control requirements;

iv. Evaluating the recipient's nutritional needs as related to medical and socioeconomic status of the home and family resources;

v. Developing a dietary plan to meet the goals and implementing the plan of care;

vi. Instructing recipient, other home health agency personnel and family/interested persons in dietary and nutritional therapy; and

vii. Preparing clinical and dietary progress notes.

6. 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 and agency staff.

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.

7. 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).

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 program, the recipient'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).

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);
 - 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 for home health services

(a) For home health services, the New Jersey Medicaid program follows 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) 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) Retroactive settlement and final reimbursement shall be based on Medicare principles of reimbursement.

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

10:60-1.9 Out-of-State approved home health agencies

(a) 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.

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

10:60-1.10 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, dish-washing;
- 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;

(b) For a hospice agency, on-site monitoring visits shall be made periodically by Division staff to the agency to review compliance with personnel, recordkeeping and service delivery requirements (Hospice Agency Review Summary Form, FD-351). The results of such monitoring visits shall be reported to the agency with a copy to the Medicaid District Office, 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 recipients for services, suspension or rescission of the agency's provider contract.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Recodified from 10:60-1.16 by R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

10:60-1.18 Provisions for fair hearings

Providers and recipients can request fair hearings as set forth in the Administration chapter at N.J.A.C. 10:49-9.10.

New Rule, R.1994 d.41, effective January 18, 1994.
See: 25 N.J.R. 2803(a), 26 N.J.R. 364(c).
Recodified from 10:60-1.17 by R.1996 d.43, effective January 16, 1996.
See: 27 N.J.R. 279(a), 28 N.J.R. 289(a).

SUBCHAPTER 2. HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

10:60-2.1 Community Care Program for the Elderly and Disabled (CCPED)

(a) The Federal Omnibus Budget Reconciliation Act of 1981 (Section 2176, P.L. 97-35) encouraged the development of community-based service programs rather than institutional service programs. This law was codified as Section 1915(c) of the Social Security Act (see 42 U.S.C. 1936n).

1. Under the provision of this Federal legislation, a request for a home and community-based services waiver for elderly and disabled individuals was submitted by the New Jersey Department of Human Services and approved by the United States Department of Health and Human Services. The waiver is renewable every five years and serves a limited number of recipients Statewide who must meet the medical and financial eligibility requirements.

(b) The Community Care Program for Elderly and Disabled (CCPED) is a waived program, administered by the Division of Medical Assistance and Health Services, initiated to help eligible recipients remain living in the community rather than in a nursing facility.

1. The program allows for the allocation of community care slots which are assigned Statewide in accordance with the needs of the population and the resources available to meet those needs. Each county has a designated

case management site such as a county welfare agency, Office on Aging, home health agency or homemaker agency.

10:60-2.2 Eligibility requirements for CCPED

(a) Financial eligibility for CCPED is determined by the county welfare agency/board of social services which serves the county where an individual resides. The standards used for income eligibility are set forth in N.J.A.C. 10:71-5.6(c)4, Table B, entitled "Variations in Living Arrangements." Both the Supplemental Security Income (SSI) community standard and the Medicaid institutional standard appear in this table. The actual amounts, recomputed periodically based upon the cost-of-living increase, are subject to change each time a cost-of-living increase occurs.

1. Recipients financially eligible for Medicaid services under the community eligibility standards are not covered under CCPED. CCPED also does not serve recipients who are eligible under the New Jersey Care . . . Special Medicaid Programs, including the Medically Needy segment of that program, or enrolled in the Garden State Health Plan or private HMO serving the Medicaid eligible population.

(b) Program eligibility criteria are as follows:

1. An applicant 65 years or older shall be eligible for Medicare benefits or have other medical insurance which includes physician coverage and hospitalization.

2. An applicant under 65 shall be determined disabled by the Social Security Administration (SSA) and be eligible for Medicare benefits or be determined disabled by the Division of Medical Assistance and Health Services, Disability Review Section, and have other medical insurance which includes physician coverage and hospitalization.

3. An applicant shall be ineligible in the community for Supplemental Security Income (SSI), or the applicant's total income, excluding deemed income, shall exceed the appropriate SSI community standard up to the Medicaid institutional standard. Parental and spousal income are not considered in the determination of eligibility.

