



STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-204

November 1, 1977

TO: MEDICAL SUPPLY AND EQUIPMENT DEALERS

SUBJECT: REVISED MEDICAL SUPPLIES AND EQUIPMENT CLAIM FORM (MC-11-C3), EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-11 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-11 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-11-C3 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form, (items 10, 12, 13 and 16), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-11 CLAIM FORM

Item 10: Indicate whether injury resulted from an automobile accident by checking the appropriate block.

Item 12: Diagnosis

A diagnosis is required. Where possible, indicate both a primary and secondary diagnosis.

You may use the codes for diagnosis listed in the International Classification of Diseases (Adapted for use in the United States), published by the Department of Health, Education and Welfare. (Do not confuse the diagnosis with the patient's complaint or symptoms; pain, swelling, etc., is not acceptable as a diagnosis.)

Item 13: EPSDT Program Referral - Complete this item for recipients under age 21.

Early Periodic Screening, Diagnosis and Treatment (EPSDT), is an aspect of the Medicaid Program which ensures that recipients under 21 years of age receive early detection of disease and illness, as well as diagnostic and treatment services. If an EPSDT screening uncovers a health problem or defect, the patient may be referred to another practitioner for further diagnosis and/or treatment.

It is essential that the Medicaid Program be able to relate diagnostic and/or treatment services to the original screening. Therefore, when a patient under 21 visits your office, a reasonable effort should be made to determine whether it is as a result of an EPSDT Program referral by asking the referring physician or clinic or the patient. If you are unable to obtain the information, check "NO".

(continued)

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Item 16 on the revised claim refers to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers.

Item 16: Prescribing Practitioner

Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the medical supply(s) and/or equipment.

In the event that you are unable to obtain the IMP Number directly from the practitioner, you may call (800) 322-8051 or (300) 322-8052 toll-free for the information. You will need the name and address of the practitioner in order to obtain the IMP Number.

If the prescribing practitioner does not have an IMP Number, insert the name only and write "NON-PAR" next to the practitioner's name. You are cautioned that the term "NON-PAR" is used only when an IMP Number has not been assigned and is unavailable through the toll-free numbers mentioned above.

Continue to follow the procedures for submitting claims as outlined in Chapter III of your Medicaid Medical Supplier Manual.

MEDICAL SUPPLIES AND EQUIPMENT BILLING INSTRUCTIONS

Instructions for Completion of Form MC-11

1. - 4. -Copy the Patient's Name, Health Services Program (HSP) Case Number, and Person Number EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card.
-For additional information, see Section 101. of your Medicaid Medical Supplier Manual.
5. -Indicate patient's age.
6. -Check appropriate block, to identify patient's sex.
7. -Check appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage.
-If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from the carrier.
-When the recipient is covered by both Medicare and Medicaid, see Section 304. of your Medicaid Medical Supplier Manual.
8. -Check as appropriate.
-If patient's illness or injury is work related, enter name and address of employer.
9. -This information is usually preprinted.
-If not preprinted, write in provider name, address, and provider number.
-Enter telephone number.
10. -Indicate whether injury resulted from an automobile accident.
11. -Indicate whether a prescription accompanies the claim when submitted for payment.
-Prescription must be attached when submitting claims for payment, which do not require prior authorization.
12. -Enter diagnosis.

13. -Complete this item for recipients under 21 years of age.
-Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening.
-Indicate if this patient is such a referral by checking the appropriate block.
14. A. -Enter date(s) item was provided.
14. B. -Leave blank.
14. C. -Describe item(s) provided, including name of manufacturer and model number.
14. D. -Enter quantity of item provided.
14. E. -If rental, insert requested rental per month.
-If you are billing for more than one month on one claim form, items A, C, D, E and F must be completed for each month.
-If purchase, insert full amount requested.
14. F. -Enter total charges for each line; e.g., if you are requesting two (2) similar \$20.00 items, enter \$40.00 in column F.
15. -Do not write in this space; for Division use only.
-When prior authorization is required, obtain authorizing signature from Local Medical Assistance Units.
16. -Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the medical supply(s) and/or equipment.
17. -Indicate whether the patient is currently in a Long Term Care Facility.
-If yes, give name and address of Long Term Care Facility.
18. -Under ordinary circumstances, the patient must sign the claim form when services have been received.
-The claim form must indicate services rendered, prior to presenting it to the patient for signature.
-If the patient's signature is unobtainable, see the Billing Chapter in your Medicaid Medical Supplier Manual.
19. -Read the Provider Certification carefully.
-The provider must sign item 17 before the claim can be considered for payment.
-Indicate the billing date which is the date the claim is mailed.



STATE OF NEW JERSEY,

DEPARTMENT OF INSTITUTIONS AND AGENCIES,

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES,

HEALTH SERVICES PROGRAM,

MEDICAL SUPPLIER
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.

MEDICAL SUPPLIER MANUAL
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MEDICAL SUPPLIES AND EQUIPMENT
N.J.A.C. TITLE 10 - CHAPTER 59

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MEDICAL SUPPLIES AND EQUIPMENT

Non-covered items (Continued)

16. Ice bags;
17. Hot water bottles;
18. Sterile or non-sterile tongue blades;
19. Heating pads;
20. Hydrocollators;
21. Infant syringes, family syringes, enema bags;
22. Nasal aspirators;
23. Eye patches;
24. Plastic gloves;
25. Medical supplies and equipment for patients in LTCF (See section 1.7(a);
26. Items not meeting the criteria outlined in section 1.2.

1.7 Prior authorization

- (a) Suppliers providing any of the following items must first obtain prior authorization from the appropriate LMAU.
 1. All durable medical equipment intended for use by a patient in a long term care facility (See section 1.2,4ii.)
 2. Rental items regardless of price;
 3. Oral hygiene devices. However, standard toothbrushes, dental floss, and so forth, are personal hygiene items and therefore, not reimbursable (See section 1.2,4i.)
 4. Orthopedic shoes are covered only under the following conditions:
 - i. When attached to a brace or bar; and/or
 - ii. When a part of the normal (customary, usual) post-fracture treatment program; and/or
 - iii. When used to correct or adapt to gross foot deformities;
 5. Cervical collars: Soft, hard, malleable frame;
 6. Abdominal belts (fashioned elastic type - not used for incisional hernia);
 7. Abdominal corsets (non-elastic type);
 8. Abdominal supports (low back non-elastic type - size to fit patient);
 9. Sacro-iliac and lumbo sacral corsets, supports or belts (male or female);

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MEDICAL SUPPLIES AND EQUIPMENT

Prior authorization (Continued)

10. Special corset, boned and reinforced with steel stays;
11. Combination corset with inside abdominal belts;
12. Elastic support stockings, and so forth;
13. Surgical weight hose;
14. Truss;
15. Knee cage (standard);
16. Hand orthosis: Short opponens (C-Bar, Lumbrical Bar);
17. Ostomy bags;
18. Medical supplies and durable medical equipment to be purchased for which the charge to the Program exceeds \$30.00;
19. Denis Browne Splints and Fillauer Bar;
20. Parts used for repair of durable medical equipment for which the charge to the program exceeds \$30.00.

- (b) Suppliers repairing durable medical equipment and requesting reimbursement for labor charges must obtain prior authorization.

1.8 Procedures for requesting prior authorization

- (a) Complete the following items on the Medical Supplies and Equipment Claim (MC-11) : 1, 2, 3, 4, 5, 6, 7, 8, 9, 14, (B, C, D, E, F), 16 and 17. Mail the claim form and the written prescription (a legible photocopy is acceptable) to the appropriate LMAU. For repairs, a written prescription is not required.
- (b) If the request is authorized, item 15 will be signed and dated by a Medicaid Medical Consultant and the Contractor's and Provider's copies will be returned to you. The LMAU will retain the LMAU copy and the prescriber's written order. You may then proceed to supply the authorized item and/or service to the recipient. (See Subchapter 2 for billing instructions.)
- (c) If the request is denied, you will receive written notification from the LMAU.

Note: See section 2.8 for prior authorization procedures for Medicare/Medicaid eligible persons.

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MEDICAL SUPPLIES AND EQUIPMENT

1.9 Purchase policy

(a) Medical equipment items shall be purchased when, in the judgement of the Medicaid Medical Consultant, the medical need will exist for a period of time long enough to make purchase more economically practical than rental.

(b) When purchase is authorized:

1. The submitted price shall be the provider's usual and customary charge to the general public.
2. Reimbursement shall be based on one of the following standards, whichever is less:
 - i. The provider's usual and customary charge to the general public; or
 - ii. An allowance determined reasonable by the Commissioner of Human Services, within the limitations set by Federal policy relative to reimbursement to individual providers.
3. In no event shall the Medicaid allowance exceed the lowest charge calculated by the Medicare Carrier, or other government agencies, or the lowest charges to other groups or individuals in the community.

(c) When purchase of a vaporizer or cool mist humidifier is prescribed:

1. Only one vaporizer or cool mist humidifier per household will be eligible for reimbursement:

Exceptions:

- (a) If medical necessity warrants the need for additional vaporizers or cool mist humidifiers.
- (b) In the event such equipment is broken and needs replacement, a statement from the provider and a new prescription must be attached to the claim form.

2. Reimbursement shall be based on one of the following standards, whichever is less:
 - i. Wholesale cost plus 50% of cost. A copy of the invoice must be submitted with the claim; or
 - ii. The provider's usual and customary charge to the general public.
3. The maximum charge allowed by the N.J. Medicaid Program for a vaporizer or a cool mist humidifier is \$30.00.

