



STATE OF <sup>①</sup>NEW JERSEY.

② DEPARTMENT OF INSTITUTIONS AND AGENCIES.

③ DIVISION OF MEDICAL ASSISTANCE

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HEALTH SERVICES PROGRAM;

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CHIROPRACTOR MANUAL.

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## FOREWORD

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

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

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

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

## CHAPTER I

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## CHAPTER I

### GENERAL INFORMATION ABOUT THE PROGRAM

#### 100. WHO IS ELIGIBLE

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

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

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

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

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

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

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

GENERAL INFORMATION

101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

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

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

Exhibit I



101.2 Validation Form (Exhibit II)

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

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

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

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

**GENERAL INFORMATION**

\_\_\_\_\_ COUNTY WELFARE BOARD

**VALIDATION FOR HEALTH SERVICES PROGRAM**

Valid Only for Month of Jan. 1970

**BUCKINGHAM 11 30 051234**

01 John	24 Olive
02 Mary	25 Sarah
20 Emma Jones	26 Adolph
21 Lila	
22 James	
23 Belinda Smith	

Exhibit II

101.3 Temporary Identification and Validation Form (Exhibit III)

In certain circumstances, a temporary identification and validation form will be issued. This form will identify the case as eligible for health services for 30 days from the date of issue.

STATE OF NEW JERSEY  
DEPARTMENT OF INSTITUTIONS AND AGENCIES  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TEMPORARY IDENTIFICATION AND VALIDATION OF ELIGIBILITY

CURRENT CASE NO.			EFFECTIVE DATE		
CTY	PROG	NUMBER	MO	DAY	YR

  

	LAST NAME	FIRST NAME	M.I.	BIRTH DATE		
				MO	DAY	YR

NOTICE TO PROVIDER OF HEALTH SERVICES:

This form, when signed by or on behalf of the person whose name is first listed, identifies the person(s) listed as eligible for payment for authorized health services under the New Jersey Health Services Program.

This form also serves as a temporary validation of eligibility for a period not exceeding 30 days from the effective date entered above.

The information appearing on this form should be used in completing the claim form to be submitted to the appropriate Contractor for the State of New Jersey.

NOTICE TO CLIENT:

This form must be signed on the line below marked "Signature" by or on behalf of the person whose name is first listed. This form must be presented to the provider of health services to prove eligibility for payment. DO NOT USE this form after receiving your plastic identification card and your monthly "Validation for Health Services".

Signature \_\_\_\_\_

Prepared By \_\_\_\_\_ Date \_\_\_\_\_

Approved By \_\_\_\_\_ Date \_\_\_\_\_

102. AUTHORIZED SERVICES FOR COVERED PERSONS

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

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

103. ELIGIBLE PROVIDERS

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

Medical and Surgical Supply Dealers;  
Certified Independent Clinical laboratories;  
Dentists;  
Hearing Aid Dealers;  
Home Health Agencies;  
Hospitals;  
Skilled Nursing Homes;  
Opticians;  
Optometrists;  
Approved Clinics (Independent Outpatient Health Facilities);  
Certified Orthotists;  
Pharmacies;  
Physicians;  
Podiatrists;  
Certified Prosthetists; (excluding dental)  
Providers of Medical Transportation  
Chiropractors  
Psychologists

104. FREE CHOICE BY COVERED PERSONS

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

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### 105. CONTRACTORS

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

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

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

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

### 106. PRIOR AUTHORIZATION

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

### 107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

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

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

## GENERAL INFORMATION

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2. When it is customary for persons in the area generally to use medical care resources and facilities outside the State of New Jersey.
3. When out of state care was provided in an emergency.
4. Services rendered by Chiropractors and Psychologists licensed by States other than New Jersey are not eligible for reimbursement under the New Jersey Health Services Program.

