

**CHAPTER 57**  
**PODIATRY SERVICES**

**Authority**

N.J.S.A. 30:4D-6b, 30:4D-7, 7a, b, and c; 30:4D-12.

**Source and Effective Date**

R.1996 d.60, effective February 5, 1996.  
See: 27 N.J.R. 4223(a), 28 N.J.R. 1015(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 57, Podiatry Services, expires on February 5, 2001.

**Chapter Historical Note**

Chapter 57, Podiatry Services Manual, became effective June 1, 1971 as R.1971 d.66. See: 3 N.J.R. 43(c), 3 N.J.R. 109(b). The provisions of Subchapter 2, Podiatry Billing Procedures, were adopted by R.1974 d.222, effective September 15, 1974. See: 6 N.J.R. 264(c), 6 N.J.R. 35(c). Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted by R.1986 d.52, effective March 3, 1986. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a). Pursuant to Executive Order No. 66(1978), Chapter 57 was readopted as R.1991 d.129, effective February 13, 1991. See: 22 N.J.R. 3439(b), 23 N.J.R. 858(b).

Chapter 57, Podiatry Services Manual, was repealed, and Chapter 57, Podiatry Services, was adopted as new rules, by R.1996 d.60, effective February 5, 1996. See: Source and Effective Date.

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**SUBCHAPTER 1. GENERAL PROVISIONS**

**10:57-1.1 Introduction**

(a) This chapter is concerned with the provision of podiatric services by a person licensed to practice podiatry in accordance with the New Jersey Medicaid program policies and procedures and the standards of practice as defined by the laws of the State of New Jersey (N.J.S.A 45:5) and the American Podiatric Medical Association.

(b) An approved New Jersey Medicaid provider of podiatric services may be reimbursed for medically necessary covered services provided within the scope of her or his license, and her or his approved New Jersey Medicaid Program Provider Agreement.

(c) A podiatrist may enroll in the New Jersey Medicaid program and provide covered, medically necessary services as an independent practitioner, or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, or a mixed practitioner practice or under the managed care program.

**10:57-1.2 Scope of services**

Podiatry care under the Medicaid program is allowable to covered persons if such services are essential. Essential podiatry care includes those services which require the professional knowledge and skill of a licensed podiatrist. For recipients in the Medically Needy Program, podiatry care is only available to pregnant women, and the aged, the blind or disabled. (For information on how to identify a covered person, please refer to N.J.A.C. 10:49-2.)

**10:57-1.3 Definitions**

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

“Flat-foot conditions” means the local condition of flattened arches regardless of the underlying etiology. Treatment of flat-foot conditions encompasses all phases of services in connection with flat feet.

“Podiatrist” means a doctor of podiatric medicine licensed to practice podiatry by the New Jersey State Board of Medical Examiners, or similarly licensed by a comparable agency in the state in which he or she practices.

“Podiatry services” means those services performed by a licensed podiatrist within the scope of practice as defined by the laws of the State of New Jersey (N.J.S.A 45:5-7) and

which are within the scope of the services covered by the New Jersey Medicaid program.

“Routine foot care” means the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone for both ambulatory and bedfast patients, and any services performed in the absence of localized illnesses, injury or symptoms involving the foot.

“Specialist” for purposes of the New Jersey Medicaid program, means a fully licensed podiatrist who:

1. Is a diplomate of the appropriate specialty board as recognized by the American Podiatric Medical Association; or
2. Has been notified of board eligibility by the appropriate specialty board as recognized by the American Podiatric Medical Association.

“Subluxation” means the structural misalignment of the joints of the feet which do not require surgical methods of treatment and/or correction, with the exception of fractures and complete dislocations.

#### 10:57-1.4 Provisions for provider participation

(a) In order to participate in the Medicaid program a podiatrist shall apply to and be approved by the New Jersey Medicaid program. Application for approval by the New Jersey Medicaid program requires completion and submission of the “Medicaid Provider Application” (FD-20) and the “Medicaid Provider Agreement” (FD-62).

1. The documents referenced above are located as Forms #8 and #9 in the Appendix at the end of the Administration Chapter (N.J.A.C. 10:49), and may be obtained from and submitted to:

Unisys Corporation  
 Provider Enrollment  
 P.O. Box 4804  
 Trenton, New Jersey 08650-4804

(b) In order to be approved as a Medicaid participating provider, the podiatrist shall be licensed by the State of New Jersey Board of Medical Examiners (See N.J.A.C. 13:35-3).

1. An out-of-State podiatrist must have comparable documentation under the applicable State requirements of the state in which the services are provided.

(c) In order to be approved as a specialist under the Medicaid program, a licensed podiatrist shall possess either of the following:

1. A specialty certification/permit issued by the specialty board as recognized by the American Podiatric Medical Association; or

2. A copy of the notification of board eligibility by the specialty board as recognized by the American Podiatric Medical Association.

(d) A photocopy of the current license, certification/permit or notification of board eligibility by the specialty shall be provided at the time of the application for enrollment.

#### 10:57-1.5 Prior authorization

(a) Authorization by the Podiatry Services Unit (“Unit”), Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625, shall be obtained prior to the provision of the following services:

1. All orthopedic footwear;
2. Custom molded foot or ankle orthoses;
3. Routine debridement of toenails, more than once every two months.

(b) A written request for authorization (Form FD-356) shall be submitted, identifying the case and containing sufficient information about the problem and plan of treatment to enable the Unit to make a proper evaluation.

#### 10:57-1.6 Basis of reimbursement

(a) Reimbursement for podiatry services covered under the New Jersey Medicaid program shall be on the basis of the customary charge, not to exceed a fixed fee schedule determined reasonable by the Commissioner of the Department of Human Services as specified at N.J.A.C. 10:57-3, and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

(b) For services rendered on or after February 10, 1995 to recipients eligible for both Medicare Part B and Medicaid, reimbursement will be made for the Medicare Part B coinsurance and deductible amounts or the Medicaid maximum allowable (less any third party payments including Medicare reimbursement), whichever is greater.

(c) Any podiatric physician who meets the above cited qualifications listed in N.J.A.C. 10:57-1.3 as a specialist and the requirements specified in N.J.A.C. 10:57-1.4 shall be eligible for specialist reimbursement.

#### 10:57-1.7 Personal contribution to care requirements for NJ KidCare-Plan C

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is \$5.00 a visit for podiatric services.

1. A podiatric visit is defined as a face-to-face contact with a medical professional, including services provided under the supervision of the podiatrist, which meets the documentation requirements of this chapter and allows the podiatrist to request reimbursement for services.

2. Podiatric visits include podiatric services provided in the office, patient's home, or any other site, except any site of the hospital, where the child may have been examined by the podiatrist or the podiatric staff.

3. The podiatrist shall collect one personal contribution to care per podiatric visit, regardless of the number of podiatric services provided in the session.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).  
See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:57-1.7, Record keeping, recodified to N.J.A.C. 10:57-1.8.

**10:57-1.8 Record keeping**

(a) Podiatrists shall keep such individual records as are necessary to fully disclose the kind and extent of the services provided and shall make such information available as the Division or its agents may request. For the initial examination, the following documentation shall be on the record, regardless of the setting where the examination was performed:

1. Date of service;
2. Chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures ordered or performed;
5. Diagnosis;
6. Prescription (including medication) and treatment.

