

CHAPTER 68

MANUAL FOR CHIROPRACTIC SERVICES

Authority

N.J.S.A. 30:4D-6b(a); 7, 7a, b and c; 30:4D-12; 42 C.F.R. 440.60.

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Chapter 68, Manual for Chiropractic Services, expires on June 28, 1996.

Chapter Historical Note

All provisions of this chapter became effective January 1, 1974 as R.1973 d.369. See: 5 N.J.R. 414(b), 6 N.J.R. 68(b). Amendments became effective October 26, 1976 as R.1976 d.335. See: 8 N.J.R. 238(c), 8 N.J.R. 558(a). Further amendments became effective July 9, 1981 as R.1981 d.249. See: 13 N.J.R. 293(a), 13 N.J.R. 417(a). Further amendments became 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. See: Source and Effective Date.

See section levels for specific rulemaking activity.

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SUBCHAPTER 1. CHIROPRACTIC SERVICES

10:68-1.1 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 chiropractic within the limits of his license by the New Jersey State Board of Chiropractic Examiners and fulfills those qualification requirements for certification as an eligible provider under Title XVIII of the Social Security Act. Chiropractors practicing in states other than New Jersey are not eligible for reimbursement under the New Jersey Health Services Program.

“Chiropractic services” means those services which are limited to manual manipulation of the spine and is provided personally by the chiropractor. It includes services furnished in the office, the patient’s home, skilled nursing facility, intermediate care facility and sheltered boarding home.

“Concurrent care” means treatment rendered by more than one chiropractor on the same patient at the same time for the same disease, illness or condition. Reimbursement can only be made to the current attending chiropractor in accordance with the above provisions.

“Consultation” is considered to be the advice, counsel, deliberation, diagnosis, proposed treatment of a qualified specialist when and as requested by the attending physician on the attending’s own patient. Since there are no chiropractic specialists within this chiropractic discipline, consultation between chiropractor is not a reimbursable service.

Qualified physical therapist means, for program payment purposes, an individual who is licensed as a physical therapist by the state in which practicing and meets one of the following requirements:

1. Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or
2. Prior to January 1, 1966, was admitted to membership by the American Physical Therapy Association, or was admitted to registration by the American Registry of Physical Therapists, or has graduated from a physical therapy curriculum in a four-year college or university approved by a state department of education; or
3. Has two years of appropriate experience as a physical therapist and has achieved a satisfactory grade on proficiency examination approved by the secretary, except that such determination of proficiency will not apply with respect to persons initially licensed by a state as a physical therapist after December 31, 1977, or seeking qualification as a physical therapist after that date; or
4. Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time

experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

5. If trained outside the United States, was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, has one year of experience under the supervision of an active member of the American Physical Therapy Association, and has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

“Qualified occupational therapist” means one who is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

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

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

“Transfer” means the relinquishing of responsibility for the continuing care of the patient by one chiropractor and the assumption of such responsibility by another chiropractor.

Amended by R.1976 d.335, effective October 26, 1976.

See: 8 N.J.R. 238(c), 8 N.J.R. 558(a).

Amended by R.1991 d.377, effective August 5, 1991.

See: 23 N.J.R. 1327(a), 23 N.J.R. 2309(a).

Revised definition of chiropractor.

10:68-1.2 Scope of services available to recipients

(a) Payment will be made for the necessary services ordered by a chiropractor subject to the following limitations (For recipients in the Medically Needy Program, chiropractic services are only available to pregnant women. For information on how to identify a covered person, please refer to N.J.A.C. 10:49-1.2):

1. “Clinical laboratory services” means professional and technical laboratory services provided to a patient by a laboratory that is qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements of such participation. Such laboratories include:

i. Independent clinical laboratories, including physician-operated, out-of-hospital laboratories which perform primarily diagnostic work referred by other physicians or practitioners, and which meet the above qualifications.

ii. Hospital laboratories holding valid certifications from the New Jersey Department of Health, and which provide laboratory services to ambulatory patients as requested by a practitioner. When laboratory service has been provided by a certified laboratory, payment shall be made only to the laboratory.

NOTE: A chiropractor cannot include in his claim any charges for laboratory services.

iii. If multichannel, automated laboratory equipment is readily available in the community and if the clinical laboratory studies ordered by the chiropractor are part of the battery of tests included in the multichannelled automated laboratory determination, then the sum of the charge for three or more clinical laboratory studies ordered by the chiropractor shall be billed to the program at a cost not to exceed a charge reflecting the customary fee for the entire battery of studies. Under no circumstances shall payment exceed the program allowances for each test when less than four clinical laboratory studies are deemed essential by the chiropractor and performed either individually or as part of a battery of studies by multichannel automated laboratory equipment.