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MEDICAL SUPPLIES AND EQUIPMENT

Purchase policy (Cont'd)

- (d) When durable medical equipment is authorized and purchased on behalf of a Medicaid recipient, ownership of such equipment will vest in the Division of Medical Assistance and Health Services. The recipient will be granted a possessory interest for as long as the recipient requires use of the equipment. When the recipient no longer needs such equipment, possession and control will revert to the Division. The recipient shall sign an agreement to this effect as part of the process of authorizing purchase of the equipment.

1.10 Rental policy

- (a) Medical equipment items may be rented when, in the judgment of the Medicaid Medical Consultant, the medical need for the item will be of such duration that rental will be more economically practical than purchase.
- (b) When rental is authorized:
 1. Authorization or reauthorization for rental, under the general category of "Medical Supplies and Equipment" shall not exceed three months duration. The duration of authorized rental will be indicated in item 15 of the form MC-11. To obtain reauthorization, the provider must submit a new prescription from the prescribing physician, indicating the continued medical need.
 2. If a medical equipment item has an approved purchase price under the Program of \$100.00 or more, the monthly rental payment will be the amount billed or 12 percent of the approved purchase price, whichever is less. Ten such payments shall be deemed to be the full purchase price and no further payments shall be made.
 3. If a medical equipment item has an approved purchase price under the Program of less than \$100.00, the monthly rental payment will be the amount billed or 20 percent of the approved purchase price, whichever is less. Six such payments shall be deemed to be the full purchase price and no further payments shall be made.
 4. If a used medical equipment item is supplied on a rental, the approved purchase price may not exceed the usual and customary or fair market value for such a used item. The rental payment may not exceed the percentage of the applicable fair market value in paragraph 2 or 3 of this subsection.
 5. The monthly rental fee for a used medical equipment item shall include a full service warranty covering the authorized period of rental.
 6. The monthly rental fee for a new medical equipment item shall include the manufacturer's guarantee and full service warranty covering the rental period(s) indicated in paragraph 2 and 3 of this subsection.

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MEDICAL SUPPLIES AND EQUIPMENT

Rental policy (Cont'd)

7. If the purchase of a rental item is authorized before the maximum rental to purchase conversion period (See paragraph 2 or 3 of this subsection), a final payment will be made equal to the remaining months of a ten-month rental period times either the amount billed or 1/10 of the approved purchase price, whichever is less. On a six-month rental, a final payment will be made equal to the remaining months of the rental period times either the amount billed or 1/6 of the approved purchase price, whichever is less.
8. If death, ineligibility, or other circumstances shall intervene, over which the New Jersey Medicaid Program may have no control, rental fees for any medical equipment item shall terminate at the end of the month such circumstance(s) occur and no further payment will be made. It shall be the provider's responsibility to notify the Program when the medical need has ceased to exist, as soon as such information becomes available.
9. Exceptions include the following:
 - i. Demurrage (rental) charges for oxygen cylinders not replaced within 30 days do not require a prior authorization, but may be billed to the New Jersey Medicaid Program by submitting the Contractor's copy of the claim form to the Contractor and the LMAU copy to the appropriate LMAU.
 - ii. Respiratory equipment such as, but not limited to, ventilators and respirators, shall not be considered purchased after rental payments reach 120 per cent of the approved purchase price as described in (b)2 and (b)3 of this subsection. (Purchase of such equipment can be approved at any time). Except:
 - (1) Note: rental of ancillary equipment such as regulators and oxygen equipment will qualify under (b)2 and (b)3 of this subsection (120%=paid).
 - (2) Note: Rental of IPPB machines will qualify under (b)2 and (b)3 of this subsection. (120%=paid).
 - (A) Repairs to an IPPB machine may be prior authorized when the item is no longer under rental. (See section 10:59-1.11 Repair Policy.)
 - (B) An IPPB machine shall be purchased when, in the judgment of the Medicaid Medical Consultant, the medical need will exist for a period of time long enough to make purchase more economically practical than rental.

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MEDICAL SUPPLIES AND EQUIPMENT

1.11 Repair policy

- (a) Medical equipment items may be repaired and suppliers reimbursed for replacement parts and/or labor charges when, in the judgment of the Medicaid Medical Consultant, the medical need for the item will continue to exist for a period of time and repair is more economical than purchase.
- (b) When repair is authorized:
 - 1. Reimbursement for replacement parts shall be based on one of the following standards, whichever is less:
 - i. The provider's usual and customary charge to the general public; or
 - ii. An allowance determined reasonable by the Commissioner of Human Services, within the limitations set by Federal policy relative to reimbursement to individual providers.
 - 2. Reimbursement for labor charge shall be \$10.00 per hour, divided into quarter hour increments of \$2.50.
 - 3. Exceptions:
 - i. Reimbursement for repairs, both parts cost and labor charge, will not be authorized for durable medical equipment under warranty.
 - ii. When combined parts cost and labor charge exceed 50 percent of replacement value, repair will not be authorized.
 - iii. Reimbursement for travel time will not be authorized.
- (c) When an emergency situation occurs and repairs are made without obtaining prior authorization, the supplier must obtain post authorization within two LMAU working days of such repair.

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BILLING PROCEDURES

2.10 Eligibility of patients from state institutions

(a) Medicaid eligibility for patient/residents of state institutions is determined by the New Jersey Division of Public Welfare's Bureau of Local Operations Area Offices. There are four area offices servicing the entire State. Eligibility problems should be referred to the appropriate office as designated below:
(See section 2.9(b)4 which identifies state institutions by number.)

	AREA OFFICE	INSTITUTION NO.
Area 1	Bureau of Local Operations	#31
	Institutional Services Section	#42
	Broadway Bank Bldg. 8th Floor	
	100 Hamilton Plaza	
	Paterson, N. J. 07505	
	201-345-1400	
Area 2	Bureau of Local Operations	#33
	Institutional Services Section	#36
	P. O. Box 118	#47
	Marlboro, N. J. 07746	
	201-946-9770	
Area 3	Bureau of Local Operations	#32
	Institutional Services Section	#35
	1478 Prospect Street	#46
	P. O. Box 1627	#48
	Trenton, N. J. 08625	#90
	609-984-7960	
Area 4	Bureau of Local Operations	#34
	Institutional Services Section	#41
	251-257 Bellevue Avenue	#44
	Hammonton, N. J. 08037	#45
	609-561-7300	

2.11 Medical Supplies and Equipment Claim (MC-11)

The form MC-11 is to be used for the purpose of billing for medical supplies and equipment and repairs to durable medical equipment. For services requiring prior authorization, item 15 must be signed and dated by a Medicaid Medical Consultant, before the claim may be considered for payment.

(a) Instructions for completion of form MC-11 (Exhibit II) follow:

Item 1 through 4 - Copy the Patient's Name, Address, Health Services Program (HSP) Case Number, and Person Number exactly as it appears on the Validation Form or Medicaid Eligibility Identification Card.

MEDICAL SUPPLIER MANUAL

BILLING PROCEDURES

Medical Supplies and Equipment Claim (MC-11) (Continued)

- For additional information, see section 101.
- Item 5 - Indicate the patient's age.
- Item 6 - Check the appropriate block, to identify the patient's sex.
- Item 7 - Check the appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage.
 - If yes, attach a copy of the decline notice or a copy of the explanation of payment from the carrier.
 - When the recipient is covered by both Medicare and Medicaid, see section 2.6.
- Item 8 - Check the appropriate box.
 - If patient's illness or injury is work related, enter the name and address of the employer.
- Item 9 - This information is usually preprinted.
 - If not preprinted, enter the provider's name, address, and provider number.
 - Enter the telephone number.
- Item 10 - Indicate whether the injury resulted from an automobile accident.
- Item 11 - Indicate whether a prescription accompanies the claim when submitting it for payment.
 - Attach the prescription when submitting claims for payment which do not require prior authorization.
- Item 12 - Enter the diagnosis.
- Item 13 - Complete this item for recipients under 21 years of age.
 - Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening.
 - Indicate if this patient is such a referral by checking the appropriate block.
 - Check "No" if unable to obtain the information.

MEDICAL SUPPLIER MANUAL

BILLING PROCEDURES

Medical Supplies and Equipment Claim (MC-11) (Continued)

Item 14.A - Enter date(s) item and/or repair service was provided.

Item 14.B - Enter appropriate code(s) - For medical supply and equipment codes see section 3.1; for orthotic appliances codes, see section 3.2; for labor charge code, see section 3.3.

Item 14.C - Describe item(s) provided, including name of manufacturer and model number. Indicate whether item is new or used by checking appropriate box.

- Indicate in quarter hour increments actual time spent repairing equipment.

Item 14.D - Enter quantity of item provided.

Item 14.E - Rental used item - Enter usual and customary charge or 12% of usual and customary charge for purchase of used item, whichever is less.

Enter usual and customary purchase price for used item under "Sale Amount".

Rental new item - Enter usual and customary rental charge or 12% of usual and customary purchase price whichever is less.

Enter usual and customary purchase price for new item under "Sale Amount".

If billing for more than one month on one claim form, items A, B, C, D, E, and F must be completed for each month.

If purchase, insert usual and customary charge requested.

Item 14.F - Enter total charges for each line; for example, if requesting two similar \$20.00 items, enter \$40.00 in column F. Enter the sum of line charges opposite "Total Charges".

Item 15. - Do not write in this space; for Division use only.

- When prior authorization is required obtain authorizing signature from LMAU.