(b) Progress notes may be brief but shall include date(s) of service, changes in patient condition, specific medications and/or other treatments.

Recodified from N.J.A.C. 10:57-1.7 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).  
See: 30 N.J.R. 1060(a).

**SUBCHAPTER 2. PROVISION OF SERVICES**

**10:57-2.1 Covered and non-covered services**

(a) The following foot care services shall not be covered:

1. Flat-foot conditions:
  - i. Exceptions:
    - (1) Treatment which is an integral part of post-fracture or postoperative treatment plan;

(2) Supportive devices (for example, arch supports, specific additions to shoes and the like) which are prescribed to palliate pain and other symptoms associated with the condition.

- ii. Treatment where the talo-crural joint is involved;
- iii. Treatment where there may be attachment of a supportive device to a brace or bar.

2. Subluxations of the feet in which the normal relationship of the bones, tendons, ligaments and supporting muscles is disturbed and which, regardless of underlying etiology, require treatment by mechanical methods (for example, whirlpool, paraffin baths, casting, strapping, splinting, padding, shortwave or low voltage currents, physical therapy, exercise manipulation, massage, and the like):

- i. Exceptions:
  - (1) Where treatment is an integral part of post-fracture or postoperative treatment plan;
  - (2) Where the talo-crural joint is involved;
  - (3) Where there may be attachment of a supportive device to a brace or bar.

3. Routine foot care, routine hygienic care:

- i. Exceptions:
  - (1) Treatment of painful corns, calluses and warts;
    - (A) When treatments are in excess of one per month, the case shall be referred for evaluation to the podiatry unit of the Division of Medical Assistance and Health Services, CN-712, Mail Code #15 Trenton, New Jersey 08625.
    - (2) Treatment of the foot for Medicaid recipients with metabolic, neurological, and peripheral diseases (for examples, diabetes, mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis, peripheral neuropathies); and
    - (3) Treatment of fungal (mycotic) and other infections of the feet and toenails.

(b) The following guidelines limit the provision of (a)3 above.

1. The importance of preventive or hygienic care for patients with a systemic illness, such as peripheral vascular disease, diabetes, or with severe physical disability is recognized. These will be considered on an individual basis by the podiatry consultant.

2. If services ordinarily considered routine are performed at the same time as and as a necessary integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections, they are covered.

3. Fungal (mycotic) and other infections of the feet and toenails require professional services which are outside the scope of "routine foot services." Diagnostic and treatment services for foot infections are covered in the same manner as services performed for infections occurring elsewhere on the body, and the same type of coverage rules apply.

4. Treatment of plantar warts that are symptomatic and/or cause disability will be considered a covered service.

#### 10:57--2.2 General provisions

(a) For purposes of reimbursement, a podiatrist and/or physician; podiatrist and/or physicians' group; shared health care facility; or providers sharing a common record are considered a single provider.

(b) When reference is made in the CPT manual to Office or other outpatient services—new patient; Hospital inpatient services—initial hospital care; Nursing facility services—comprehensive nursing facility assessments; and Domiciliary, Rest home, or Custodial care services—new patient; the intent of Medicaid is to consider this service as the initial visit. When the setting for this initial visit is an office or residential health care facility, for reimbursement purposes it is limited to a single visit. Future use of this category of codes will be denied when the recipient is seen by the same physician, group of physicians, or involves a shared health care facility which is a group of physicians sharing a common record. Reimbursement for an initial office visit also precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

1. Reimbursement for an initial office visit or initial residential health care facility visit will be disallowed, if a preventive medicine service, EPSDT examination or office consultation were billed within a 12-month period by a podiatrist, podiatric group, shared health care facility, or practitioner sharing a common record.

2. If the setting is a nursing facility or hospital, the initial visit concept will still apply for reimbursement purposes despite CPT reference to the term initial hospital care or comprehensive nursing facility assessments. Subsequent readmissions to the same facility may be reimbursed as initial visits, if the readmission occurs more than 30 days from a previous discharge from the same facility by the same provider. In instances when the readmission occurs within 30 or less days from a previous discharge, the provider shall bill the relevant HCPCS procedure codes specified in the qualifier under the headings Subsequent hospital care or Subsequent nursing facility care.

3. Initial hospital visit during a single admission will be disallowed to the same physician, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service. It is also to be understood that in order to receive reimbursement for an initial visit, one of the minimum documentation requirements must be met.

i. HCPCS 99201 and 99202 are exceptions to the above requirements outlined in the qualifier for the initial visit. For HCPCS 99201 and 99202, the provider shall follow the qualifier applied to routine visit or follow-up care visit, for reimbursement purposes.

ii. When reference is made, in the CPT, to Office or other outpatient services—established patient; Hospital inpatient services—subsequent hospital care; Nursing facility services—subsequent nursing facility care; and Domiciliary, Rest home or Custodial care services—established patient; the intent of Medicaid is to consider this service as the Routine Visit or Follow-Up Care visit. The setting could be office, hospital, nursing facility or residential health care facility. In order to document the record for reimbursement purposes, a progress note for the noted visits should include the minimum documentation specified in N.J.A.C. 10:57-1.7.

iii. House call procedure codes refer to a podiatrist visit limited to the provision of podiatric care to an individual who would be too ill to go to a podiatrist's office and/or is "home bound" due to his/her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a home visit.

#### 10:57--2.3 Provisions regarding surgery

(a) Specific requirements for surgery procedures may be found at N.J.A.C. 10:57-3.2(b).

1. Certain surgical procedures are carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the provider may bill a value for Separate Procedure.

2. Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional reimbursement on a fee-for-service basis.

3. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total reimbursement shall be the allowance of the primary procedure plus 50 percent of the allowance of the secondary procedure to a total maximum of 200 percent unless otherwise specified in this section.

4. Anesthesia services rendered to his or her patient by the operating podiatrist are considered part of the surgical procedure and will not receive any additional reimbursement.

5. Reimbursement will be made for an assistant surgeon when the service is medically necessary and when a duly qualified surgical resident or house physician is unavailable, and when the primary procedure performed has a procedure code specialist fee of at least \$142.00. The allowance permitted is a maximum of 15 percent of the listed specialist fee. The minimum payment is \$27.00.

#### 10:57-2.4 Radiology services

(a) Specific requirements for radiology procedures may be found at N.J.A.C. 10:57-3.2(c).

1. Reimbursement will be made for the combined technical and professional component of the reimbursement for the procedure code notwithstanding any state-

ment to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

#### 10:57-2.5 Consultation policies

(a) A consultation is recognized for reimbursement only when performed by a specialist, as the term is defined at N.J.A.C. 10:57-1.3, who is recognized as such by this Program and the request has been made by or through the patient's attending physician or other licensed practitioner and the need for such a request would be consistent with good medical practice. Two types of consultation are recognized for reimbursement—comprehensive consultation and limited consultation.

(b) If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness, then the provider shall not bill for an initial visit if he or she bills for the consultation.

