CHAPTER 68

CHIROPRACTIC SERVICES

Authority

N.J.S.A. 30:4D–6b(a); 30:4D–7, 7a, b and c; 1905(g) of the Social Security Act 42 U.S.C. § 1396(d); 42 C.F.R. § 440.60(b)2.

Source and Effective Date

R.1996 d.264, effective June 3, 1996.
See: 28 N.J.R. 1460(a), 28 N.J.R. 2999(a).

Executive Order No. 66(1978) Expiration Date

Chapter 68, Chiropractic Services, expires on June 3, 2001.

Chapter Historical Note

Chapter 68, Manual for Chiropractic Services, was adopted as R.1973 d.369, effective January 1, 1974. See: 5 N.J.R. 414(b), 6 N.J.R. 68(b). Chapter 68 was amended by R.1976 d.335, effective October 26, 1976. See: 8 N.J.R. 238(c), 8 N.J.R. 558(a); R.1981 d.249, effective July 9, 1981. See: 13 N.J.R. 293(a), 13 N.J.R. 417(a); and R.1986 d.286, effective June 16, 1986 (operative July 1, 1986). See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

Pursuant to Executive Order No. 66(1978), Chapter 68 was readopted by R.1986 d.309, effective July 7, 1986. See: 18 N.J.R. 1053(b), 18 N.J.R. 1594(a).

Pursuant to Executive Order No. 66(1978), Chapter 68 was readopted by R.1991 d.377, effective June 28, 1991. See: 23 N.J.R. 1327(a), 23 N.J.R. 2309(a).

Chapter 68, Manual for Chiropractic Services, was repealed and a new Chapter 68, Chiropractic Services, was adopted by R.1996 d.264, effective June 3, 1996. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:68–1.1 Purpose

The purpose of this chapter is to provide rules governing the provision of chiropractic services to Medicaid beneficiaries.

10:68–1.2 Scope of services

(a) Coverage of a chiropractor's services shall be limited to treatment by means of manipulation of the spine which the chiropractor is legally authorized by the State to personally perform (see 42 C.F.R. §440.60). The chiropractor may prescribe certain services as outlined in N.J.A.C. 10:68–2, Services Prescribed by the Chiropractor.

1. Services may be provided in the office, the beneficiaries' home, a nursing facility, or a residential health care facility. Services shall not be reimbursed for chiropractic services provided in intermediate care facilities for the mentally retarded (ICF/MRs) or in residential treatment centers.

10:68–1.3 Definitions

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

"Chiropractor" means a doctor of chiropractic licensed to practice within the scope of that license issued by the New Jersey State Board of Chiropractic Examiners, or by a comparable State agency in the state in which the chiropractor is located; and fulfills those qualification requirements for certification as an eligible provider under Title XVIII of the Social Security Act (Section 1861(r)(5) and 42 U.S.C. §1396d).

"Chiropractic services" means those services personally provided by the chiropractor which are limited to the adjustment and manipulation of the articulations of the spine and related structures and whose purpose is the relief of certain abnormal clinical conditions of the human body causing discomfort resulting from the impingement upon associated nerves.

"Clinical laboratory services" means professional and technical laboratory services provided by an independent clinical laboratory when ordered and provided by, or under the direction of, a physician or other licensed practitioner of the healing arts, within the scope of his or her practice, as

defined by the laws of the state in which the physician or practitioner practices; and when furnished by a laboratory that meets the Clinical Laboratory Improvement Act of 1987 (CLIA). (See N.J.A.C. 10:68–2.4.)

"Consultation" means the advice, counsel, deliberation, diagnosis, and proposed treatment by a specialist when and as requested by an attending physician or the attending's own patient.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health in accordance with N.J.A.C. 8:39 for participation in Medicaid and primarily engaged in providing:

1. Nursing care and related services for patients who require medical, nursing care, and social services;

2. Rehabilitative services for the rehabilitation of the injured, disabled, or sick; or

3. Health–related care and services on a regular basis to patients who because of a mental or physical condition require care and services above the level of room and board. However, the nursing facility is not primarily for the care and treatment of patients with mental diseases which require continuous 24–hour supervision by qualified mental health professionals.