Item 16 - Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the medical supply(ies) and/or equipment.

- If the prescribing practitioner does not have an IMP Number, insert only the practitioner's name and write "NON-PAR" next to it. PLEASE PRINT.

MEDICAL SUPPLIER MANUAL

BILLING PROCEDURES

Medical Supplies and Equipment Claim (MC-11) (Continued)

- Item 17. - Indicate whether the patient is currently in a long-term care facility.
- If yes, give the name and address of long-term care facility.
- Item 18. - Under ordinary circumstances, the patient must sign the claim form when services have been received.
- The claim form to be signed should indicate services rendered, and the patient must not sign a blank claim 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.

i. Illiterate patient

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

ii. Other

If a patient is physically or mentally incapable of signing, a minor child, deceased, or for other reasons his signature is not obtainable through reasonable efforts, 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.

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

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3.2 Orthotic appliance codes

The following are orthotic appliance codes:

<u>Procedure Code</u>	<u>Description</u>
	Cervical Collar
3813	soft
3814	hard
3815	malleable frame
6663	Abdominal belt, elastic type
6348	Abdominal corsets, non-elastic
6684	Sacro-Illiic Corsets, supports or belts, male or female
6677	Lumbo Sacral Corsets, supports or belts, male or female
6667	Dorsal-lumbar spinal support
3607	Special corset, boned and reinforced with steel stays
6993	Combination corset with inside abdominal belt
6358	Scrotal truss, unilateral
6359	Scrotal truss, bilateral
6356	Hernia support, unilateral
6357	Hernia support, bilateral
3950	Knee Cage, standard
3778	Hand Orthosis, short opponens C-Bar
3782	Lumbrical bar
6348	Miscellaneous supplies and equipment

3.3 Labor charge code

<u>Procedure Code</u>	<u>Description</u>
6996	DME labor - labor in ¼ hour increments of \$2.50 (specify time spent)

MEDICAL SUPPLIER MANUAL

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

INDEX

10:59-3.1 INTRODUCTION

3.2 HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT

- (a) Ambulation Devices
- (b) Bathing Equipment
- (c) Decubitus Care Equipment
- (d) Hospital Beds
- (e) Hospital Bed Accessories
- (f) Oxygen and Related Respiratory Equipment
- (g) IPPB Machines
- (h) Humidifiers/Nebulizers For Use With Oxygen
IPPB Equipment Compressors
- (i) Suction Pump/Room Vaporizers
- (j) Patient Lifts
- (k) Pneumatic Compressor and Appliances
(Lymphedema Pump)
- (l) Safety Equipment
- (m) Transcutaneous and/or Neuromuscular
Electrical Nerve Stimulators
- (n) Traction Equipment
- (o) Trapeze Equipment and Fracture Frame
- (p) Wheelchairs
- (q) Repairs and Replacement Supplies,
Not Otherwise Specified
- (r) Durable Medical Equipment,
Not Otherwise Classified

3.3 HCPCS CODES FOR MEDICAL SUPPLIES

3.4 HCPCS CODES FOR ORTHOPEDIC FOOTWEAR

3.5 HCPCS CODES FOR HYPERALIMENTATION
EQUIPMENT AND SUPPLIES

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:59-3.1 INTRODUCTION

(a) The New Jersey Medicaid Program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS Codes as listed in this Subchapter are relevant to Medicaid medical supplier services and must be used when filing a claim.

1. The responsibility of the medical supplier provider when rendering services and requesting reimbursement is listed in Subchapter 1. and Subchapter 2. of the Medical Supplier Manual.

2. Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes for medical suppliers are as follows:

i. UE - Used Durable Medical Equipment

ii. DD - Powdered Enteral Formulae - this should be used when enteral powdered products are supplied

3. "B.I." (By Invoice) means that the invoice must be attached to the MC-11 claim form. Payment will be made by adding 50 percent to the invoice cost. If the invoice cost is excessive in comparison to invoice costs submitted by other providers, the provider may be required to supply additional information.

10:59-3.2 HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT

HCPCS
CODE

DESCRIPTION

(a) AMBULATION DEVICES

CANES

- E0100 Cane, includes Canes of All Materials, Adjustable or Fixed with tip
- E0105 Cane, Quad or Three Prong, includes Canes of All Materials, Adjustable or Fixed with tips

CRUTCHES

- E0110 Crutch, Forearm, includes Crutches of Various Materials, Adjustable or Fixed, Pair, Complete with tips and handgrips
- E0115 Crutch, Underarm includes Crutches of Various Material, Adjustable or Fixed, Each
- E0120 Crutch Underarm includes Crutches of Various Materials, Adjustable or Fixed, Pair

WALKERS

- E0130 Walker, Rigid (Pickup), Adjustable or Fixed Height
- E0135 Walker, Folding (Pickup), Adjustable or Fixed Height
- E0141 Walker, Wheeled, without Seat
- E0145 Walker, Wheeled, with Seat and Crutch Attachments
- E0146 Walker, Wheeled, with Seat

(b) BATHING EQUIPMENT

- E0160 Sitz Type Bath, Portable, fits over Commode Seat
- E0163 Commode Chair, Stationary, with Fixed Arms
- E0164 Commode Chair, Mobile, with Fixed Arms
- E0166 Commode Chair, Mobile, with Detachable Arms
- X0050 Commode, Pivot Arm
- E0167 Pail or Pan for use with Commode Chair

10:59-3.2 HCPCS CODES FOR DURABLE MEDICAL EQUIPMENT

HCPCS
CODE

DESCRIPTION

E0179 Bathroom Equipment, includes: Rails, Seats, Stools, Benches,
any Type

(c) DECUBITUS CARE EQUIPMENT

E0180 Pressure Pad, Alternating with Pump

E0181 Pressure Pad, Alternating with Pump, Heavy Duty

(d) HOSPITAL BEDS

E0250 Hospital Bed, with side Rails, Fixed Height, with Mattress

E0255 Hospital Bed, with side Rails, Variable Height, (Hi-Lo), with
Mattress

E0265 Hospital Bed, Total Electric (Head, Foot and Height
Adjustment, with Mattress)

(e) HOSPITAL BED ACCESSORIES

E0300 Mattress, Replacement for Medically Necessary Bed Owned by
the Beneficiary or Subscriber

NOTE: Subscriber refers to Medicaid owned

E0310 Bed Side Rails, Full Length

E0315 Bed Accessories: Boards or Tables, any Type

E0320 Bedpan, includes Fracture and Standard Pans

E0325 Urinal, Male, any material

NOTE: Excluding Stainless Steel Urinals

E0326 Urinal, Female, any material

NOTE: Excluding Stainless Steel Urinals

(f) OXYGEN AND RELATED RESPIRATORY EQUIPMENT

E0400 Oxygen Contents, Gaseous, Per Cubic Feet

E0410 Oxygen Contents, Liquid, Per Pound

E0425 Stationary Compressed Gas System, includes use of Container,
Cart or Carrying Case, Regulator with Flow Gauge, Humidifier,
Nebulizer, Cannula or Mask and Tubing

HCPCS
CODE

DESCRIPTION

E0430 Oxygen System, Gaseous, Portable, includes Portable Container, Supply Container, Cart or Carrying Case, Regulator with Flow Gauge, Humidifier Cannula or Mask and Tubing

E0440 Oxygen System, Liquid, Stationary, includes use of Reservoir, Contents Indicator, Flowmeter, Humidifier, Cannula or Mask and Tubing

E0450 Volume Ventilator

E0455 Oxygen Tent, Excluding Group or Pediatric Tents

E1351 Cannula

E1353 Regulator

(g) IPPB MACHINES

E0510 IPPB Machines with Automatic Valves, External Power Source includes Cylinder Regulator, Built-In Nebulization

(h) HUMIDIFIERS/NEBULIZERS FOR USE WITH OXYGEN IPPB EQUIPMENT

E0550 Humidifier, Durable for Extensive Supplemental Humidification during IPPB Treatments or Oxygen Delivery, e.g., Cascade

E0560 Humidifier, Durable for Supplemental Humidification during IPPB Treatment or oxygen Delivery, e.g., Cascade Jr.