(c) If there is no referring physician, podiatrist or licensed practitioner, then an initial visit code should be billed instead of a consultation code.

(d) If the patient is seen for the same illness on repeated visits by the same consultant, these visits are considered routine visits or follow-up care visits and not consultations.

(e) Consultation codes will be declined in an office or residential health care facility setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians, podiatrists and/or licensed practitioners sharing common records. A routine visit code is applicable under these circumstances.

(f) If a prior claim for comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the same physician/podiatrist, physician/podiatrist group, shared health care facility or physicians/podiatrists using a common record except in those instances where the consultation required the utilization of one hour or more of the podiatrist's personal time. Otherwise, limited consultation codes would be considered the applicable codes to utilize if their criteria are met.

#### 10:57-2.6 Podiatric orthotic services

(a) Payment will be allowed for orthotic services rendered by a podiatrist for his or her own patients with prior authorization (See N.J.A.C. 10:57-1.5).

(b) Services provided by a prosthetic and orthotic (P&O) facility must be billed directly to the program by the P&O facility, and not by the referring practitioner. (See N.J.A.C. 10:55, Prosthetic and Orthotic Services.)

#### 10:57-2.7 Clinical laboratory services

(a) "Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by HCFA in accordance with the Clinical Laboratory Improvement Act (CLIA) and ordered by a physician or other licensed practitioner, within the scope of his or her practice as defined by the laws of the State of New Jersey and/or of the state in which the practitioner practices.

(b) Clinical laboratory services are furnished by clinical laboratories and by physician office laboratories (POLs) that meet the Health Care Financing Administration (HCFA) regulations pertaining to clinical laboratory services defined in the Clinical Laboratory Improvement Amendments Act (CLIA) of 1988; 1902(a)(9) of the Social Security Act; 42

U.S.C. 1396a(a)(9); and as indicated at N.J.A.C. 10:61-1.2, the Medicaid program's Independent Clinical Laboratory Services chapter.

(c) All independent clinical laboratories and other entities performing clinical laboratory testing shall possess certification as required by CLIA 1988, and the New Jersey Department of Health rules found at N.J.A.C. 8:44 and 8:45.

(d) A podiatrist may claim reimbursement for clinical laboratory services performed for his or her own patients within his or her own office, subject to the following:

1. A podiatrist shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid recipients; and

2. The clinical laboratory tests shall be standard clinical laboratory procedures consistent with the podiatrist's CLIA certification, certificate of waiver or certificate of registration as an independent clinical laboratory.

(e) When the clinical laboratory test is performed on site, the venipuncture shall not be reimbursable as a separate procedure; its cost is included within the reimbursement for the lab procedure.

(f) When a podiatrist refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under the CLIA, as described at (a) and (b) above, to perform the required laboratory test(s);

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health, as described above at (b) and (c), or comparable agency in the state in which the laboratory is located;

3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid program in accordance with (b) above, and

4. Independent clinical laboratories shall bill the New Jersey Medicaid program for all reference laboratory work performed on their premises. The podiatrist will not be reimbursed for laboratory work performed by a reference laboratory.

#### 10:57-2.8 Hospital outpatient department services

(a) A hospital-based podiatrist who is salaried and whose services are reimbursed as part of the hospital's cost shall not bill fee-for-service to the New Jersey Medicaid program.

1. A podiatrist practicing in the hospital outpatient department, whose reimbursement is not part of the hospital's cost, may bill fee-for-service independent of the hospital charges for professional service according to Medicare principles of reimbursement, if the arrangement with the hospital permits it.

**10:57-2.9 Diagnostic radiology services**

Payment will be allowed for necessary radiological services by a podiatrist, subject to the limitations of his or her licensure. Routine X-rays for screening purposes shall not be reimbursed.

**10:57-2.10 Multiple visits; out of office**

(a) Podiatry services rendered in a residential or medical facility (that is, hospital, nursing home, or extended care facility) shall be based on referral by the attending physician.

(b) Multiple visits to patients in the same health facility or congregate living arrangement will be reimbursed on an out-of-office visit basis for the initial visit to each patient and on an office visit basis for each subsequent visit to each patient receiving services.

**10:57-2.11 Pharmaceutical; podiatrist administered drugs**

(a) The New Jersey Medicaid program shall reimburse podiatrists for certain approved drugs administered intradermally, subcutaneously, intramuscularly or intravenously in the office, home, or independent clinic setting according to the following reimbursement methodologies, and the requirements of N.J.A.C. 10:51.

1. Podiatrist-administered medications shall be reimbursed directly to the podiatrist under certain situations. (See HCPCS, N.J.A.C. 10:57-2 for a listing of HCPCS procedure codes.)

i. A "J" code may be billed in conjunction with an office, home, or independent clinic visit when the criteria for an office or home visit is met and the procedure code for the method of drug administration. The HCPCS 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration.

ii. The New Jersey Medicaid program has assigned HCPCS procedure codes and Medicaid maximum fee allowances to certain, selected drugs for which reimbursement to the podiatrist is based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug, or the podiatrist's acquisition cost, whichever is less.

iii. Unless otherwise indicated in N.J.A.C. 10:57-2, the Medicaid maximum fee allowance is determined based on the AWP per unit which equals one cubic centimeter (cc) or milliliter (ml) of drug volume for each unit. For drug vials with a volume equal to one cubic centimeter (cc) or milliliter (ml), the Medicaid maximum fee allowance shall be based on the cost per vial.

iv. A visit for the sole purpose of an injection is reimbursable as an injection and not as an office visit plus an injection. On the other hand, if the criteria of an office or home visit are met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

v. No reimbursement will be made for injection given as a preoperative medication or as a local anesthetic which is part of an operative or surgical procedure, since this injection would normally be included in the prescribed fee for such a procedure.

2. In situations where a drug required for administration has not been assigned a "J" code or level III HCPCS procedure code, the drug shall be prescribed and obtained from a pharmacy which directly bills the New Jersey Medicaid program. In this situation, the podiatrist shall bill only for the administration of the drug, using HCPCS 90799.

**10:57-2.12 Pharmaceutical services**

(a) All covered pharmaceutical services provided under the New Jersey Medicaid program shall be provided to Medicaid recipients within the scope of N.J.A.C. 10:49, Administration Chapter; N.J.A.C. 10:51, Pharmaceutical Services.

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### SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

**10:57-3.1 Introduction to the HCPCS procedure code system**

(a) The New Jersey Medicaid program uses the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology—4th Edition (CPT-4) (American Medical Association, P.O. Box 10950, Chicago, IL 60610. Attention: Order Department) architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT-4 numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT-4 procedure narratives for Level I codes are not included in this manual, but are hereby incorporated by reference.

(b) HCPCS has been developed as a three-level coding system, as follows:

1. Level I codes: Narratives for these codes are found in CPT-4, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT-4 for use primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners and clinical nurse specialists, independent clinics and independent laboratories. Level I procedure codes, and fees for each, for which podiatrists may bill, can be found at N.J.A.C. 10:57-3.2.

2. Level II codes: These codes are assigned by HCFA for physician and non-physician services which are not in CPT-4. Narratives for these codes, and the fees for each, can be found at N.J.A.C. 10:57-3.3.