"Residential health care facility" means a facility, licensed by the New Jersey State Department of Health, which furnishes food and shelter to four or more persons 18 years of age and older who are unrelated to the owner and which provides dietary services, recreational activities, supervision of self-administration of medications, supervision of and assistance in activities of daily living (ADL) and assistance in obtaining health services to one or more of such persons. As used in this chapter, the term "residential health care facility" means a "boarding home for sheltered care" as defined by the New Jersey State Department of Health (see N.J.A.C. 8:43).

10:68–1.4 Application for provider status; chiropractor

(a) Any chiropractor may apply to the New Jersey Medicaid program for approval as a Medicaid provider, if he or she is a chiropractor licensed by the State Board of Chiropractic Examiners in accordance with N.J.A.C. 13:44E, or licensed by a comparable State agency in the state in which the chiropractor practices.

(b) See N.J.A.C. 10:49–3 for additional requirements for provider participation.

(c) An applicant shall complete a Medicaid Provider Application (FD–20; see N.J.A.C. 10:49, Appendix #8) and a Medicaid Provider Agreement (FD–62; see N.J.A.C. 10:49, Appendix #9). The forms may be obtained from, and shall be submitted to:

Unisys Corporation
Provider Enrollment
P.O. Box 4804
Trenton, NJ 08650–4804

(d) The application and agreement shall be accompanied by a photocopy of the applicant's current license as a chiropractor.

(e) The applicant shall receive notification of approval or disapproval from the Medicaid fiscal agent. If approved, the chiropractor shall be furnished with a provider manual and assigned a Medicaid provider identification number. The chiropractor shall use the assigned provider identification number on all billing documents submitted to the Medicaid fiscal agent.

10:68–1.5 Basis of reimbursement

(a) Reimbursement for covered chiropractic services provided to a Medicaid beneficiary is provided on the basis of the customary charge (fee–for–service) not to exceed an allowance determined reasonable by the Commission of the New Jersey State Department of Human Services and contained in N.J.A.C. 10:68–3.2.

1. In no event shall the charge to the New Jersey Medicaid program exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

2. The chiropractor may be reimbursed for an initial diagnostic and/or evaluation visit in the absence of manipulation of the spine performed during that visit. The HCPCS procedure code for this service, Y3433, cannot be billed with the procedure code A2000 on the same date of service for the same patient.

3. The procedure codes which are used when submitting claims are listed in N.J.A.C. 10:68–3.2, Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). The Fiscal Agent Billing Supplement, Appendix A, incorporated herein by reference, provides information about the claim form and billing instructions. Claims for services rendered shall be submitted by providers in accordance with the Fiscal Agent Billing Supplement.

(b) Reimbursement shall not be made for broken appointments, nor shall the provider ask the beneficiary to pay for broken appointments.

10:68–1.6 Recordkeeping

(a) All chiropractors shall keep such individual records as are necessary to fully disclose the kind and extent of services provided in accordance with the rules of the Board of Chiropractic Examiners in N.J.A.C. 13:44E–2.2 and the Division, at N.J.A.C. 10:49–9.4 and 9.5.

1. This information shall be made available upon request of the New Jersey Medicaid program or its agents.

(b) Patient visits are subject to post-payment review of the medical necessity for treatment. The absence of medical necessity subjects the provider to recovery of fees already received.

(c) For the initial examination, the record shall include as a minimum, the following documentation:

1. The date of service;
2. The chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures ordered;
5. The diagnosis(es); and
6. The treatment plan.

(d) Subsequent progress notes may be brief, but shall include date, pertinent history, physical findings and specific treatment.