### 108. GENERAL EXCLUSIONS

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

Payment is not made for:

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

NOTE: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the practitioner to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;
4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;
5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;
6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy (including any benefits payable under the "New Jersey Automobile Reparation Act", P.L. 1972, c.70), any other private or governmental health benefit system, or through any similar third party liability;
7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage:

## GENERAL INFORMATION

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

### 109. CONFIDENTIALITY OF RECORDS

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

### 110. UTILIZATION OF INSURANCE BENEFITS

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

#### 1. Title XVIII

For those individuals who are covered under Medicare, responsibility for payment by the New Jersey Health Services Program will be limited to the unsatisfied deductible to the extent that the payments do not exceed the maximum allowable under the Program in the absence of other coverage.

#### 2. Workmen's Compensation

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

#### 3. Other Health Insurance

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

## GENERAL INFORMATION

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

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

### 112. PROVISION FOR APPEALS - FAIR HEARING

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

### 113. FRAUD

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

### 114. CIVIL RIGHTS

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

### 115. OBSERVANCE OF RELIGIOUS BELIEF

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

## GENERAL INFORMATION

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### 116. PROGRAM PARTICIPATION

- A. Participation in the Health Services Program of a provider of services is subject to suspension or revocation for good cause shown.

Any of the following shall, inter alia, constitute a good cause for suspension or revocation:

1. Presentment for allowance or payment any false or fraudulent claim for services or merchandise;
2. Submitting false information for the purpose of obtaining greater compensation than that to which he is legally entitled;
3. Submitting false information for the purpose of obtaining authorization requirements;
4. Failure to disclose or make available to the Division or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefore;
5. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of peers;
6. Engaging in a course of conduct or performing an act deemed improper or abusive of the Health Services Program following notification that said conduct should cease;
7. Breach of the terms of agreement of participation entered into with the Division or failure to comply with the terms of providers certification on claim form.
8. Over-utilizing Health Services Program by inducing, furnishing, or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the recipient.
9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;
10. Violating any provision of P.L. 1968, c. 413, (Health Services Act), or any rule or regulation promulgated by the Commissioner of Institutions and Agencies pursuant thereto;
11. Conviction of any crime involving moral turpitude;
12. Violation of applicable State regulations relating to professional conduct or Code of Ethics.

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CHAPTER II  
CHIROPRACTIC SERVICES

200. CHIROPRACTOR'S SERVICES

201. DEFINITIONS

201.1 Chiropractor

"Chiropractor" means a Doctor of Chiropractic licensed to practice Chiropractic within the limits of his license by the New Jersey State Board of Medical 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.

201.2 Chiropractic Services

"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.

201.3 Consultation

A "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 chiropractors is not a reimbursable service.

201.4 Concurrent Care

Concurrent care refers to 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.

201.5 Transfer

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

201.6 Rehabilitation Services

"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.

201.7 Qualified Physical Therapist

"A qualified physical therapist" is one who:

- A. has graduated from a physical therapy curriculum approved by:
  - 1. The American Physical Therapy Association; or
  - 2. The Council on Medical Education and Hospitals of the American Medical Association; or
  - 3. The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or
- B. Prior to January 1, 1966:
  - 1. has been admitted to membership by the American Physical Therapy Association; or
  - 2. has been admitted to registration by the American Registry of Physical Therapists; or
  - 3. has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or
- C. if he is currently licensed or registered to practice physical therapy pursuant to State law, he:
  - 1. was licensed or registered prior to January 1, 1970 and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the Public Health Service; or
  - 2. 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 he rendered services upon the order of and under the direction of attending and referring physicians; or

D. If trained outside the United States:

1. has 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; and
2. is a member of a member organization of the World Confederation for Physical Therapy; and
3. has completed one year's experience under the supervision of an active member of the American Physical Therapy Association; and
4. has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

201.8 Speech Therapist

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

201.9 Qualified Occupational Therapist

A "qualified occupational therapist" 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.

202. SCOPE OF SERVICES AVAILABLE TO RECIPIENTS

Payment will be made for the necessary services ordered by a chiropractor subject to the following limitations:

202.1 Clinical Laboratory Services

"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:

- A. 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.
- B. 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.

Where 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.

- C. If multi-channel, 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 multi-channelled 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 multi-channel automated laboratory equipment.