3. Level III codes: Level III codes identify services unique to the New Jersey Medicaid program. These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Narratives for these codes, and the fees paid for each, can be found at N.J.A.C. 10:57-3.4.

(c) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," "FOLLOW-UP DAYS" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

1. Alphabetic and numeric symbols under "IND" and "MOD":

These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters shall not be ignored because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT-4, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

IND = lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used.

An explanation of the indicators and qualifiers used in this column is located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:

- A = "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.
- E = "E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100% of the Medicaid maximum fee allowance, even if the procedure is done on the same patient by the same surgeon at the same operative session. The procedure codes are excluded indicating that office visit codes are not reimbursed in addition to procedure codes for surgical procedures.
- L = "L" preceding any procedure code indicates that the complete narrative for the code is located in N.J.A.C. 10:57-3.3 or 3.4.
- N = "N" preceding any procedure code means that qualifiers are applicable to that code. (See N.J.A.C. 10:57-3.5)
- HCPCS CODE = HCPCS procedure code numbers.
- MOD = Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's modifier codes for podiatry services are:
  - 20 = Microsurgery: When the service is performed using the techniques of microsurgery, including the aid of an operating microscope, modifier '20' may be added to the surgical procedure.
  - 22 = Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
  - 26 = Professional Component: Certain procedures are a combination of a physician and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number. If a professional component type service is keyed without the '26' modifier and a manual pricing edit is received, resolve the edit by adding the '26' modifier.
  - 50 = Bilateral Procedure: Unless otherwise identified in the listing, bilateral procedures requiring separate incisions that are performed at the same operative session, should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.
  - 51 = Multiple Procedures: When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary, additional or lesser procedure(s) may be identified by adding the modifier '51' to the secondary procedure number(s).
  - 52 = Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the podiatrist's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
  - 62 = Two Surgeons: Under certain circumstances, the skill of two surgeons (usually with different skills) may be required in the management of a specific procedure. Under such circumstances the separate services may be identified by adding the modifier '62' to the procedure number used by each surgeon for reporting his or her services.
  - 66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or podiatrists, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician or podiatrist with the addition of the modifier '66' to the basic procedure number used for reporting services.

- 75 = Concurrent Care Services Rendered By More Than One Physician Or Podiatrist: When the patient's condition requires the additional services of more than one physician or podiatrist, each physician or podiatrist may identify his or her services by adding the modifier '75' to the procedure code for the basic service performed.
  - 76 = Repeat Procedure By Same Podiatrist: The podiatrist may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.
  - 77 = Repeat Procedure By Another Podiatrist: The podiatrist may need to indicate that a basic procedure performed by another podiatrist had to be repeated. This situation may be reported by adding modifier '77' to be repeated service.
  - 80 = Assistant Surgeon: Surgical assistant services are identified by adding this modifier '80' to the usual procedure number(s).
  - LT = Left Side: Used to identify procedures performed on the left side of the body.
  - RT = Right Side: Used to identify procedures performed on the right side of the body.
  - TC = When applicable, a charge may be made for the technical component alone. Under those circumstances the technical component is identified by adding the modifier 'TC' to the usual procedure code.
  - XE = Non-Medicare-Covered Service—to indicate a service provided to a Medicare/Medicaid recipient is not reimbursable by Medicare.
  - YJ = This certifies that the patient's condition meets HCFA guidelines for coverage of routine foot care.
  - YN = This certifies that the patient's condition meets HCFA guidelines for coverage of debridement of mycotic nails.
  - YO = This certifies that the patient's condition meets the Medicaid guidelines for coverage of corns, warts, and calluses.
- DESCRIPTION = Code narrative:  
 Narratives for Level I codes are found in CPT-4.  
 Narratives for Level II and III codes are found at N.J.A.C. 10:57-3.3 and 3.4, respectively.
- FOLLOW-UP DAYS = Number of days for follow-up care which are considered as included as part of the procedure code for which no additional reimbursement is available.
- MAXIMUM FEE = New Jersey Medicaid program's maximum reimbursement allowance.
- ALLOWANCE = If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to evaluate and price the service. Attach a copy of any additional information to the claim form.

(d) Listed in this subsection are general policies of the New Jersey Medicaid program that pertain to HCPCS. Specific information concerning the responsibilities of a podiatrist when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:57-1.7, Recordkeeping and 10:57-1.6, Basis of Reimbursement.

1. General requirements are as follows:
  - i. When filing a claim, the appropriate HCPCS procedure codes must be used, in conjunction with modifiers when applicable.
  - ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in this subchapter (N.J.A.C. 10:57-3.2, 3.3, 3.4).
  - iii. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

iv. The "Maximum Fee Allowance" as noted with these procedure codes represents the maximum payment for the given procedure for the podiatrist. When submitting a claim, the podiatrist must always use her or his usual and customary fee.

(1) Listed values for all surgical procedures include the surgery and the follow-up care included in the maximum fee allowance for the period (indicated in days) in the column titled "Follow-Up Days."

v. The HCPCS procedure codes that are billable in conjunction with office visit codes are listed at N.J.A.C. 10:57-3.5, Qualifiers. (See the "N" designation in the "Indicator" column.)

vi. The use of a procedure code will be interpreted by the New Jersey Medicaid program as evidence that the practitioner personally furnished, as a minimum, the services for which it stands.

**10:57-3.2 HCPCS Procedure Codes and Maximum Fee Allowance**

(a) MEDICINE

IND	HCPCS Code	Mod	Maximum Fee Allowance	
			\$	NS
	90703		3.40	3.40
	90703	52	2.50	2.50
	90718		3.35	3.35
N	90780		45.00	40.00
N	90781		45.00	40.00
N	90799		2.50	2.50
	99025		22.00	17.00
N	99082		4.00	4.00
	99199		B.R.	B.R.
N	99201		16.00	14.00
N	99202		16.00	14.00
N	99203		22.00	7.00
N	99204		22.00	17.00
N	99205		22.00	17.00
E N	99211		16.00	14.00
E N	99212		16.00	14.00
E N	99213		16.00	14.00
E N	99214		16.00	14.00
E N	99215		16.00	14.00
N	99221		22.00	17.00
N	99222		22.00	17.00
N	99223		22.00	17.00
N	99231		16.00	14.00
N	99232		16.00	14.00
N	99233		16.00	14.00
	99238		16.00	14.00
N	99241		44.00	N.A.
N	99242		44.00	N.A.
N	99243		44.00	N.A.
N	99244		62.00	N.A.
N	99245		62.00	N.A.
N	99251		44.00	N.A.
N	99252		44.00	N.A.
N	99253		44.00	N.A.
N	99254		62.00	N.A.
N	99255		62.00	N.A.
	99261		16.00	14.00
	99262		16.00	14.00
	99263		16.00	14.00