SUBCHAPTER 2. SERVICES PRESCRIBED BY THE CHIROPRACTOR

10:68–2.1 General provisions

(a) Chiropractors may prescribe services within the scope of their license to practice and within the limitations of the New Jersey Medicaid program. The prescriber shall ensure the patient's free choice of provider when ordering and/or prescribing services such as clinical laboratory services, medical supplies and durable medical equipment, physical therapy, pre-fabricated orthoses and diagnostic radiology services. (See also N.J.A.C. 13:44E–1.1(c)).

(b) The chiropractor shall include his or her Medicaid Provider Services Number (MPSN) on all written prescriptions.

(c) The chiropractor shall include, on each prescription, the patient's diagnosis and, when possible, state the length of time estimated for use or need for items such as durable medical equipment. The Medicaid District Office may contact the chiropractor for more information about the patient if a prescribed item requires the medical supplier to request prior authorization from the New Jersey Medicaid program.

10:68–2.2 Chiropractic services in a nursing facility or residential health care facility by providers in a partnership or corporation

(a) When chiropractic services are provided to a Medicaid beneficiary in a nursing facility, payment shall not be made for those services if provided by an owner, administrator, stockholder of the company or corporation, or by anyone who otherwise has a direct financial interest in the institution.

(b) If a Medicaid beneficiary receives care from more than one member of a chiropractic partnership or corporation, the maximum payment allowance will be the same as that of a single attending chiropractor.

10:68–2.3 Consultation

Consultation between chiropractors shall not be reimbursed by the New Jersey Medicaid program, since there are no chiropractic specialists within the chiropractic discipline. (See N.J.A.C. 10:68–1.3 for definition of consultation.)

10:68–2.4 Services prescribed by a chiropractor; clinical laboratory services

(a) A chiropractor shall not include any charges for laboratory services in a claim for reimbursement; however, he or she may order those professional and technical laboratory services for Medicaid beneficiaries that are consistent with chiropractic practice. The New Jersey Medicaid program shall reimburse a clinical laboratory for covered services rendered to Medicaid beneficiaries that has met the following requirements:

1. Licensure and/or approval by the New Jersey Department of Health or comparable agency in the state in which the facility is located, including meeting certificate of need and licensure requirements, when required, and all applicable laboratory provisions of N.J.A.C. 8:45;

2. Certification as an independent laboratory under Title XVIII Medicare program (see 42 C.F.R. §493.1);

3. Compliance with the requirements for an independent clinical laboratory under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) (see 1902(a)(9) of the Social Security Act; 42 U.S.C. §1396a(a)(9)).

10:68–2.5 Services prescribed by a chiropractor; medical supplies, durable medical equipment and prefabricated orthoses

(a) Medical supplies and durable medical equipment that are essential for the beneficiary's condition shall be reimbursed to an approved durable medical equipment or medical supplies provider under the following conditions:

1. The medical supplies and durable medical equipment shall be prescribed by a chiropractor, within his or her scope of practice, and provided by a medical supplier approved for participation in the New Jersey Medicaid program, in accordance with N.J.A.C. 10:59.

2. The medical supplies and durable medical equipment provider shall obtain prior authorization from the Medicaid District Office (MDO) for certain medical supplies and durable medical equipment in accordance with N.J.A.C. 10:59.

(b) Pre–fabricated orthotics that are essential for the patient's medical condition shall be reimbursed when prescribed by a licensed chiropractor, within the scope of his or her service, and supplied either by an approved provider of medical supplies and equipment in accordance with N.J.A.C. 10:59, or an approved prosthetic and orthotic *provider in* accordance with N.J.A.C. 10:55.

(c) Medical supplies, durable medical equipment and prefabricated orthotics are not reimbursable by the New Jersey Medicaid program when available at no charge from community resources (such as the Lions Club, Senior Citizen Centers, Office of the Aged, or other service organizations).