#### 202.2 Services to Persons in Skilled Nursing Facilities and Intermediate Care Facilities

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.

#### 202.3 Radiology Services

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

#### 202.4 Physical Medicine and Rehabilitation

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 in 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.

A. Requirements

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.

B. Distinction Between Physical Therapy Services and Restorative Nursing Care

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.

C. Where Care May be Provided

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

## 202.5 ORTHOPEDIC SHOES

### A. When are Orthopedic Shoes Reimbursable?

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.

### B. Definition of Shoes

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

NOTE: See Section 205 "Prescription Policies" for additional information.

## 203. GENERAL POLICY

### 203.1 Record Keeping

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.

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

- A. Date of service
- B. Chief complaint(s)
- C. Pertinent historical and physical data
- D. Reports of diagnostic procedures ordered
- E. Diagnosis(es)
- F. Treatment plan

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

204. BASIS OF PAYMENT

Reimbursement for covered services furnished under the Health Services Program shall be on the basis of the customary charge prevailing in the community for the same service, not to exceed an allowance determined reasonable by the Commissioner (Institutions & Agencies) and further limited by federal policy relative to payment of practitioners and other individual providers.

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.

NOTE 1: Reimbursement for chiropractic services will be made only for periods when eligibility is current.

NOTE 2: Reimbursement is not made for, and recipients may not be asked to pay for, broken appointments.

205. PRESCRIPTION POLICIES

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.

Chiropractors are urged to familiarize themselves with all aspects of this section in order to effect economies consistent with good medical practices and to facilitate prompt payment to the provider.

All New Jersey licensed chiropractors are eligible to prescribe within the limits of their New Jersey Chiropractic licensure.

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.

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.

A. Supplies, Equipment and Shoes

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 (i.e., the American Cancer Society, service organizations, etc.). 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.

B. Prosthetics and Orthotics

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.

C. Physical Medicine and Rehabilitation

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

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

- a. 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.

- b. 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.

CHAPTER III  
 CHIROPRACTOR BILLING PROCEDURES

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CHAPTER III  
CHIROPRACTOR BILLING PROCEDURES

300. BILLING PROCEDURES

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

301. GENERAL POLICY

Billing should be done on a monthly basis. Claims for payments of services must be received not later than 90 days following the last date of service as indicated on the claim. For purposes of this time limitation, a claim is a submission in writing, which indicates a request for reimbursement in connection with medical services of a specified nature furnished to an eligible recipient. If a claim, as defined above, is received within the time limit specified, the claim is considered to be filed timely, even though additional information is supplied after the time limitations.

302. PATIENT IDENTIFICATION

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 (See Section 101.).

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 guarantee that an individual is covered. Authorization becomes invalid upon termination of eligibility.

303. PRIOR AUTHORIZATION

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

304. COMBINATION MEDICARE/MEDICAID CLAIMS

Services covered under Medicare rendered by non-institutional providers to a Medicare/Medicaid eligible person shall be billed on Form SSA-1490, REQUEST FOR MEDICARE PAYMENT, and the claims sent directly to the Medicare intermediary, Prudential, Medicare B Division, P.O. Box 6500, Millville, New Jersey 08332. The provider must record the Health Insurance Claim Number in Item 2 and the New Jersey Health Services Case and Person Number in Item 5 on SSA-1490. (See Exhibit I)

305. DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS (LMAU)

The following is a list of Local Medical Assistance Units, their county of location, their county(ies) of jurisdiction, their addresses and

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 LMAU serving the provider's area. The LMAU will assist the provider by answering the questions and/or directing the provider to the appropriate Eligibility Determination Agency.

306. PHYSICIANS AND PRACTITIONERS CLAIMS (MC-8)

This form is used for the purpose of billing for covered services of physicians, podiatrists, optometrists, psychologists and chiropractors. Billing should be done on a monthly basis and submitted for payment as soon after the end of the month as is possible.