IND	HCPCS Code	Mod	Maximum Fee Allowance			IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units
			\$	\$	NS					\$	\$	NS	
N	99271		44.00		N.A.								
N	99272		44.00		N.A.			15	18.00		16.00		3
N	99273		44.00		N.A.			15	22.00		20.00		3
N	99274		62.00		N.A.			15	27.00		24.00		3
N	99275		62.00		N.A.			15	32.00		27.00		3
N	99281		9.00		7.00			15	32.00		27.00		3
N	99282		9.00		7.00			15	32.00		27.00		3
N	99283		9.00		7.00			15	91.00		78.00		5
N	99284		9.00		7.00			90	37.00		32.00		3
N	99285		9.00		7.00			90	47.00		42.00		3
N	99301		22.00		17.00			90	61.00		53.00		4
N	99302		22.00		17.00			90	90.00		79.00		4
N	99303		22.00		17.00			90	121.00		105.00		4
E N	99311		16.00		14.00			90	140.00		121.00		4
E N	99312		16.00		14.00			90	162.00		139.00		4
E N	99313		16.00		14.00			90	186.00		160.00		4
N	99321		22.00		17.00	E		0	13.00		11.00		3
N	99322		22.00		17.00	E		0	13.00		11.00		3
N	99323		22.00		17.00	E		0	6.00		6.00		3
E N	99331		16.00		14.00	E		0	6.00		6.00		3
E N	99332		16.00		14.00	E		0	13.00		11.00		3
E N	99333		16.00		14.00	E		0	13.00		11.00		3
N	99341		16.00		14.00	E		0	16.00		14.00		3
N	99342		16.00		14.00	E		0	6.00		6.00		3
N	99343		35.00		35.00	E		0	6.00		6.00		3
N	99351		16.00		14.00			0	10.00		10.00		3
N	99352		16.00		14.00			0	5.00		5.00		3
N	99353		35.00		35.00			0	3.00		3.00		3
	99499		B.R.		B.R.			0	16.00		14.00		3
								30	42.00		37.00		3
								30	59.00		50.00		3
								60	42.00		37.00		3
								90	69.00		59.00		3
								0	18.00		16.00		3
								0	24.00		21.00		3
								0	30.00		26.00		3
								7	57.00		48.00		5
								7	57.00		48.00		5
								30	30.00		26.00		3
								30	67.00		59.00		4
								30	82.50		70.00		4
								30	99.00		84.00		4
								30	110.00		94.00		4
								30	143.00		120.00		4
								30	67.00		59.00		4
								30	145.00		126.00		4
								30	242.00		210.00		4
								60	193.00		168.00		4
								60	242.00		210.00		4
								60	193.00		168.00		3
								45	121.00		105.00		3
								45	61.00		53.00		4
								45	151.00		131.00		4
								30	76.00		65.00		3
								45	68.00		54.00		3
								45	68.00		54.00		3
								45	121.00		105.00		4
								45	121.00		105.00		3
								30	81.00		68.00		3
								0	35.00		35.00		3
								0	35.00		35.00		3
								0	35.00		35.00		3
								0	16.00		14.00		5
								0	35.00		35.00		3
								0	16.00		14.00		0
								0	24.00		20.00		0
								0	32.00		27.00		0
								0	16.00		14.00		3
								0	21.00		18.00		3
								0	54.00		45.00		3
								0	16.00		14.00		3
								0	8.00		7.00		3

(b) SURGERY

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units
				\$	\$	NS	
	10060		0	13.00		11.00	3
	10061		30	48.00		42.00	4
	10120		0	18.00		16.00	3
	10121		30	34.00		29.00	4
	10140		0	18.00		16.00	3
	10141		30	48.00		42.00	3
	10160		0	13.00		11.00	3
	10180		14	100.00		85.00	3
	11000		0	13.00		11.00	4
	11001		0	6.00		5.00	3
	11040		0	13.00		11.00	3
	11041		0	13.00		11.00	3
	11042		0	16.00		14.00	3
	11043		0	16.00		14.00	3
	11044		0	48.00		42.00	3
	11050		0	13.00		11.00	3
	11050	YO	0	16.00		14.00	3
	11051		0	18.00		15.00	3
	11051	YO	0	18.00		15.00	3
	11052		0	23.00		20.00	3
	11052	YO	0	23.00		20.00	3
	11100		0	13.00		11.00	4
	11101		0	5.00		4.00	3
	11300		15	18.00		16.00	3
	11301		15	22.00		20.00	3
	11302		15	27.00		24.00	3
	11303		30	32.00		27.00	3
	11305		15	18.00		16.00	3
	11306		15	22.00		20.00	3
	11307		15	27.00		24.00	3
	11308		15	32.00		27.00	3
	11400		15	18.00		16.00	3
	11401		15	22.00		20.00	3
	11402		15	27.00		24.00	3
	11403		15	32.00		27.00	3
	11404		15	32.00		27.00	3
	11406		15	32.00		27.00	3