10:68–2.6 Services prescribed by a chiropractor; physical therapy services

(a) Physical therapy services, when prescribed by a chiropractor under his or her scope of practice (see N.J.A.C. 13:44E–2.14) shall be reimbursed to an approved provider, in accordance with this section. Providers shall secure prior authorization from the Medicaid District Office (MDO) when physical therapy services are provided, except when the services are provided in a hospital outpatient setting. Initial and subsequent prior authorization shall not exceed 60 calendar days. Chiropractors shall not be reimbursed directly for physical therapy services.

(b) Physical therapy services are authorized only under the following conditions:

1. When the chiropractor, in written communication with the physical therapist, prescribes through detailed orders which shall be placed on the patient's chart prior to the physical therapy treatment being initiated. These orders shall include a statement covering the medical necessity for therapy, the objectives of the treatment, a therapy prescription including the specific means and methods to be used, and the estimated number and frequency of treatments.

i. Physical therapy services shall be definitive as to type and scope of procedures to be provided. General prescriptions such as "physical therapy three times a week," "physical therapy, as needed," or similarly worded blanket authorization shall not be accepted by Medicaid as a legitimate prescription since no treatment is named and the physical therapist is in effect prescribing the patient's regime.

2. The chiropractor shall instruct the physical therapist to file notes in the patient's chart, at least weekly, reflecting the patient's response to treatment. These notes shall be forwarded to the referring chiropractor in order for the chiropractor to coordinate the plan of care and document appropriately in the patient's record, as required by N.J.A.C. 13:44E.

3. The chiropractor shall coordinate physical therapy with the attending physician's plan of care in a nursing facility (see N.J.A.C. 10:63–2.4 and 2.12.)

4. Formal physical therapy is not indicated when evidence indicates that similar types of care could be provided by the nursing unit by rehabilitative nursing or other techniques.

(c) Physical therapy services shall 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. (See N.J.A.C. 13:44E–2.14.)

1. Physical therapy shall be related to the active treatment regime designed by the chiropractor to elevate the patient to his maximum level of functions which has been lost or reduced by reason of injury or illness.

2. Restorative nursing care, as distinct from physical therapy, as a prescribed service by the chiropractor, may be provided under the following conditions:

i. These include measures as maintaining good alignment and proper positioning of bedfast patients, keeping patients active and out of bed in accordance with the chiropractor's orders, and developing the patient's independence in activities of daily living by teaching self-care, transfer and ambulation activities by the nursing staff. Restorative nursing procedures performed by licensed nurses constitute a part of skilled nursing care when they are prescribed by a chiropractor and are designed to restore functions which have been lost or reduced by illness or injury.

ii. Restorative nursing services, though prescribed by the chiropractor, are not reimbursed directly to the chiropractor.

10:68–2.7 Services prescribed by a chiropractor; diagnostic radiological services

The New Jersey Medicaid program shall reimburse for diagnostic radiological services prescribed by a chiropractor within their scope of practice as determined by the New Jersey State Board of Chiropractic Examiners, or the applicable agency in the state in which the chiropractor practices. Diagnostic radiological services of any type are reimbursable only when provided by a specialist in radiology as recognized by the New Jersey Medicaid program or by the State Medicaid agency in the state in which the Radiologist practices.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:68–3.1 Introduction

(a) The New Jersey Medicaid program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in N.J.A.C. 10:68–3.2 are relevant to Medicaid chiropractic services and must be used when filing a claim.

1. The responsibility of the chiropractor when rendering services is listed in N.J.A.C. 10:68–1 and 2.

10:68–3.2 HCPCS codes for chiropractic services and maximum fee schedule

HCPCS Code	Description	Maximum Fee Allowance
A2000	Manipulation of spine	$6.00
Y3433	Initial diagnostic and/or evaluation visit by chiropractor	6.00

QUALIFIER: The HCPCS codes for an initial diagnostic and/or evaluation visit in the absence of manipulation of the spine during that visit may be billed.

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation
P.O. Box 4801
Trenton, New Jersey 08650–4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN 049
Trenton, New Jersey 08625