2. When chiropractors' services are provided to persons in a skilled nursing facility or intermediate care facility payment will not be made for any practitioner or therapy services rendered by an owner, administrator, stockholder of the company or corporation, or who otherwise has a direct financial interest in the institution.

3. Radiology services of any type are reimbursable only when provided by a specialist in radiology as recognized by the New Jersey Health Services Program.

4. Physical medicine and rehabilitation services include physical therapy, occupational therapy, speech therapy and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best possible functional level. It does not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form, massage, routine calisthenics or group exercises, assistance in any activity or use of a simple mechanical device not requiring the special skill of a qualified physical therapist. Rehabilitation services shall be made available to covered persons as an integral part of a comprehensive medical care program. Such services include not only intermittent or part-time service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

(b) Requirements include the following:

1. The chiropractor in communication with the physical therapist must prescribe (authorize in writing) the specific means or methods to be used by the therapist and the frequency of therapy services.

2. Physical therapy must be related to the active treatment regimen designed by the chiropractor to elevate the patient to his maximum level of function which has been lost or reduced by reason of injury or illness.

3. "Physical therapy as needed" or a similarly worded blanket authorization does not suffice as an accepted prescription since no specific treatment is named and the physical therapist is in effect prescribing the patient's regimen.

(c) Distinction between physical therapy services and restorative nursing care are:

1. Restorative nursing care includes such measures as maintaining good body 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.

2. Nursing personnel may also assist patients in practicing the use of prosthetic and orthotic devices and in carrying out the prescribed physical treatment if requested by the chiropractor.

3. 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.

(d) Rehabilitation services may be provided by a home health agency in the patient's home or other place of residence; or to a patient in a skilled nursing facility; or intermediate care facility or in a hospital outpatient department; or in an approved clinic (independent outpatient health facility not part of a hospital). (The therapist cannot be reimbursed directly by the program.)

(e) Orthopedic shoes are reimbursable under the New Jersey Health Services Program when prior authorized and prescribed under the following conditions:

1. When attached to a brace or bar;
2. When part of the normal post-operative or post-fracture treatment program;
3. When used to correct gross foot deformities;
4. When the ankle (talo-crural) joint is included in the shoe.

(f) Shoes with or without accompanying appliances, used to prevent or correct gross deformities of the feet and consisting of the following basic parts:

1. Correct straight last lines;
2. Heels with sufficient bearing surfaces;
3. Toe with ample room for function;
4. Sole with sufficient weight for foot protection;
5. A rigid shank;
6. Properly fitting upper;
7. Smooth and protective lining;
8. Snug fitting heel counter;
9. Properly fitted as to length and width.

Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).

See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

Added text to (a) "For recipients in ..."

10:68-1.3 General policy

(a) Chiropractors are to keep individual records as are necessary to fully disclose the kind and extent of services provided to make such information available as the Division or its agents may request.

(b) For the initial examination, the record shall show the following as a minimum:

1. Date of service;
2. Chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures ordered;
5. Diagnosis(es);
6. Treatment plan.

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

10:68-1.4 Basis of payment

(a) Chiropractors shall use HCPCS Code A2000—manual manipulation of the spine—when submitting a claim to the New Jersey Medicaid Program. (Reference is made to N.J.A.C. 10:54-4.)

(b) In no event shall the charge to the program exceed the charge by the provider for identical services to other governmental agencies, or groups or individuals in the community. If a patient receives care from more than one member of a partnership or corporation in the same discipline, the maximum payment allowance would be the same as that of a single attending chiropractor.

1. Reimbursement for chiropractic services shall be made only for periods when eligibility is current.
2. Reimbursement is not made for, and recipients may not be asked to pay for, broken appointments.

Amended by R.1991 d.377, effective August 5, 1991.

See: 23 N.J.R. 1327(a), 23 N.J.R. 2309(a).

Revised subsection (a) regarding use of HCPCS Code for claim submission.

10:68-1.5 Prescription policies

(a) This Section is intended to describe the chiropractor's responsibility in the writing of prescriptions in order to maintain the traditional patient-prescriber-provider relationship and to insure the recipient free choice of provider.

(b) Chiropractors are urged to familiarize themselves with all aspects of this Section in order to effect economics consistent with good medical practices and to facilitate prompt payment to the provider.

(c) All New Jersey licensed chiropractors are eligible to prescribe within the limits of their New Jersey chiropractic licensure.