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units	IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units
				\$	\$	NS						\$	\$	NS	
	17002		0	4.00		3.00	3	27654		90	314.00		267.00	4	
	17010		0	42.00		36.00	0	27656		90	114.00		97.00	3	
	17100		0	18.00		15.00	0	27658		90	121.00		105.00	3	
	17101		0	6.00		5.00	3	27659		90	121.00		105.00	3	
	17102		0	4.00		3.00	3	27664		90	90.00		79.00	3	
	17104		0	76.00		59.00	3	27665		90	90.00		79.00	3	
	17105		0	100.00		85.00	0	27685		90	151.00		131.00	4	
	17110		0	16.00		14.00	0	27686		90	202.00		175.00	3	
	17200		0	16.00		14.00	0	27687		30	171.00		146.00	3	
	17201		0	8.00		7.00	3	27695		90	302.00		263.00	3	
	17270		15	29.20		24.81	3	27696		90	342.00		291.00	3	
	17271		15	43.74		37.20	3	27698		90	227.00		197.00	3	
	17272		15	52.20		44.36	3	27700		90	249.00		216.00	3	
	17273		15	61.48		52.26	3	27705		90	272.00		236.00	3	
	17274		15	76.81		65.30	3	27707		90	113.00		100.00	3	
	17276		15	94.27		80.15	3	27709		90	350.00		298.00	3	
	17304		0	100.00		85.00	3	27712		90	288.00		251.00	3	
	17305		0	25.00		21.00	3	27752		90	121.00		105.00	3	
	17306		0	25.00		21.00	3	27754		90	145.00		126.00	3	
	17307		0	25.00		21.00	3	27756		90	211.00		184.00	3	
	17310		0	15.00		13.00	0	27760		90	79.00		68.00	3	
	17340		0	18.00		15.00	3	27762		90	79.00		68.00	3	
	20000		0	18.00		16.00	3	27764		90	105.00		91.00	3	
	20005		0	45.00		40.00	4	27766		90	151.00		131.00	3	
	20206		0	29.00		25.00	3	27780		7	45.00		39.00	3	
E	20500		0	16.00		14.00	3	27781		30	45.00		39.00	3	
E	20501		0	16.00		14.00	3	27782		90	61.00		53.00	3	
	20520		7	51.00		45.00	3	27784		90	121.00		105.00	3	
	20525		7	102.00		90.00	4	27786		90	72.00		63.00	3	
E	20550		0	13.00		11.00	0	27788		90	79.00		68.00	3	
E	20600		0	13.00		11.00	3	27790		90	105.00		91.00	3	
E	20605		0	13.00		11.00	3	27792		90	151.00		131.00	3	
	20615		0	80.00		68.00	3	27810		90	121.00		105.00	3	
	20650		0	55.00		47.00	4	27812		90	145.00		126.00	3	
	20660		0	18.00		13.00	3	27814		90	211.00		184.00	3	
	20670		0	24.00		21.00	3	27816		30	100.00		85.00	3	
	20680		21	121.00		105.00	4	27818		90	121.00		105.00	3	
	20680	52	21	61.00		53.00	4	27820		90	141.00		123.00	3	
	24410		90	211.00		184.00	3	27822		90	242.00		210.00	3	
	26504		30	86.00		74.00	3	27823		90	242.00		210.00	3	
	27497		90	211.00		179.00	5	27824		30	100.00		85.00	3	
	27499		90	300.00		280.00	5	27825		90	121.00		105.00	3	
	27530		30	74.00		65.00	3	27826		90	242.00		210.00	3	
	27532		90	121.00		105.00	3	27827		90	242.00		210.00	3	
	27534		90	145.00		126.00	3	27828		90	242.00		210.00	3	
	27535		90	242.00		210.00	3	27829		90	305.00		263.00	3	
	27603		30	114.00		97.00	3	27830		30	60.00		51.00	3	
	27604		0	16.00		14.00	3	27831		30	80.00		68.00	3	
	27605		15	29.00		25.00	0	27832		90	164.00		142.00	3	
	27606		30	63.00		54.00	3	27840		45	61.00		53.00	0	
	27607		30	228.00		194.00	3	27842		45	61.00		53.00	3	
	27610		60	182.00		158.00	3	27844		45	152.00		131.00	3	
	27612		30	182.00		158.00	3	27846		90	305.00		263.00	3	
	27613		0	16.00		14.00	3	27848		60	275.00		233.00	3	
	27614		0	29.00		25.00	3	27860		0	61.00		53.00	3	
	27615		60	228.00		194.00	3	27870		90	302.00		263.00	3	
	27618		0	29.00		25.00	3	27871		90	302.00		263.00	3	
	27619		30	57.00		49.00	3	27881		60	266.00		226.00	3	
	27620		60	182.00		158.00	3	27889		60	242.00		210.00	3	
	27625		90	211.00		184.00	3	28001		0	18.00		16.00	3	
	27626		60	228.00		194.00	3	28002		0	36.00		32.00	3	
	27630		30	90.00		79.00	3	28005		30	150.00		128.00	3	
	27637		60	285.00		243.00	4	28008		60	61.00		53.00	3	
	27640		60	211.00		184.00	4	28010		0	24.00		21.00	3	
	27641		60	211.00		184.00	4	28011		0	37.00		32.00	3	
	27645		90	342.00		291.00	4	28020		60	109.00		95.00	3	
	27646		90	342.00		291.00	4	28022		60	109.00		95.00	3	
	27647		90	371.00		316.00	4	28024		60	37.00		32.00	3	
	27648		0	61.00		53.00	3	28030		30	143.00		122.00	3	
	27650		90	227.00		197.00	4	28035		30	171.00		146.00	3	
	27652		90	314.00		267.00	4	28043		0	29.00		25.00	3	

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes Basic Units	IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes Basic Units
				S	\$ NS						S	\$ NS	
	28045		0	57.00	49.00	3	28296		60	200.00	170.00	3	
	28046		60	228.00	194.00	3	28297		60	200.00	170.00	3	
	28050		30	171.00	146.00	3	28298		30	171.00	146.00	3	
	28052		30	103.00	88.00	3	28299		60	200.00	170.00	3	
	28054		30	86.00	74.00	3	28300		60	228.00	194.00	3	
	28060		30	143.00	122.00	3	28302		60	217.00	185.00	3	
	28062		60	228.00	194.00	3	28304		30	171.00	146.00	3	
	28070		30	171.00	146.00	3	28305		60	217.00	185.00	3	
	28072		30	103.00	88.00	3	28306		90	113.00	100.00	3	
	28080		30	121.00	105.00	3	28307		60	217.00	185.00	3	
	28086		30	160.00	136.00	3	28308		90	113.00	100.00	3	
	28088		30	114.00	97.00	3	28309		60	257.00	219.00	3	
	28090		30	90.00	79.00	3	28310		30	69.00	59.00	3	
	28092		30	61.00	53.00	3	28312		30	46.00	40.00	3	
	28100		60	121.00	105.00	4	28313		90	90.00	79.00	3	
	28102		60	200.00	170.00	3	28315		60	55.00	47.00	3	
	28103		60	200.00	170.00	3	28320		60	200.00	170.00	3	
	28104		30	143.00	122.00	4	28322		30	143.00	122.00	3	
	28106		60	200.00	170.00	3	28340		90	90.00	79.00	3	
	28107		60	200.00	170.00	3	28341		90	90.00	79.00	3	
	28110		30	69.00	59.00	3	28344		45	42.00	37.00	3	
	28112		30	103.00	88.00	3	28345		90	90.00	79.00	3	
	28113		30	103.00	88.00	3	28400		30	68.00	59.00	3	
	28114		90	242.00	210.00	3	28405		90	90.00	79.00	3	
	28116		30	171.00	146.00	3	28406		60	228.00	194.00	3	
	28118		30	143.00	122.00	3	28410		90	113.00	99.00	3	
	28119		30	143.00	122.00	3	28415		90	151.00	131.00	3	
	28120		60	90.00	79.00	4	28420		90	300.00	255.00	3	
	28122		60	90.00	79.00	4	28430		30	82.00	72.00	3	
	28124		60	90.00	79.00	4	28435		90	90.00	79.00	3	
	28126		30	143.00	122.00	3	28440		90	113.00	99.00	3	
	28130		90	211.00	184.00	3	28445		60	275.00	234.00	3	
	28140		60	121.00	105.00	3	28450		30	41.00	36.00	3	
	28150		90	90.00	79.00	3	28455		90	61.00	53.00	3	
	28153		30	69.00	59.00	3	28456		30	121.00	103.00	3	
	28160		90	90.00	79.00	3	28460		90	90.00	79.00	3	
	28171		90	371.00	316.00	3	28465		90	121.00	105.00	3	
	28173		90	371.00	316.00	3	28470		30	18.00	16.00	3	
	28175		90	371.00	316.00	3	28475		90	42.00	37.00	3	
	28190		0	18.00	16.00	3	28476		30	82.00	70.00	3	
	28192		30	34.00	29.00	4	28480		90	63.00	56.00	3	
	28193		30	34.00	29.00	4	28485		90	90.00	79.00	3	
	28200		90	121.00	105.00	3	28490		30	18.00	16.00	3	
	28202		30	161.00	137.00	3	28495		30	30.00	26.00	3	
	28208		90	61.00	53.00	3	28496		30	60.00	51.00	3	
	28210		30	103.00	88.00	3	28500		45	90.00	79.00	3	
	28220		60	113.00	99.00	3	28505		30	120.00	102.00	3	
	28222		60	139.00	119.00	3	28510		30	18.00	16.00	3	
	28225		60	113.00	99.00	3	28515		30	30.00	26.00	3	
	28226		60	139.00	119.00	3	28520		45	79.00	63.00	3	
	28230		30	42.00	37.00	3	28525		30	90.00	77.00	3	
	28232		60	139.00	119.00	3	28531		30	59.00	50.00	3	
	28234		60	139.00	119.00	3	28540		45	61.00	53.00	0	
	28236		60	200.00	170.00	3	28545		45	61.00	53.00	3	
	28238		30	171.00	146.00	3	28546		30	69.00	59.00	3	
	28240		30	61.00	53.00	3	28550		45	107.00	92.00	3	
	28250		30	143.00	122.00	3	28555		90	211.00	184.00	3	
	28260		30	171.00	146.00	3	28570		45	61.00	53.00	0	
	28261		60	200.00	170.00	3	28575		45	61.00	53.00	3	
	28262		60	212.00	184.00	3	28580		45	107.00	92.00	3	
	28264		60	285.00	243.00	3	28585		90	211.00	184.00	3	
	28270		30	69.00	59.00	3	28600		45	61.00	53.00	0	
	28272		30	29.00	25.00	3	28605		45	61.00	53.00	3	
	28280		45	61.00	53.00	3	28606		30	69.00	59.00	3	
	28285		90	90.00	79.00	3	28610		45	104.00	91.00	3	
	28286		30	68.00	57.00	3	28615		30	143.00	122.00	3	
	28288		21	72.00	63.00	3	28630		45	61.00	53.00	0	
	28290		60	90.00	70.00	3	28635		7	65.00	55.00	3	
	28292		90	139.00	121.00	3	28640		45	104.00	91.00	3	
	28293		90	242.00	210.00	3	28645		90	121.00	105.00	3	
	28294		90	141.00	123.00	3	28660		0	16.00	14.00	0	