X0200 Nebulizer, Pocket Size

E0570 Nebulizer, with Compressor, e.g., Devilbiss Pulmo-Aid

E0575 Nebulizer, Self-Contained, Ultrasonic

E0580 Nebulizer, Durable, Glass or Autoclavable Plastic, Bottle Type, for use with Regulator or Flowmeter

E0585 Nebulizer, with Compressor and Heater

(i) SUCTION PUMP/ROOM VAPORIZERS

E0600 Suction Pump, Home Model, Portable

E0605 Vaporizer, Room Type

HCPCS
CODE

DESCRIPTION

(j) PATIENT LIFTS

E0625 Patient Lift, Kartop, Bathroom or Toilet

NOTE: Excluding Kartop Patient Lift

E0630 Patient Lift, Hydraulic, with Seat or Sling

(k) PNEUMATIC COMPRESSOR AND APPLIANCES (LYMPHODEMA PUMP)

E0665 Pneumatic Appliance for use with Pneumatic Compressor, Full Arm

(l) SAFETY EQUIPMENT

E0700 Safety Equipment, e.g., Belt, Harness or Vest

(m) TRANSCUTANEOUS AND/OR NEUROMUSCULAR ELECTRICAL NERVE STIMULATORS

E0720 Tens, Two Lead, Localized Stimulation

E0730 Tens, Four Lead, Larger Area/Multiple Nerve Stimulation

X3700 Osteogenic Stimulation

(n) TRACTION EQUIPMENT

TRACTION-CERVICAL

E0840 Traction Frame, attached to Headboard, Simple Cervical Traction

E0850 Traction Stand, Free Standing, Simple Cervical Traction

TRACTION - OVERDOOR

E0860 Traction Equipment, Overdoor, Cervical

TRACTION - PELVIC

E0890 Traction Frame, attached to Footboard, Simple Pelvic Traction

E0900 Traction Stand, Free Standing, Simple Pelvic Traction, e.g., Buck's

(o) TRAPEZE EQUIPMENT AND FRACTURE FRAME

E0910 Trapeze Bars, A/K/A Patient Helper, attached to Bed, with Grab Bar

E0920 Fracture Frame, attached to Bed, includes Weights

HCPCS
CODE

DESCRIPTION

E0930 Fracture Frame, Free Standing, includes Weights

E0947 Fracture Frame, attachments for Complex Pelvic Traction

(p) WHEELCHAIRS

WHEELCHAIR - ECONOMY

E1221 Wheelchair with Fixed Arm, Footrest

ROLLABOUT CHAIR

E1030 Rollabout Chair, without Arms

E1035 Geriatric Chair

E1036 Positioning Chair (Submit brand name, model number and specifications)

WHEELCHAIR - FULL - RECLINING

E1050 Fully-Reclining Wheelchair, Fixed Full length Arms, Swing Away Detachable Elevating Legrests

WHEELCHAIR - STANDARD

E1130 Standard Wheelchair, Fixed Full Length Arms, Fixed or Swing Away Detachable Footrests

E1160 Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests

WHEELCHAIR - AMPUTEE

E1170 Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests

E1172 Amputee Wheelchair, Detachable Arms (Desk or Full Length) without Footrest or Legrest

E1180 Amputee Wheelchair, Detachable Arms (Desk or Full Length) Swing Away Detachable Footrests

E1190 Amputee Wheelchair, Detachable Arms (Desk or Full Length) Swing Away Detachable Elevating Legrests

E1200 Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest

HCPCS
CODE

DESCRIPTION

WHEELCHAIR - POWER

E1210 Motorized Wheelchair with Microswitch Control, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests

WHEELCHAIR - SPECIAL SIZE

E1220 Specially Sized or Constructed Wheelchairs, (Indicate Brand Name, Model Number, and Justification)

WHEELCHAIR - LIGHTWEIGHT

E1240 Lightweight Wheelchair, Detachable Arms, (Desk or Full Length) Swing Away Detachable Legrest

E1250 Lightweight Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest

E1260 Lightweight Wheelchair, Detachable Arms (Desk or Full Length) Swing Away Detachable Footrest

E1270 Lightweight Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests

WHEELCHAIR - HEAVY DUTY

E1280 Heavy Duty Wheelchair, Detachable Arms (Desk or Full Length) Elevating Legrests

E1285 Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest

E1290 Heavy Duty Wheelchair, Detachable Arms (Desk or Full Length) Swing Away Detachable Footrest

E1295 Heavy Duty Wheelchair, Fixed Full Length Arms, Elevating Legrest

(q) REPAIRS AND REPLACEMENT SUPPLIES

E1350 Repair or Non-Routine Service (e.g., Breaking Down Sealed Components) Requiring the Skill of a Technician

(r) DURABLE MEDICAL EQUIPMENT, NOT OTHERWISE CLASSIFIED

E0607 Home, Blood Glucose Monitor

E0608 Apnea Monitor

E0776 I.V. Pole

X0250 Pneumogram, 12-24- Hours with or without Interpretation

10:59-3.3 HCPCS CODES FOR MEDICAL SUPPLIES

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>
A4252	Irrigation Kits, Nonsterile
A4341	Indwelling Catheter, Foley Type, Two-Way, Teflon
A4342	Indwelling Catheter, Foley Type, Two-Way, Latex
A4343	Indwelling Catheter, Foley Type, Two-Way, Latex with Teflon Coating
A4344	Indwelling Catheter, Foley Type, Two-Way, All Silicone
A4345	Indwelling Catheter, Foley Type, Two-Way, Silicone with Elastomer Coating
A4346	Indwelling Catheter, Foley Type, Three Way, Latex or Teflon for Continuous Irrigation
A4347	External Catheter, Condom Type
A4350	Catheter Care Kit, the Orifice or an Indwelling Catheter
A4360	Colostomy Set
A4365	Ostomy Bags, Disposable/closed
A4366	Ostomy Bags, Reusable or Drainable
A4380	Ileostomy Set
A4390	Ileal Bladder Set
A4400	Irrigation Set for Irrigation of Ostomy
A4421	Not Otherwise Classified Ostomy Supplies
A4430	Ureterostomy Set
A4460	Elastic Bandage, Ace
A4490	Surgical Stockings Above Knee Length, Each
A4495	Surgical Stockings Thigh Length, Each
A4500	Surgical Stockings Below Knee Length, Each
A4510	Surgical Stockings Full Length, Each
A4554	Disposable Underpads, All sizes, e.g., Chux's

HCPCS
CODE

DESCRIPTION

A4555	Primary Surgical Dressing Kit, e.g., Sterile Dressings, Pads, etc.
X7200	Hypodermic Syringes over 5cc
X7300	Rectal Syringes (per eligible Diagnosis)
A4565	Slings
A4572	Rib Belt
X6600	Elastic Support (Wrist, Ankle or Knee)
X7520	Disposable Diapers

10:59-3.4 HCPCS CODES FOR ORTHOPEDIC FOOTWEAR

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>	<u>MEDICAID DOLLAR VALUE</u>
<u>ORTHOPEDIC SHOES, SHOE MODIFICATIONS AND TRANSFERS</u>		
<u>FOOT</u>		
<u>INSERT, REMOVABLE, MOLDED TO PATIENT MODEL</u>		
L3000	Foot, Insert, Removable, Molded to Patient Model, "UCB" Type, Berkeley Shell, Each	45.00
L3010	Foot, Insert, Removable, Molded to Patient Model, Longitudinal Arch Support, Each	45.00
L3020	Foot, Insert, Removable, Molded to Patient Model, Longitudinal/Metatarsal Supports, Each	45.00
X4290	Filler for Amputee Toes	16.00
L3030	Foot, Insert, Removable, Formed to Patient Foot, Each-Arch Supports, Removable, Pre-molded, Each	45.00
X4800	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Whitman Ordinary	37.00
X4801	Arch Support, Foot Plate: (Plaster cast taken by Vendor) Leather - Mayer	27.00
X4802	Arch Support, Foot Plate: (Plaster cast taken by Vendor) Leather - Schaffer	27.00
X4803	Arch Support, Foot Plate: (Plaster cast taken by Vendor) Leather - Schaffer with metatarsal pad	30.00
X4804	Arch Support, Foot Plate: (Plaster cast taken by Vendor), Leather - Whitman Combination	43.00
X4805	Arch Support, Foot Plate: (Plaster cast taken by Vendor), Leather - Rohadur Plastic	36.00
X4810	Velcro Straps attached to a pair of shoes	10.00
L3100	Hallus-Valgus Night Dynamic Splint	11.50

HCPCS
CODE

DESCRIPTION

MEDICAID
DOLLAR VALUE

ABDUCTION AND ROTATION BARS

L3140	Foot, Abduction Rotation Bars (Dennis Browne Type), attached to Shoe	11.50
L3150	Foot, Abduction Rotation Bars (Dennis Browne Type), clamped to Shoe	11.50
L3160	Foot-Torque Heels	7.00

SPACE SHOES

X4850	Space Shoe Rubber Raise for Shoe: 1/4 " Raise	6.00
X4851	Space Shoe Rubber Raise for Shoe: 1/2 " Raise	7.00
X4852	Space Shoe Rubber Raise for Shoe: 3/4 " Raise	10.00
X4853	Space Shoe Rubber Raise for Shoe: 1 " Raise	20.00
X4854	Space Shoe Rubber Raise for Shoe: Each additional 1/2 " Raise	8.00

ORTHOPEDIC FOOTWEAR

L3201	Orthopedic Shoe, Oxford with Supinator or Pronator-Infant	*B.I.
L3202	Orthopedic Shoe, Oxford with Supinator or Pronator-Child	B.I.
L3203	Orthopedic Shoe, Oxford with Supinator or Pronator-Junior	B.I.
L3204	Orthopedic Shoe, Hightop with Supinator or Pronator-Infant	B.I.
L3206	Orthopedic Shoe, Hightop with Supinator or Pronator-Child	B.I.
L3207	Orthopedic Shoe, Hightop with Supinator or Pronator-Junior	B.I.
L3208	Surgical Boot, Each-Infant	B.I.