(d) The chiropractor's social security number must appear on all prescriptions. The appearance of this number instead of the chiropractor's name serves to expedite the mechanical aspects of processing the prescription claim. This requirement is a necessary and efficient step in computing each claim.

(e) Each prescription must include the patient's diagnosis and when possible state the length of time estimated for use or need (durable medical equipment, therapy services). For items described below requiring prior authorization, the prescriber may be contacted by the local medical assistance unit for more information about the patient to assist in the authorization determination.

(f) Medical supplies, equipment, prefabricated prosthetics and orthotics, and other assistive devices that are essential for the patient's medical condition are allowable when prescribed by a licensed chiropractor and are supplied by an approved provider of medical supplies and equipment. Such items are not reimbursable by the program when available at no charge from community resources (that is, the American Cancer Society, service organizations and so forth). The provider of supplies and equipment must obtain prior authorization from the local medical assistance unit for the following:

1. All durable medical equipment intended for use by a patient in a long term care facility;
2. Rental items regardless of price;
3. Oral hygiene devices;
4. Denis brown splints and fillauer bar;

5. Orthopedic shoes;
6. Medical supplies and durable medical equipment to be purchased for which the charge to the program exceeds \$20.00;
7. All ostomy bags and supplies regardless of price.

(g) Custom-made prosthetic and orthotic appliances (required to support or strengthen the body or replace parts thereof) are allowable when prescribed by a licensed chiropractor, prior authorized by the local medical assistance unit and fabricated in an approved prosthetic and/or orthotic shop. Custom-made appliances may be provided to Medicaid patients only by certified prosthetists and/or orthotists. Contact the local medical assistance unit to ascertain which prosthetic and orthotic dealers are eligible under the program.

(h) Physical, speech and occupational therapy require prior authorization in all approved locations except hospitals in accordance with the following:

1. Procedures when prescribing all rehabilitation services:

- i. The chiropractor should place detailed orders on the patient's chart prior to the treatment being initiated, specifying goals or potentials.

- ii. The chiropractor should instruct the physical therapist, or others of the allied health professions, to file notes in the patient's chart similar to nursing notes at least weekly, reflecting the patient's response to treatment.

- iii. The chiropractor should review the patient's record at least every 30 days, when in a skilled nursing facility, to determine if treatment is being provided according to his orders and indicate by signing the treatment records. Treatment that is being provided but which has not been prescribed or authorized by the chiropractor, should be discontinued immediately.

- iv. Formal physical and occupational 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.

2. Prior authorization: Except in a hospital setting, prior approval from the local medical assistance unit is required for rehabilitation services. Initial or subsequent authorization shall not exceed 60-calendar days and shall be granted only when the following conditions are met:

- i. All rehabilitation services of any type shall be supported by a written recommendation of a licensed chiropractor including a statement covering the medical necessity for therapy, the objective of treatment, a therapy prescription and the estimated number of treatments.

ii. Therapy prescriptions must be definitive as to type and scope of procedures to be rendered. Prescriptions such as "Physical therapy three times a week" will not be accepted.

SUBCHAPTER 2. CHIROPRACTOR BILLING PROCEDURES

10:68-2.1 General billing procedures

(a) A claim is a bill which indicates a request for payment for a Medicaid-reimbursable service provided to a Medicaid-eligible individual. The claim may be submitted hard copy or by means of an approved method of automated data exchange.

(b) This subchapter contains basic information necessary for the submission of a claim. Included is a sample form approved for use in submitting claims for covered items or services and appropriate instructions for the proper completion of the form.

Amended by R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
(a) added; existing text numbered as (b).

10:68-2.2 Timeliness of claim submission and claim inquiry

For timeliness of claim submission and claim inquiry, see N.J.A.C. 10:49-1.12.

Amended by R.1986 d.309, effective August 4, 1986.
See: 18 N.J.R. 1053(b), 18 N.J.R. 1594(a).
New text for (a). Old text recodified to (b).
New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Repealed rule was general policy.

10:68-2.3 Patient identification

(a) Verify that the patient is a covered person on the first visit and each visit thereafter. This is done by viewing the patient's validation form.

(b) It is especially important to review a patient's validation form on each visit when extended plans of treatment have been authorized. Prior authorization is no guaranty that an individual is covered. Authorization becomes invalid upon termination of eligibility.

10:68-2.4 Prior authorization

When submitting claims for payment, make certain all authorizations have been properly signed and are attached.