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes Basic Units
				\$	NS	
	28665		0	35.00	30.00	3
	28670		45	18.00	16.00	3
	28675		60	47.00	40.00	3
	28705		90	361.00	307.00	3
	28715		90	272.00	236.00	3
	28725		90	182.00	158.00	3
	28730		60	203.00	173.00	3
	28735		60	226.00	192.00	3
	28737		60	200.00	170.00	3
	28740		90	166.00	126.00	3
	28750		90	90.00	79.00	3
	28755		90	90.00	79.00	3
	28760		90	200.00	173.00	3
	28800		90	211.00	184.00	3
	28805		90	211.00	184.00	3
	28810		90	121.00	105.00	3
	28820		45	42.00	37.00	3
	28820	50	45	63.00	56.00	3
	28820	51	45	63.00	56.00	3
	28825		45	42.00	37.00	3
	28825	50	45	63.00	56.00	3
	28825	51	45	63.00	56.00	3
	28899		0	B.R.	B.R.	0
E	29405		0	42.00	37.00	3
E	29425		0	47.00	42.00	3
E	29440		0	12.00	10.00	3
E	29450		0	24.00	21.00	3
E	29450	50	0	37.00	32.00	3
E	29455		0	37.00	32.00	3
E	29515		0	42.00	37.00	3
E	29540		0	18.00	16.00	0
E	29550		0	16.00	14.00	0
E	29580		0	18.00	16.00	3
E	29590		0	12.00	10.00	0
E	29700		0	14.00	12.00	3
E	29730		0	9.00	8.00	3
E	29740		0	9.00	8.00	3
E	29750		0	9.00	8.00	3
E	29750	50	0	15.00	13.00	3
E	29751		0	15.00	13.00	3
E	29799		0	B.R.	B.R.	0
	29894		0	100.00	85.00	3
	29895		90	200.00	170.00	4
E N	36415		0	1.80	1.80	0
	52280		0	27.00	N.A.	0
E	64450		0	18.00	16.00	0
	64600		0	37.00	32.00	0
	64605		0	48.00	42.00	0
	64630		0	61.00	53.00	3
	64702		90	79.00	68.00	3
	64704		90	105.00	91.00	3
	64774		30	42.00	37.00	3
	64776		30	53.00	45.00	3
	64778		30	30.00	26.00	3
	64782		30	79.00	68.00	3
	64783		30	70.00	60.00	3
	64784		30	131.00	114.00	4
	64831		90	79.00	68.00	3
	64832		30	43.00	37.00	3
	64834		90	105.00	91.00	3
	64856		90	210.00	183.00	3

IND	HCPCS Code	Mod	Maximum Fee Allowance
	73610		7.60
	73615		28.80
	73615	26	10.80
	73615	TC	18.00
	73620		10.00
	73620	26	3.60
	73620	TC	6.40
	73630		13.00
	73630	26	5.40
	73630	TC	7.60
	73650		10.00
	73650	26	3.60
	73650	TC	6.40
	73660		5.00
	73660	26	3.60
	73660	TC	1.40

(d) PATHOLOGY & LABORATORY SERVICES

IND	HCPCS Code	Mod	Maximum Fee Allowance
	80150		15.00
	80152		15.00
	80154		21.50
	80156		20.00
	80158		20.00
	80160		15.00
	80162		15.00
	80164		10.00
	80166		15.00
	80168		24.50
	80170		12.60
	80172		1.80
	80174		15.00
	80176		18.00
	80178		9.00
	80182		12.00
	80184		12.80
	80185		19.00
	80186		19.00
	80188		20.00
	80190		15.00
	80192		15.00
	80194		15.00
	80196		7.00
	80198		15.00
	80202		12.00
	80299		10.80
	81000		1.20
	81003		1.50
	81005		1.00
	82043		4.30
	82044		1.00
	82131		24.00
	82820		14.92
A	82947		3.00
	83026		2.00
	83050		3.00
	83051		1.20
	83925		22.00
	83937		65.00
	84315		3.00
A	84520		3.00
	84540		3.00
A	84550		3.00
	84560		3.00
	85002		1.20
	85008		1.20
	85013		1.50
	85014		1.50
	85018		1.20
	85031		3.00

(c) RADIOLOGY

IND	HCPCS Code	Mod	Maximum Fee Allowance
	73600		10.00
	73600	26	3.60
	73600	TC	6.40
	73610		13.00
	73610	26	5.40

IND	HCPCS Code	Mod	Maximum Fee Allowance
	85170		0.60
	85175		3.90
	85210		3.00
	85220		25.00
	85230		25.00
	85240		25.00
	85244		29.00
	85245		10.00
	85246		10.00
	85247		10.00
	85250		27.00
	85260		26.00
	85270		26.00
	85280		26.00
	85290		8.00
	85291		7.00
	85292		28.00
	85293		28.00
	85300		15.00
	85301		16.00
	85302		17.00
	85303		18.00
	85306		18.00
	85335		10.00
	85337		10.00
	85345		1.80
	85347		3.00
	85525		17.00
	85576		10.00
	85597		20.00
	85610		3.00
	85611		4.50
	85612		13.00
	85613		10.00
	85670		6.60
	85675		6.42
	85705		7.90
	86003		20.00
	86005		5.00
	86039		15.00
	86156		3.00
	86157		9.00
	86160		9.00
	86161		9.00
	86302		19.00
	86306		20.00
	86430		1.80
	86431		4.50
	86485		4.00
	86585		4.00
	86588		13.20
	86602		10.00
	86606		10.00
	86609		10.00
	86612		10.00
	86628		10.00
	86631		10.00
	86632		15.00
	86635		10.00
	86638		12.50
	86641		12.50
	86671		15.00
	86692		20.00
	86694		12.80
	86695		12.80
	86774		5.40
	86787		12.60
	86790		B.R.
	86793		8.00
N	87040		9.00
N	87070		9.00
	87076		6.00