*B.I. - By Invoice Plus 50%

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>	<u>MEDICAID DOLLAR VALUE</u>
L3209	Surgical Boot, Each-Child	* B.I.
L3211	Surgical Boot, Each-Junior	B.I.
L3212	Benesch Boot, Pair-Infant	B.I.
L3213	Benesch Boot, Pair-Child	B.I.
L3214	Benesch Boot, Pair-Junior	B.I.
L3215	Orthopedic Footwear, Ladies Shoes, Oxford	B.I.
L3217	Orthopedic Footwear, Ladies Shoes, Hightop-Depth Inlay	B.I.
L3222	Orthopedic Footwear, Mens Shoes- Hightop-Depth Inlay	B.I.
L3223	Orthopedic Footwear, Mens Surgical Boot-Each	B.I.
L3230	Orthopedic Footwear, Custom Shoes Depth Inlay	B.I.
L3250	Orthopedic Footwear, Custom Molded Shoe, Removable Inner Mold, Prosthetic Shoe, Each	111.00

SHOE MODIFICATION

LIFTS

L3310	Lifts-Elevation, Heel and Sole, Neoprene, per Inch	17.50
L3320	Lifts-Elevation, Heel and Sole, Cork, per Inch	42.00

WEDGES

L3340	Heel Wedge, Sach	3.00
L3350	Heel Wedge	3.00
L3360	Sole Wedge-Outside Sole	4.00
L3370	Sole Wedge-Between Sole	4.00

* B.I. - By Invoice Plus 50%

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>	<u>MEDICAID DOLLAR VALUE</u>
L3390	Outflare Wedge	12.00
L3400	Metatarsal Bar Wedge-Rocker	4.00
L3410	Metatarsal Bar Wedge-Between Sole	4.00
L3420	Full Sole and Heel Wedge * Between Sole *	8.00
<u>HEELS</u>		
L3460	Heel-New Rubber, Standard	3.00
L3470	Heel-Thomas Extended to Ball	6.00
L3480	Heel-Pad and Depression for Spur	6.00
L3485	Heel-Pad, Removable for Spur	3.00
<u>MISCELLANEOUS SHOE ADDITIONS</u>		
L3510	Miscellaneous Shoe Additions, Insole Rubber	2.00
L3530	Miscellaneous Shoe Additions, Sole-Half	4.00
L3540	Miscellaneous Shoe Additions, Sole-Full	8.00
<u>TRANSFERS OR REPLACEMENT</u>		
L3600	Transfers of an Orthosis From One Shoe to Another, Caliper Plate Existing	35.00
L3610	Transfers of an Orthosis From One Shoe to Another, Caliper Plate New	35.00
L3620	Transfers of an Orthosis From One Shoe to Another, Solid Stirrup Existing	35.00
L3630	Transfers of an Orthosis From One Shoe to Another, Solid Stirrup New	35.00
L3640	Transfers of an Orthosis From One Shoe to Another, Dennis Browne Splint (Riveton), Both Shoes	7.00

HCPCS
CODE

DESCRIPTION

MEDICAID
DOLLAR VALUE

ADDITIONAL SERVICES

The following listing sets forth procedure codes, narrative descriptions, and the Medicaid fee schedule for services which may be performed by providers other than certified prosthetists and orthotists (shoe dealers).

CASTING

X4890	Foot	50.00
X4891	Foot, Ankle	65.00
X4892	Foot, Ankle, Shin	70.00

COMPONENTS

L2230	Additions to Lower Extremity, Split Flat Caliper Stirrups, and Plate Attachment	56.00
L2240	Additions to Lower Extremity, Round Caliper and Plate Attachment	45.00
L2270	Additions to Lower Extremity, Varus/Valgus Correction ("T") Strap, Padded/Lined or Malleolus Pad	32.00
L2280	Additions to Lower Extremity, Molded Inner Boot	87.00
L2310	Additions to Lower Extremity, Abduction Bar-Straight	60.00
L2360	Additions to Lower Extremity, Extended Steel Shank	30.00

GENERAL OR NEW ORTHOSIS OR REPAIR
OR REPLACEMENT

L2210	Additions to Lower Extremity, Dorsiflexion Assist (Plantar Flexion Resist)	40.00
X3610	"D" Ring	11.00
L3620	Transfers of an Orthosis from one shoe to another, Solid Stirrup Existing	35.00
X4280	Velcro Strap used with orthoses	18.00

HCPCS
CODE

DESCRIPTION

MEDICAID
DOLLAR VALUE

OTHER

L4200 Repair of Orthotic Device, Hourly Rate 35.00

NOTE: Allowed for Replacement or Repair

X3680 Travel Time (portal to portal) 30.00

10:59-3.5 HCPCS CODES FOR HYPERALIMENTATION EQUIPMENT AND SUPPLIES

<u>HCPCS CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>
<u>ENTERAL AND PARENTERAL THERAPY</u>		
<u>ENTERAL FORMULAE AND MEDICAL SUPPLIES</u>		
B4150		Enteral Formulae; Category I: Intact Protein/Protein Isolates (e.g., Ensure, Osmolite, Isocal, Renu, Sustacal, Travasorb Liquid, Precision Isotonic, Travasorb MCT, Isotein HN, Compleat B, Vitaneed, Meritene, Isotonic, Isotein NH Protogen) for 30 days
B4150	DD	Enteral Formulae; Category I: Intact Protein/Protein Isolates (e.g., Ensure, Osmolite, Isocal, Renu, Sustacal, Travasorb Liquid, Precision Isotonic, Travasorb MCT, Isotein HN, Compleat B, Vitaneed, Meritene, Isotonic, Isotein NH Protogen) for 30 days <u>NOTE:</u> DD means powdered nutrients, enteral only.
X8016		Enteral Formulae; Category I: Intact Protein/Protein Isolates; Travasorb MCT
X8016	DD	Enteral Formulae; Category I: Intact Protein/ Protein Isolates; Travasorb MCT <u>NOTE:</u> DD means powdered nutrients, enteral only.
B4152		Enteral Formulae; Category II: Intact Protein/Protein Isolates (Calorically Dense) (e.g. Magacal, Isocal HCN, Osmolite, Tramacal, Sustacal HC, Ensure Plus, Ensure Plus HN) for 30 days
B4153		Enteral Formulae; Category III: Hydrolyzed Protein/Amino Acids (e.g., High Nitrogen Vivonex, Criticare HN, Vivonex T.E.N. (Total Enteral Nutrition) Vital (Vital HN), Travasorb HN, Vipep, Precision) for 30 days
B4153	DD	Enteral Formulae; Category III: Hydrolyzed Protein/Amino Acids (e.g., High Nitrogen Vivonex, Criticare HN, Vivonex T.E.N. (Total Enteral Nutrition) Vital (Vital HN), Travasorb HN, Vipep, Precision) for 30 days <u>NOTE:</u> DD means powdered nutrients, enteral only
X8017		Enteral Formulae; Category IV: Defined Formula for Special Needs (Hepatic)

<u>HCPCS CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>
X8017	DD	Enteral Formulae; Category IV: Defined Formula for Special Needs (Hepatic) <u>NOTE:</u> DD means powdered nutrient, enteral only
B4154		Enteral Formulae; Category IV: Defined Formula for Special Metabolic Need, (e.g., Hepatic-Aid, Trivasorb, Vivonex T.E.N., Traum-Aid, Trivasorb Hepatic, Trivasorb Renal, Amin-Aid) for 30 days
B4154	DD	Enteral Formulae Category IV: Defined Formula for Special Metabolic Need, (e.g., Hepatic-Aid, Trivasorb, Vivonex T.E.N., Traum-Aid, Trivasorb Hepatic, Trivasorb Renal, Amin-Aid) for 30 days <u>NOTE:</u> DD means powdered nutrient, enteral only
B4155		Enteral Formulae; Category V: Modular Components (Protein, Carbohydrates, Fat) (e.g., Propac, Gerval Protein, Promix, Casec, Moducal, Controlyte, Polycose Liquid or Powder, Sumacal, Microlipids, MCT Oil, Nutri-Source) for 30 days
B4157		Enteral Formulae; Prepackaged Delivery System and Formula (E.G., Entrition, Entri-Pak) for 30 days
B4159		Enteral Feeding Supply Kit for 1 month
X7100		Nasogastric tubing without Stylet
X7105		Nasogastric tubing with Stylet
X7110		Enteral Supply, Flexitainer Feeding Bag
X7115		Enteral Supply, Vivonex Delivery System
X7120		Enteral Supply, Stomach Tube
X8065		Gravity Set (Tubing and Container)
X8070		Enteral Tubing
E0776		IV Pole
E0777		Enteral Infusion Pump
E0779		Parenteral Infusion Pump

HCPCS
CODE

MOD

DESCRIPTION

PARENTERAL NUTRITION SOLUTION AND SUPPLIES

B4180	Parenteral Nutrition Solution; Carbohydrates, any Strength, (500 ML=1 Unit)
B4184	Parenteral Nutrition Solution; Lipids, Per 500 ML any Strength, (500 ML= 1 Unit) with Administration Set
B4188	Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrate Solution any Strength, per 1000 ML
B4192	Parenteral Nutrition Solution; Compounded Amino Acid Carbohydrate Solution any Strength, per 2000 ML
B4196	Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrate Solution, any Strength, per 3000 ML
B4198	Parenteral Nutrition Solution; Compounded Amino Acid Carbohydrate Solution, any Strength, over 3000 ML
B4200	Albumin 25%, (50 ML= 1 Unit)
B4220	Parenteral Nutrition Supply Kit for 1 Month
B4239	IV Administration Set with Drainage Tubing
B4242	Heparin, Any Strength Porcine or Beef Up to 1000 Units, 10-30 ML
B4251	Destructclip

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

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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

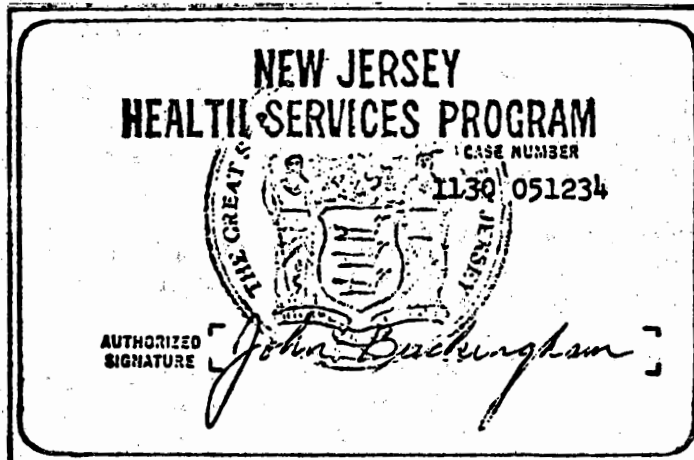
101. HOW TO IDENTIFY A COVERED PERSON

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

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 by State law to podiatrists and optometrists;
- (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.