306.1 Instructions for Completion of Form MC-8 (See Exhibit II)

- 1-4. NAME, ADDRESS, CASE NO. AND PERSON NO. - Copy Patient's Name, H.S.P. Case Number and Patient Person Number EXACTLY as it appears on the Validation Form (See Section 101.).
- 5-6. Self-explanatory.
7. OTHER INSURANCE OR LIABILITY COVERAGE - If patient has other Health Insurance or Liability Coverage, check appropriate block, and attach copy of explanation of payment from the carrier.
8. EMPLOYMENT RELATED - If patient's illness or injury is work related enter name and address of employer.
9. NAME AND ADDRESS OF PROVIDER - (This information may be preprinted).
10. Self-explanatory.
11. Write in Name of institution, if place of service is other than doctor's office or patient's home. To be completed in addition to Question 12B.
12. REPORT OF SERVICES -
  - A. Enter date(s) of each visit.
  - B. Place of service.
  - C. Enter diagnosis.
  - D. Enter a description of the service.
  - E. Not Applicable
  - F. Enter your usual and customary charge for each service or procedure.
13. CONSULTATION - Provide full name of referring physician for consultations.

14. **PATIENT'S CERTIFICATION** - Under ordinary circumstances, the patient must sign the claim form when services have been received. The claim form to be signed should indicate service rendered, and the patient must not sign a blank claim form prior to receiving services or as a condition for receiving services.

However, when the patient's signature is unobtainable, the following procedures may be used.

A. Illiterate Patient

The patient may sign by mark (X), and the signature must be witnessed by another person including the provider of service who signs his name and address on the same line.

B. Other

If a patient is physically or mentally incapable of signing, a minor child, deceased, or for other reasons the patient's signature is not obtainable, through reasonable effort, the form may be signed on his behalf by:

1. A parent, or
2. A legal guardian, or
3. A relative, or
4. A friend, or
5. An individual provider, or
6. A representative of an institution providing care or support, or
7. A representative of a governmental agency providing assistance.

Attached to the claim form or written directly on the form should be a brief explanation of reason patient was not personally able to sign and relationship of signee to the patient-recipient.

15. **PROVIDER'S CERTIFICATION** - The provider **MUST** sign and date the form before the claim may be considered.

306.2 Mailing Instructions

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

The Prudential Insurance Company of America  
P.O. Box 1900  
Millville, New Jersey 08332

# REQUEST FOR MEDICARE PAYMENT EXHIBIT I

**MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)**

Form Approved  
Budget Bureau No.  
72-0730

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

## PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

<p><b>When completed, send this form to:</b></p>	<p>Copy from <b>YOUR OWN HEALTH INSURANCE CARD</b> → (See example on back)</p>	<p><b>1</b> Name of patient (First name, Middle initial, Last name)</p>
<p><b>2</b> Health insurance claim number</p>		<p>Letter <input type="checkbox"/> Male <input type="checkbox"/> Female</p>
<p><b>3</b> Patient's mailing address</p>	<p>City, State, ZIP code</p>	<p>Telephone Number</p>
<p><b>4</b> Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)</p>		<p>Was your illness or injury connected with your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>5</b> If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.</p>		
<p>Insuring organization or State agency name and address</p>		<p>Policy or Medical Assistance Number</p>
<p><b>6</b> I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.</p>		
<p>Signature of patient (See instructions on reverse where patient is unable to sign)</p>		<p>Date signed</p>
<p><b>SIGN HERE</b> →</p>		

## PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7	A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
					\$	
<p><b>8</b> Name and address of physician or supplier (Number and street, city, State, ZIP code)</p>				<p>Telephone No.</p>	<p><b>9</b> Total charges \$</p>	
<p>Physician or supplier code</p>				<p><b>10</b> Amount paid \$</p>		
				<p><b>11</b> Any unpaid balance due \$</p>		
<p><b>12</b> Assignment of patient's bill (See reverse)  <input type="checkbox"/> I accept assignment and will accept the charge determination of the Medicare carrier as the FULL charge.  <input type="checkbox"/> I do not accept assignment.</p>				<p><b>13</b> Show name and address of facility where services were performed (If other than home or office visits)</p>		
<p><b>14</b> Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)</p>				<p><input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DDS Other degree _____</p>	<p>Date signed</p>	