4. An applicant's own resources shall not exceed the Medicaid Only limits. Resources of a parent are not deemed. While the spouse's resources are considered, up to one-half of the total resources are protected for the use of the spouse.

5. An applicant shall be in need of the type of care provided in an institutional setting and meet, at a minimum, the New Jersey's Medicaid Program's nursing facility's level of care criteria.

6. In order for an applicant to be enrolled in the program, a waiver slot shall be available.

(c) The total cost of services for the recipient in the community reimbursed by Medicaid shall not exceed the established cost limitation for institutional care for that recipient.

(d) A Medicaid Eligibility Identification (MEI) card shall be distributed to the recipient eligible for CCPED. Approved services are listed on the card as exhibited in N.J.A.C. 10:49, Appendix A.

(e) Retroactive eligibility is not available to CCPED recipients; no service received prior to the date of enrollment shall be considered for reimbursement.

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

10:60-2.3 Services available under CCPED

(a) Services provided under CCPED complement the services provided under the Medicare Program or other physician and hospital benefit coverage for non-Medicare eligible individuals. A modified package of seven Medicaid covered services is available.

(b) Services provided under CCPED include the following:

1. Case management: A process in which a social worker or professional nurse is responsible for planning, locating, coordinating, and monitoring a group of services designed to meet the individual health needs of the recipient being served. The case manager is the pivotal person in establishing a service package.

i. Case management is not provided when a recipient is in an inpatient hospital setting and the stay extends beyond a full calendar month.

2. Home health care: Provided by a licensed home health agency, which may include skilled nursing care; homemaker/home health aide services; physical and occupational therapy; speech-language pathology services; medical social services and medical supplies. Medical supplies are limited to a maximum of \$50.00 per month. Covered home care services are provided according to medical, nursing and other health-related needs, as documented in the recipient's plan of care.

3. Homemaker services: Personal care, household tasks, and activities of daily living, provided to a recipient in the home by either a home health agency or a homemaker agency.

4. Medical day care: A program of medically supervised, health and health related services provided in an ambulatory care setting to recipients who are non-residents.

5. Social adult day care: A comprehensive social and health related outpatient program for the frail, moderately handicapped, slightly confused recipient who needs care during the day.

6. Medical transportation: Non-emergency transporting of a recipient by an approved, suitable vehicle to obtain health services. Transportation may be provided by invalid coach or by lower modes of service that are arranged/provided by the county welfare agency/board of social services.

7. Respite care: A temporary service offered on an intermittent basis to recipients being cared for at home. The purpose of this service is to relieve the informal caregivers, allowing for a leave of absence in order to reduce stress or to meet a family crisis. Respite care can be provided in a recipient's home by a home health agency, homemaker agency, or in a nursing facility for limited periods of time. Nursing home respite care is limited to 30 days per calendar year.

(c) The services listed under (b) above may be limited in duration or amount depending upon the cost of the service plan under CCPED and the medical needs of the recipient.

(d) Other services covered by the New Jersey Medicaid Program are not available to the CCPED recipient.

10:60-2.4 Procedures used as financial controls for CCPED

(a) Total program costs shall be restricted by limits placed on the number of community care slots assigned each county and on per recipient costs. The Division may elect to exclude individuals for whom there is an expectation that costs to Medicaid for waiver services may exceed the cost of nursing facility care.

(b) A case manager shall be responsible for the development of the service plan with each recipient/family and with input from the provider agencies and Medicaid professional staff. The case manager shall be responsible for monitoring the cost of the service package.

(c) CCPED Statewide per recipient service cost limits shall be determined by the Division of Medical Assistance and Health Services once a year and distributed to the case management sites and Medicaid District Offices.

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

10:60-2.5 Basis for home health agency reimbursement and cost reporting (CCPED)

(a) A home health agency participating in the CCPED program shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for home health services provided. Fees shall be based on the lower of audited cost report data which is inflated to the current year, Medicare cost limits or agency charges. Agencies shall be precluded from receiving additional reimbursement for the cost of the community care services above the fee established by the Medicaid program. This applies to both freestanding and hospital-based home health agencies.