GENERAL INFORMATION

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.

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.

GENERAL INFORMATION

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

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.

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

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

The Program, in most instances, shall cover the amount of any deductible or co-insurance liability under Title XVIII of the Social Security Act for all covered persons 65 years of age or older.

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

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

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.

CHAPTER II

MEDICAL SUPPLIES AND EQUIPMENT

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CHAPTER II
MEDICAL SUPPLIES AND EQUIPMENT

200. MEDICAL SUPPLIES AND EQUIPMENT

This Chapter is concerned with all medical supplies and equipment excluding prosthetic appliances and orthotic devices (i.e. braces, artificial limbs, eye aids, dentures, hearing aids, etc.).

201. DEFINITIONS

201.1 Medical Supplies

"Medical Supplies" refers to the consummable, expendable, disposable or non-durable items which are prescribed by a practitioner, being medically necessary for use by an eligible recipient. (e.g. disposable pads)

EXCLUSIONS: Medicine chest items and personal hygiene items. (See Sections 204, 205)

201.2 Medical Equipment

"Medical Equipment" refers to an item, article or apparatus which has the following characteristics:

1. Is primarily and customarily used to serve a medical purpose.
2. Is generally not useful to a person in the absence of a disease, illness or injury.
3. Can withstand repeated use (durable) and is non-expendable (e.g. hospital bed, oxygen equipment, wheel chair, walker, suction equipment, etc.).

NOTE: Medical Supplies and Equipment ordered for patients in a participating medical institution are considered part of the institution's cost, and cannot be billed directly to the Program by the supplier.

EXCEPTION: When unusual circumstances require medical equipment not usually found in a Long Term Care Facility, such medical equipment may be reimbursable with prior authorization from the Local Medical Assistance Unit serving County where the facility is located. (See Section 305).

202. ELIGIBLE PROVIDERS

1. All pharmacies operating under a valid permit issued by the Board of Pharmacy of the State of New Jersey and all medical-surgical suppliers having an established place of business in New Jersey which is open to the public during normal business hours.

2. All pharmacies outside of New Jersey operating under a valid permit issued by the Board of Pharmacy of the State in which the pharmacies are located and all medical-surgical suppliers outside of New Jersey who meet the definition as a provider by Medicaid in the State in which they are located.

202.1 Provisions for Participation

1. All services and supplies shall be furnished in accordance with the policies, procedures, and payment allowances established by the Division of Medical Assistance and Health Services.
2. Payment by the Health Services Program for purchase or rental shall constitute full payment for the supplies or equipment furnished and no additional charge shall be made to or on behalf of the eligible recipient.

NOTE: For Medicare/Medicaid eligible recipients, See Section 304. "Combination Medicare/Medicaid Claims".

3. Properly identified representatives of the Division of Medical Assistance and Health Services may inspect the original prescription or order on file and may audit records pertaining to costs of medical supplies provided to covered persons.

203. PRESCRIPTION POLICIES

Medical Supplies and Equipment require a personally signed, legible, dated order by the prescribing practitioner and shall contain the following information:

1. Patient's name, address, Health Services Program Number, and Person Number.
2. Description of supplies and/or equipment prescribed.

NOTE: Phrase "wheelchair" or "Patient needs wheelchair" is insufficient. Order must describe type and style of wheelchair.

3. Length of time medical equipment item is required.
4. Diagnosis and summary of patient's physical condition, to support need for item(s) prescribed.

EXCEPTION: The initial request for authorization of "Ostomy Bags and Supplies" must be accompanied by a prescription as described in items 1-4 above. However the New Jersey Health Services Program Medical Consultant will determine upon review of the prescription and consultation with the prescriber if necessary, whether the patient will have an indefinite need for such supplies. If it is determined that such need will be indefinite, the Local Medical Assistance Unit will

notify the Medical Surgical Supplier, upon granting of the initial authorization, that monthly prescriptions will no longer be required for such supplies for that patient, however, prior authorization will be required.

204. NON-COVERED ITEMS

Payment will not be authorized for the following:

1. Personal incidentals, including items for personal cleanliness, body hygiene, and grooming (e.g. standard tooth brushes, mouth washes, dentifrices, deodorants, shampoos, plain and deodorant soaps, cosmetics, sanitary pads, shaving items, etc.).
2. Supplies administered or directly furnished by practitioners.
3. Items available without charge through programs of other public or voluntary agencies (e.g. New Jersey State Department of Health, Heart Association, etc.).
4. First aid supplies (i.e. sterile gauze, adhesive tape, adhesive bandage, cotton).

EXCEPTION: When a covered person requires an unusual or excessive amount of any first aid supplies for use in the home care of an illness or injury, prior authorization must be requested from the appropriate Local Medical Assistance Unit. (See Section 305)

5. Orthopedic mattress.
6. Environmental control equipment and supplies.

EXCEPTION: Vaporizers.

7. Inflatable rubber invalid rings.
8. Stainless steel urinals.
9. Stainless steel bedpans.
10. Water bed or mattress.
11. Equipment for administration of oxygen for patients in long term care facilities.

NOTE: Oxygen itself however, is a reimbursable item when supplied to an eligible recipient in a long term care facility. The supplier should bill the contractor for such oxygen as a medical supply item. Amounts of oxygen costing more than \$20.00 require prior authorization. See Chapter III Section 306.1 item 11C for billing instructions for oxygen.

MEDICAL SUPPLIES AND EQUIPMENT

205. PRIOR AUTHORIZATION

Suppliers providing any of the following items must first obtain prior authorization from the appropriate Local Medical Assistance Unit.

1. All durable medical equipment intended for use by a patient in a Long Term Care Facility. (See 201.2 NOTE)
2. Rental items regardless of price.
3. Oral hygiene devices.

NOTE: Standard tooth brushes, dental floss, etc., are personal hygiene items and therefore, not reimbursable. (Please see Section 201.1)

4. Denis Browne splints and Fillauer bar.
5. Orthopedic Shoes

NOTE: Orthopedic shoes are reimbursable under the New Jersey Health Services Program under the following conditions:

- a. When attached to a brace or bar and/or
 - b. When part of the normal (customary, usual) post-fracture treatment program and/or
 - c. When used to correct gross foot deformities and/or
 - d. When the talo-crural (ankle) joint is included in the shoe.
6. Medical supplies and durable medical equipment to be purchased for which the charge to the Program exceeds \$20.00. EXCEPTION: All "Ostomy Bags and Supplies" require prior authorization regardless of price. (See Section 203 Prescription Policies.)

205.1 Procedures for Requesting Prior Authorization

Complete the following items on the Medical Supplies and Equipment claim (MC-11A-C1): 1, 2, 3, 4, 5, 6, 7, 8, 9, 11 (B, C, D, E, F) 13 and 14. Mail the claim form and the prescriber's written order (a legible photocopy is acceptable) to the appropriate Local Medical Assistance Unit.

If the request is authorized, item 12 will be signed and dated by a Medicaid Medical Consultant and the Contractor's and Provider's Copies will be returned to you. The Local Medical Assistance Unit will retain the Local Unit copy and the prescriber's written order. You may then proceed to supply the authorized item to the recipient. (See Section 303 for Billing Instructions.)

MEDICAL SUPPLIES AND EQUIPMENT

If the request is denied, you will receive written notification from the Local Medical Assistance Unit.

NOTE: See Section 304 for prior authorization procedures for Medicare/Medicaid eligible persons.

206. PURCHASE POLICY

Medical Equipment items shall be purchased when, in the judgement of the Medical Consultant in the Local Medical Assistance Unit the medical need will exist for a long enough period of time to make purchase more economically practical than rental.

When purchase is authorized:

1. The approved purchase price shall be the manufacturer's suggested retail price minus a discount of 10%. In the absence of a published manufacturer's retail price, reimbursement shall be on the basis of the customary charge, not to exceed an allowance determined reasonable by the Commissioner (Institutions and Agencies), and further limited by Federal Policy relative to reimbursement of practitioners and other individual providers. In no event shall the allowance exceed the charge by the provider to other government agencies, or other groups or individuals in the community.

207. RENTAL POLICY

Medical Equipment items may be rented when in the judgement of the Medical Consultant in the Local Medical Assistance Unit, the medical need for the item will be of such short duration that rental will be more economically practical than purchase.

207.1 When Rental is Authorized

1. Authorization or re-authorization for rental, under the general category of "Medical Supplies and Equipment" shall not exceed three (3) months duration. The duration of authorized rental will be indicated in Section 12 of the MC-11A-C1. To obtain re-authorization, the provider must submit a new prescription from the prescribing physician, indicating the continued medical need.
2. If a Medical Equipment item has an approved purchase price under the Medicaid Program of \$100 or more, the monthly rental payment will be 12% of the approved purchase price and after ten (10) such payments the item shall be deemed to be purchased and no further payments shall be required.
3. If a Medical Equipment item has an approved purchase price under the Medicaid Program of less than \$100, the monthly rental payment will be 20% of the approved purchase price and six (6) such payment shall be deemed to be the full purchase price and no further payments shall be made.