\*O—Doctor's Office  
IL—Independent Laboratory

H—Patient's Home (If portable X-ray services, identify the supplier)  
IH—Inpatient Hospital

ECF—Extended Care Facility  
OH—Outpatient Hospital

OL—Other Locations  
NH—Nursing Home



Department of Institutions and Agencies  
 Division of Medical Assistance and Health Services  
**PHYSICIANS AND PRACTITIONERS CLAIM**

**EXHIBIT II**

03

1. Patient's Last Name		First Name		2. Patient's Street Address			Telephone Number																												
3. Health Services Program Case No.				4. Patient Person #	5. Age	6. Sex		City	State	ZIP Code																									
<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>														<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>			<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>			<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>				<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>			<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>			<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>			<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>		
7. Other Health Insurance or Liability Coverage? If Yes, attach copy of Explanation of Payment from carrier. (If Medicare - See Section 304 of Manual)							Yes No		<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>		8. Was Patient's Illness or Injury connected with his employment? If Yes, give Name and Address of Employer here.		Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>																						
9. PROVIDER OF SERVICE INFORMATION										10. Did injury result from automobile accident? Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		11. Give Name of Institution if Place of Service is other than Doctor's Office or Patient's Home.																							
Social Security or Employer I.D. Number (Enter only when not printed below)										<table border="1" style="width: 100%; text-align: center;"> <tr> <th colspan="2">TOTAL AMOUNT A</th> <th colspan="2">TOTAL AMOUNT B</th> <th>CODE</th> <th>JAM</th> <th>HOSPITAL PROVIDER NUMBER</th> </tr> <tr> <td colspan="2" style="height: 20px;"> </td> <td colspan="2" style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>		TOTAL AMOUNT A		TOTAL AMOUNT B		CODE	JAM	HOSPITAL PROVIDER NUMBER								<table border="1" style="width: 100%; text-align: center;"> <tr> <td colspan="2" style="height: 20px;"> </td> <td colspan="2" style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>									
TOTAL AMOUNT A		TOTAL AMOUNT B		CODE	JAM	HOSPITAL PROVIDER NUMBER																													
Name and Address						FOR CONTRACTOR'S USE ONLY																													
Telephone Number						TOTAL AMOUNT A		TOTAL AMOUNT B		CODE	JAM	HOSPITAL PROVIDER NUMBER																							

12. REPORT OF SERVICES								
1- Doctor's Office	2-Patient's Home	3- Inpatient Hospital	4- Outpatient Hospital	5-Skilled Nursing Home	6-Independent Laboratory	7-Clinic (Other than Hospital based)	8-Other Locations (Specify in 12C)	9-Emergency Room
A. DATE OF EACH VISIT	B. PLACE OF SERV.	C. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES	D. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE OF SERVICE				E. CHECK (✓) IF FAMILY PLANNING	F. CHARGE
								\$

13. IF CONSULTATION - Give Name of Referring Physician \_\_\_\_\_ TOTAL CHARGES \$ \_\_\_\_\_

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

15. PROVIDER CERTIFICATION. I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payments in full without additional charge to the patient or others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. I understand that fraud or concealment will be punishable under applicable Federal or State law, or both.  
 Provider Signature \_\_\_\_\_  MD  DO  Other Degree \_\_\_\_\_ Date Signed \_\_\_\_\_

FOR PAYMENT MAIL TO: The Prudential Insurance Co. of America - P.O. Box 1900 - Millville, N.J. 08332

FOR CONTRACTOR'S USE ONLY																	
CARD	DATES OF SERVICE					PLACE	TYPE	R-0 R-1	# OF VISITS	PROC	VALUE	AMOUNT A	AMOUNT B	CODE	JAM	DATE RECEIVED	
	YR	MO	DAY	MO	DAY											YR	JULIAN DATE
	PROCEDURE CODE (1)			PROCEDURE CODE (2)			PROCEDURE CODE (3)			PRIMARY DX.	SECOND DX.						