IND	HCPCS Code	Mod	Maximum Fee Allowance
	87081		9.00
	87084		3.00
	87101		8.00
	87102		8.00
	87103		8.00
	87106		8.00
	87181		5.80
N	87184		9.00
	87186		13.00
	87187		13.00
	87192		0.60
	87197		15.00
	87210		2.40
	87220		2.40

10:57-3.3 Descriptions of Level II Codes

IND	HCPCS Code	Mod	Description	Maximum Fees Allowance		
				S	\$	NS
	G0001		Routine venipuncture QUALIFIER: This service is reimbursable in the provider office laboratory (POL) when the specimen is referred out to an independent clinical laboratory for testing. Venipuncture is not reimbursable when billed by the independent clinical laboratory. It is considered all inclusive as part of the laboratory test.	1.80		1.80
	J0690		Injection, cefazolin sodium, up to 500 mg	1.92		1.92
	J0696		Injection, ceftriaxone sodium, per 250 mg	10.24		10.24
	J1100		Injection, dexamethasone	0.80		0.80
	J1200		Injection, diphenhydramine HCL, up to 50 mg	0.55		0.55
	M0101		Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care (excludes debridement of nail(s))	16.00		4.00
	M0101	YJ	Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care (excludes debridement of nail(s))	16.00		14.00
	M0101	YO	Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care (excludes debridement of nail(s))	16.00		14.00
	Q0112		All potassium hydroxide (KOH) preparations	2.40		2.40

10:57-3.4 Descriptions of Level III Codes

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance		
				S	\$	NS
	W2650		Casting for molded shoes. Prior authorization is required.	21.00		21.00
	W2655		Casting for arch support. Prior authorization is required.	5.00		5.00
	W8920		Visit to obtain blood specimens by venous or arterial puncture "first person in nursing home."	1.80		1.80
	W8925		Each additional person in nursing home.	0.60		0.60
	X4800		Arch support foot plate: (plaster cast taken by vendor) leather whitman ordinary	50.00		50.00

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance	
				\$	NS
	X4801		Arch support foot plate: (plaster cast taken by vendor) leather, mayer	45.00	45.00
	X4802		Arch support foot plate: (plaster cast taken by vendor) leather schaffer	45.00	45.00
	X4803		Arch support foot plate: (plaster cast taken by vendor) leather schaffer with metatarsal pad	75.00	75.00
	X4804		Arch support foot plate (plaster cast taken by vendor) leather whitman combination	75.00	75.00
	X4805		Arch support foot plate (plaster cast taken by vendor) leather-rohadur plastic	75.00	75.00
	X4894		Orthopedic shoe articulated	72.00	72.00

**10:57-3.5 Qualifiers for podiatry services**

(a) The following is a list of HCPCS procedure codes with their associated qualifiers. Providers shall use the following procedure codes in billing each of the procedures.

1. HCPCS 36415—Once per visit per patient. Not applicable if the laboratory study, in any part, is performed by the office staff or by the provider.

2. HCPCS 87040, 87070, 87081, 87141—Culture codes. May only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture, 87081.

3. HCPCS 90780—IV infusion therapy. Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, hand-written chart documentation including time and indication of physician's presence with the patient to the exclusion of his other duties.

4. HCPCS 90781—IV infusion therapy. Not be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, hand-written chart documentation including time and indication of podiatrist's presence with the patient to the exclusion of his or her other duties.

5. HCPCS 90799—Unlisted therapeutic or diagnostic injection. May be used for intradermal, subcutaneous, or intra-arterial injections. Reimbursement is on a flat fee basis and is all inclusive for the cost of the service and the materials. Intravenous and intra-arterial injections are reimbursable only when performed by the podiatrist.

6. HCPCS 99082—Unusual travel. May be used for travel costs only associated and billed with HOUSE CALL or HOME VISIT. (See HCPCS 99341, 99342, 99343, 99351, 99352, 99353.)

7. HCPCS 99201, 99202, 99203, 99204, 99205, 99221, 99222, 99223, 99301, 99302, 99303, 99321, 99322, 99323—Office or other outpatient services—new patient; Hospital inpatient services—initial hospital care; Nursing facility services—comprehensive nursing facility assessments; and Domiciliary, Rest home, or Custodial care services—new patient.

i. Excludes Preventive Health Care for patients through 20 years of age.

8. HCPCS 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99311, 99312, 99313, 99331, 99332, 99333—Office or other outpatient services—established patient; Hospital inpatient services—subsequent hospital care; Nursing facility services—subsequent nursing facility care; and Domiciliary, Rest home or Custodial care services—established patient.

i. Excludes Preventive Health Care for patients through 20 years of age.

9. HCPCS 99341, 99342, 99343, 99351, 99352 and 99353—Home services and House calls.

i. Do not distinguish between specialist and non-specialist.

ii. These codes do not apply to residential health care facility or nursing facility setting.

iii. HCPCS 99341, 99342, 99351 and 99352 apply when the provider visits the Medicaid recipients in their home setting and the visit does not meet the criteria specified under House Call listed above.

iv. The HCPCS codes 99244, 99245, 99254, 99255, 99274 and 99275 shall be utilized for Comprehensive Consultation.

(1) HCPCS 99244, 99245, 99254, 99255, 99274 and 99275, require a comprehensive evaluation by history and physical examination within the scope of a podiatric specialist's practice is required. An alternative to that would be the utilization of one or more hours of the consulting podiatrist's personal time in the performance of the consultation.

(2) HCPCS 99244, 99245, 99254, 99255, 99274 and 99275 require the following applicable statements, or language essentially similar to those statements, to be inserted in the "remarks" section of the claim form. The form is to be signed by the podiatrist who performed the consultation.

Examples:

"I personally performed a comprehensive evaluation by history and physical examination within the scope of my podiatric practice as a specialist." or  
 "This consultation utilized 60 or more minutes of my personal time."

10. The HCPCS codes 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272 and 99273 shall be utilized for Limited Consultation. The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as comprehensive consultation as noted above.

11. When a podiatrist sees a patient in the emergency room, the podiatrist shall use the Office visit procedure codes 99211, 99212, 99213, 99214 and 99215. These are the same procedure codes that would have been used if the podiatrist had seen the patient in his or her podiatry office. Records of that visit shall become part of the notes in the office chart.

**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, replace-

ment 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  
P.O. Box 4801  
Trenton, New Jersey 08619-4801

or contact:

Office of Administrative Law  
Quakerbridge Plaza, Building 9  
CN 049  
Trenton, New Jersey 08625-0049