MEDICAL SUPPLIES AND EQUIPMENT

4. The monthly rental fee shall include the manufacturer's guarantee and a full service warranty during the rental period(s) indicated in part 2 and 3 above.
5. If death, eligibility, or other circumstances over which the New Jersey Health Services Program may have no control, shall intervene, rental fees for any Medical Equipment item shall automatically terminate during the month such circumstance(s) occur and no further payment will be made. It shall be the provider's responsibility to notify the New Jersey Health Services Program when the medical need has ceased to exist, as soon as such information becomes available.

EXCEPTION 1: Demurrage (rental) charges for oxygen cylinders not replaced within 30 days do not require a prior authorization, but may be billed to the New Jersey Health Services Program by submitting the Contractor's copy of the claim form to the Contractor and the Local Medical Assistance Unit copy to the appropriate Local Medical Assistance Unit.

EXCEPTION 2: Respiratory equipment e.g. IPPB Machine, etc. shall not be considered purchased after rental payments reach 120% of approved purchase price as described in items 2 and 3 above.

CHAPTER III

BILLING PROCEDURES

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CHAPTER III
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. In all cases, claims must be submitted no later than ninety (90) days after the last date services were rendered.

NOTE: If billing on a monthly basis for an authorized three month rental, insert in item 12 the statement "see previous claim form" for the second and third month. Reauthorization from the Local Medical Assistance Unit is required for continued rental beyond the third month.

302. PATIENT IDENTIFICATION

Verify that the patient is a covered person. This is done by viewing the patient's Validation Form (See Section 101) which is issued on the first day of each month. (See also New Jersey Health Services Program Newsletter 1-27 issued 10/4/71 to identify eligibles from State institutions). It is especially important to review a patient's Validation form prior to billing when rentals have been authorized. Prior authorization is no guarantee that an individual is covered.

303. PRIOR AUTHORIZATION

Items or services requiring prior authorization should not be provided until the authorization is received. Following receipt of authorization from the Local Medical Assistance Unit and dispensing of item, complete item 11A, have the patient sign the claim (item 15) and forward the Contractor's copy to Prudential for reimbursement. Retain the Provider's copy for your records. It is not necessary to submit the Practitioner's written order together with a prior authorized claim.

303.1 Claims Not Requiring Prior Authorization

Submit a completed Contractor's copy (MC-11A-C1) to Prudential together with the order (prescription) from the prescribing practitioner. (See Section 203.) All items on the MC-11A-C1 MUST be completed except item 12.

304. COMBINATION MEDICARE/MEDICAID CLAIMS

All services allowable under Medicare which are provided to an individual eligible for both Medicare and Medicaid benefits shall be billed on Form SSA-1490 REQUEST FOR MEDICARE PAYMENT, and the claims are to be sent directly to the Medicare Intermediary, Prudential (Medicare B Division, P.O. Box 2000, Millville, New Jersey 08332). Providers should understand that they are agreeing to accept assignment when billing in this manner. In order to obtain Medicaid consideration, the provider MUST record the correct New Jersey Health Services Case and Person Number in item 5 in addition to the Health Insurance Claim Number in item 2 of Form SSA-1490. (A Sample SSA-1490 is shown as Exhibit I)

The Medicaid Program alone will reimburse the provider of durable medical equipment (DME) for covered items provided to combination Medicare/Medicaid eligible persons. The provider will not receive partial payment from Medicare and partial payment from Medicaid for durable medical equipment.

304.1 Combination Claim for DME Not Requiring Prior Authorization

For covered items for a Medicare/Medicaid eligible person not requiring prior authorization under the Medicaid Program, submit the original and one copy of the fully completed Form SSA-1490 "Request For Medicare Payment" directly to (Prudential, Medicare B Division, P.O. Box 2000, Millville, New Jersey 08332).

The prescribing physician's prescription, complete with patient's name, diagnosis and a specified period of necessity must be attached. The provider will receive direct reimbursement from Medicaid for the item, not separate payments from Medicare and Medicaid.

304.2 Combination Claims for DME Requiring Prior Authorization

For items requiring prior authorization under the Medicaid Program, the provider is to submit the physician's prescription complete with patient's name, diagnosis and a specified period of necessity and four (4) copies (Use two claim forms with a carbon in between) of the completed form SSA-1490 to the appropriate Local Medical Assistance Unit. The item(s) must be fully described in item 7C on form SSA-1490.

The Local Medical Assistance Unit will review the prescription and item(s) requested and render a decision. If authorized, the Medicaid Medical Consultant will describe the terms of the authorization, insert the date of authorization and affix his signature in item 5 on the SSA-1490. The Local Unit will retain the one copy of form SSA-1490 and will return the original, and two copies together with the prescription to the provider.

BILLING PROCEDURES

When billing, the provider is to submit two authorized copies of the 1490 and the prescription to Prudential, Medicare B Division, P.O. Box 2000, Millville, New Jersey 08332.

All reimbursement to the provider will be made by the Medicaid Program. If a purchase has been authorized, the provider will receive a lump sum payment from Medicaid. If rental or rental purchase has been authorized, the monthly payments will be made by Medicaid only.

If the authorization is not granted, the Local Medical Assistance Unit will notify the provider of the reason(s) and will write "Authorization Denied" on the bottom line of item 7 on the SSA-1490. In such cases if the provider decides to supply the item(s), which is reimbursable under Medicare, the claim should be submitted to Medicare. Any reimbursement will be made by Medicare; Medicaid will not reimburse the provider for any deductible or coinsurance for items for which prior authorization has been denied.

305. JURISDICTION FOR AUTHORIZATION OF SERVICES: DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS

As a rule, requests for prior authorization are to be made to the Local Medical Assistance Unit (LMAU) serving the county(ies) identified by the first two digits of the eligible person's Health Services Program Case Number. A list of LMAU's and the counties which they serve is listed below:

EXCEPTIONS:

- A. Patients in Long Term Care Institutions, (e.g. skilled nursing facilities, sheltered boarding homes, special hospitals).

Requests for authorization are to be referred to the LMAU serving the county wherein the long term care facility is located.

- B. Children Identified by a Code 60 as the 3rd and 4th Digits of the Health Services Program Case Number, (e.g. 1260001234)

These children are under the jurisdiction of the New Jersey Division of Youth and Family Services (formerly Bureau of Childrens Services). Requests for authorization are to be referred to the LMAU serving the county wherein the child is residing.

BILLING PROCEDURES

<u>County Code</u>	<u>County</u>	<u>Street Address</u>	<u>Municipality</u>	<u>Zip Code</u>	<u>P.O. Box</u>	<u>Telephone</u>
01	Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1970	609-344-2861
05	Cape May	" " "	" "	" "	" "	" " "
02	Bergen	50 Main Street	Hackensack	07601		201-488-5667
03	Burlington	Chesley & Alloway Bldg. Rt. 38 & Bayrestown Rd.	Mt. Holly	08060		609-261-0448
04	Camden	530 Cooper Street	Camden	08101	19	609-365-3926
06	Cumberland	7 E. Broad Street	Bridgeton	08302	440	609-451-6550
07	Essex	796 Broad Street	Newark	07101	1576	201-648-2470
08	Gloucester	42 Delaware Avenue	Woodbury	08096	1900	609-845-7185
17	Salem	" " "	" "	" "	" "	" " "
09	Hudson	100 Newkirk Street	Jersey City	07306		201-792-6390
10	Hunterdon	6 Court Street	Flemington	08822		201-782-1130
18	Somerset	" " "	" "	" "	" "	" " "
21	Warren	" " "	" "	" "	" "	" " "
11	Mercer	324 E. State Street	Trenton	08625	2465	609-292-7315
12	Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-246-0653
13	Monmouth	320 Broad Street	Red Bank	07701		201-842-6440
14	Morris	4 Court Street	Morristown	07960		201-267-1700
19	Sussex	" " "	" "	" "	" "	" " "
15	Ocean	1851 Hooper Ave.	Toms River	08753		201-255-6226
16	Passaic	152 Market Street	Paterson	07509	2863	201-523-2800
20	Union	7 Bridge Street	Elizabeth	07201		201-355-8860

C. Patients from State Institutions

For eligible Medicaid recipients from State institutions the first two digits of the Health Services Program Identification Number identify the institution. Specific Local Medical Assistance Units have been assigned to handle prior authorization requests for patients from each institution:

<u>IF PATIENT'S HSP IDENTIFICATION NUMBER BEGINS WITH:</u>	<u>RESIDENCE IS IN:</u>	<u>CONTACT THE LOCAL MEDICAL ASSISTANCE UNIT BELOW:</u>
31	Greystone Park Psychiatric Hosp.	Morris
32	Trenton Psychiatric Hospital	Mercer
33	Marlboro Psychiatric Hospital	Monmouth
34	Ancora Psychiatric Hospital	Camden
35	N.J. Neuropsychiatric Institute	Hunterdon
36	Arthur Brisbane Child Center	Monmouth
41	Vineland State School	Cumberland
42	North Jersey Training School Totowa	Passaic
44	Woodbine State School	Atlantic
45	New Lisbon State School	Burlington
46	E.R. Johnstone Training & Research Center	Burlington
47	Woodbridge State School	Middlesex
48	Hunterdon State School	Hunterdon
90	Family Care	Mercer

BILLING PROCEDURES

305.1 Eligibility of Patients from State Institutions

Medicaid eligibility for patients/residents of State Institutions is determined by the New Jersey Division of Public Welfare's Bureau of Local Operations Area Offices. There are four Area Offices servicing the entire State. Eligibility problems should be referred to the appropriate office as designated below:

	AREA OFFICE	INSTITUTION NO. (SEE ABOVE)
Area 1	Bureau of Local Operations	#31
	Institutional Services Section	#42
	1479 Route No. 23	
	Wayne, N.J. 07470 201-696-6868	
Area 2	Bureau of Local Operations	#33
	Institutional Services Section	#36
	P.O. Box 118	#47
	Marlboro, N.J. 07746 201-946-9770	
Area 3	Bureau of Local Operations	#32
	Institutional Services Section	#35
	211 E. State Street	#46
	Trenton, N.J. 08625	#48
	609-292-5931	#90
Area 4	Bureau of Local Operations	#34
	Institutional Services Section	#41
	1170 White Horse Pike	#44
	Hammonton, N.J. 08037	#45
	609-556-2589	

306. MEDICAL SUPPLIES AND EQUIPMENT CLAIM (MC-11A-C1)

This form is to be used for the purpose of billing for medical supplies and equipment. For services requiring prior authorization, item 12 must be signed and dated by a Medicaid Medical Consultant, before the claim may be considered for payment.