10:68-2.5 Combination Medicare/Medicaid claims

Services covered under Medicare rendered by noninstitutional providers to a Medicare/Medicaid eligible person shall be billed on the Health Insurance Claim Form 1500

N.J., and the claims sent directly to the Medicare Carrier, Prudential, Medicare B Division, P.O. Box 2222, Linwood, New Jersey 08221. The provider must record the medical insurance claim number in item 6 and the Health Services Program (HSP) (Medicaid) case and person number in item 8 on the claim form.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Incorporated billing procedures using HCFA-1500 claim form, and deleted references to form HCFA-1500.
Amended by R.1986 d.309, effective August 4, 1986.
See: 18 N.J.R. 1053(b), 18 N.J.R. 1594(a).
Substantially amended.

10:68-2.6 Directory of Medicaid District Offices (MDO)

(a) The following is a list of Medicaid District Offices, their county of location, and their county(ies) of jurisdiction. It should be noted the first two digits of the patient's Health Services Program case number indicates which MDO has jurisdiction in processing prior authorization requests. The complete address and telephone number of each MDO appears at N.J.A.C. 10:49-1, Appendix A.

1st Two Digits on HSP Case	County
01	Atlantic
02	Bergen
03	Burlington
04	Camden
05	Cape May
06	Cumberland
07	Essex
08	Gloucester
09	Hudson
10	Hunterdon
11	Mercer
12	Middlesex
13	Monmouth
14	Morris
15	Ocean
16	Passaic
17	Salem
18	Somerset
19	Sussex
20	Union
21	Warren

(b) Exceptions include the following:

1. Patient in long term care institutions (for example, skilled nursing facility, intermediate care facility, sheltered boarding home, special hospital): Requests for prior authorization are to be referred to the MDO serving the county wherein the long term care institution is located.
2. Children identified by numbers from "01" through "21" as the first and second digits and "60" as the third and fourth digits of the Health Services Program case number (for example, 0160-001234, 1160-005678, 2160-009123). These children are under the jurisdiction of the New Jersey Division of Youth and Family Services (formerly Bureau of Children's Services). Requests for

prior authorization are to be referred to the MDO serving the county wherein the child is residing.

(c) Medicaid eligibility is determined for four different agencies (for example, County Welfare Boards, Bureau of Local Operations of the New Jersey Division of Public Welfare, New Jersey Division of Youth and Family Services, and the Federal Social Security Administration). Provider inquiries concerning patient eligibility and/or applications for eligibility may be directed to the appropriate eligibility determination agency (if known by the provider) or to the MDO serving the provider's area. The MDO will assist the provider by answering the questions and/or directing the provider to the appropriate eligibility determination agency.

Amended by R.1986 d.309, effective August 4, 1986.
See: 18 N.J.R. 1053(b), 18 N.J.R. 1594(a).
Added text "The complete address . . . Appendix A."

10:68-2.7 Health Insurance Claim Form 1500—N.J.

(a) This form is used for the purpose of billing for covered services of physicians, podiatrists, optometrists, psychologists, and chiropractors.

(b) Mail the original copy (contractor's copy) together with authorization form (when appropriate) to:

The Prudential Insurance Company of America
P.O. Box 471
Data Base Systems Division
Millville, New Jersey 08332

NOTE: Forms were included with the text of the adopted rules above but are not reproduced herein. Information concerning these forms may be obtained by contacting the Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).

Deleted references to form MC-8 in catchline and substituted catchline concerning HCFA-1500 claim form.

Amended by R.1986 d.309, effective August 4, 1986.
See: 18 N.J.R. 1053(b), 18 N.J.R. 1594(a).
Deleted text "Billing should be . . . 10:49-1.12.)"

10:68-2.8 Automated Data Exchange

(a) Any approved provider may request approval to submit claims for reimbursement via an approved method of Automated Date Exchange. All costs of rental/purchase of a terminal, installation, maintenance, and usage of telephone lines are the responsibility of the provider.

(b) Requests for approval must be submitted to the appropriate Contractor:

The Prudential Insurance Co.
P.O. Box 471
Millville, New Jersey 08332

or

Blue Cross of New Jersey
33 Washington Street
Newark, New Jersey 07102

(c) Any provider approved for an Automated Data Exchange claim submission system must comply with all regulations and restrictions set forth by The New Jersey Medicaid Program.

(d) A random billing sample will be audited after a three month period. The review to compare data received via the Automated Data Exchange against the medical records will consist primarily of statement of charges, nature of services rendered, employment or accident related, other coverage, patient/provider signature, and verification that charges and procedure codes match services performed.

1. Subsequent audits will be scheduled at six-month intervals if the error rate is acceptable.

R.1981 d.250, eff. July 9, 1981.
See: 13 N.J.R. 269(a), 13 N.J.R. 418(a).