306.1 Instructions for Completion of Form MC-11 (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 monthly Validation Form. (See Section 101.)
- 5-6 Self Explanatory
- 7 Self Explanatory
- 8 Self Explanatory

BILLING PROCEDURES

- 9 Name and Address of provider - (This information may be preprinted.)
- 10 Self Explanatory - Prescription must be attached to all claims not requiring prior authorization.
- 11 A. Enter date item provided.
B. Leave Blank.
C. Describe item(s) provided including name of manufacturer and model number. NOTE: If billing for oxygen indicate in this section whether oxygen was picked up by patient or if it was delivered to the patient by the provider. Also specify tank size(s).
D. Enter quantity.
E. If rental, insert the requested rental per month. If you are billing for more than one month on one claim form items A, B, C, D, E, and F must be completed for each month. If purchase, insert full amount requested.
F. Enter total charges for each item e.g. if you are requesting two (2) similar \$20. items enter \$40. in column F.
- 12 Authorization Signature - When prior authorization is required, obtain from Local Medical Assistance Unit the Medical Consultant's signature.
- 13 Prescribing Practitioner - Give name and Social Security Number of Physician or Practitioner prescribing the equipment or supplies.
- 14 LONG TERM CARE - If the patient is confined to a long term facility such as an Extended Care Facility or Skilled Nursing Home, check the appropriate block and give the name and address of the facility in the space provided.
- 15 PATIENT CERTIFICATION - Under ordinary circumstances, the patient must sign the claim form when services have been received. The claim form to be signed should indicate services 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 services 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 efforts, 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.

- 16 PROVIDER CERTIFICATION - The provider MUST sign and date form before the claim may be considered.

306.2 Mailing Instructions

Mail the Original Copy (Contractor's Copy) to:

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

Retain the second copy (Provider Copy) for your records.

The third copy (Local Medical Assistance Unit Copy) is retained by the Local Unit for all authorized claims. For claims not requiring prior authorization the provider may destroy the third copy.

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.
72-10730

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

When completed, send this form to:

The Prudential Insurance Co. of America
Medicare B Division
P. O. Box 2000—Millville, N. J. 08332

Copy from
**YOUR OWN
HEALTH
INSURANCE
CARD**
(See example
on back)

Name of patient (First name, Middle initial, Last name)

Health insurance claim number
Letter

Male Female

3 Patient's mailing address

City, State, ZIP code

Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)

Was your illness or injury connected with your employment?
 Yes No

5 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.

Insuring organization or State agency name and address

Policy or Medical Assistance Number

6 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.

Signature of patient (See instructions on reverse where patient is unable to sign)

Date signed

SIGN
HERE

PART II—PHYSICIAN OR SUPPLIER TO FILL IN THROUGHOUT

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
					\$	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No.

9 Total charges \$

10 Amount paid \$

Physician or supplier code

11 Any unpaid balance due \$

12 Assignment of patient's bill (See reverse)

I accept assignment and will accept the charge determination of the Medicare carrier as the FULL charge.
 I do not accept assignment.

13 Show name and address of facility where services were performed (If other than home or office visits)

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

MD DO DDS
Other degree _____

Date signed

*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

CHAPTER IV

LISTINGS

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Medical Supply Codes.....	25-29
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MEDICAL SUPPLY CODES

<u>CODE</u>	<u>ITEM</u>
0010	Hospital Bed (Standard)
0020	Hospital Bed (Sears Standard with Rails)
0050	Hospital Bed (Hi Lo)
0060	Hospital Bed (Hi Lo with Mattress & Rails)
0070	Hospital Bed (Bi Level)
0080	Hospital Bed (Multi Height with Rails)
0090	Hospital Bed (Multi Height with Mattress & Rails)
0100	Hospital Bed (Electric)
0110	Hospital Bed (Electric)
0140	Wheelchair (Standard)
0170	Wheelchair (Standard with commode)
0180	Wheelchair (With detachable foot rests)
0200	Wheelchair (With elevating leg rests)
0220	Wheelchair (Wooden)
0240	Wheelchair (Lightweight)
0260	Wheelchair (Lightweight with detachable leg rests)
0280	Wheelchair (Heavy duty)
0300	Wheelchair (Amputee)
0320	Wheelchair (One hand drive)
0350	Wheelchair (Electric)
0380	Suction Pumps
0420	Aspirators (Mechanical)
0470	Siderails
0500	Overbed Tables
0530	Safety Strap
0550	Tilt Table
0570	Trapeze Bars (overbed)
0610	Mattress
0640	Alternating Pressure Pads (full bed)
0670	Alternating Pressure Pads (small)
0690	Alternating Pressure Pads (Wheelchair)
0710	Bedboards
0730	Mattress Raisers
0810	Geriatric Chairs
0820	Mobile Lounge
0830	Glidabout
0850	Hemodialysis Machine
0870	Hemodialysis Equipment
0950	Bed Pans (Plastic)
0960	Bed Pans (Fracture)
0970	Bed Pans (Stainless Steel, Fracture)
0980	Bed Pans (Enamel)
1010	Commode (Standard or Heavy Duty)
1030	Commode (E & J Pivot Arm)
1040	Commode (With Adjustable Legs)
1050	Commode (Stationary Chair)
1060	Commode (Pivot Arm Mobile Chair)
1070	Wheelchair Commode

MEDICAL SUPPLY CODES

<u>CODE</u>	<u>ITEM</u>
1080	Commode (Folding Chair)
1090	Commode (Kazek padded)
1130	Whirlpools
1170	Whirlpools (Aqua Spa)
1180	Whirlpools (Imperial)
1190	Whirlpools (Thermo Jet, Arm or Foot)
1200	Whirlpools (Federal)
1210	Whirlpools (Portable E & J)
1240	Toilet Seats (Hi John)
1250	Toilet Seats (With Rails)
1260	Toilet Seats (Ejector)
1300	Toilet Rails
1310	Toilet Rails (Safety Frame)
1330	Bathtub Rails
1340	Bath Seats
1360	Sitz Baths (Regular U. Temp., overtoilet)
1370	Sitz Baths (Chair)
1400	Walkers (Non-adjustable)
1410	Walkers (Adjustable)
1420	Walkers (Folding, Non-adjustable)
1430	Walkers (Folding, Adjustable)
1440	Walkers (Non-adjustable with seat)
1450	Walkers (Adjustable with seat)
1460	Walkers (Open end with seat)
1470	Walkers (Open end with seat and crutch attach.)
1480	Walkers (Closed end with seat)
1510	Canes (Wooden)
1520	Canes (Aluminum Adjustable)
1530	Canes (Quad)
1540	Canes (Canadian)
1550	Canes (Tripod)
1590	Crutches (Wooden)
1600	Crutches (Aluminum, Adjustable)
1610	Crutches (One crutch)
1620	Crutches (Forearm Aluminum, Adjustable)
1630	Crutches (Canadian)
1670	Patient Lift
1680	Patient Lift (Bath Lift)
1710	Parallel Bars
1730	Restorators
1740	Restorators
1750	Exercycle
1760	Hand Grips
1790	Stimulators
1800	Stimulators (Birtcher)
1810	Stimulators (Minalators)
1820	Stimulators (Medcolator)
1840	Heating Pads
1850	Hydrocollators (Standard)
1860	Hydrocollators (Contoured)
1870	Aqua K Pads (With Heating Unit)

MEDICAL SUPPLY CODES

<u>CODE</u>	<u>ITEM</u>
1900	Heat Lamps (Hanova-Neptune)
1910	Heat Lamps (Infra Red)
1940	Diathermy (Sanitex)
1950	Diathermy
1960	Diathermy
1970	Diathermy
2000	Mastectomy Sleeve
2010	Jobst Lymph Sleeve
2020	Lymphedema Sleeve
2060	Surgical Stockings (Bauer & Black)
2070	Surgical Stockings (Jobst)
2080	Single Leg Leotard
2130	Stump Shrinker
2160	Therabath
2210	IPPB (P-B Series Mod. TV2P-330 or PV3P330)
2230	IPPB (Model TV4)
2240	IPPB (AP4-440)
2250	IPPB (AP5)
2260	IPPB (AP5B)
2270	IPPB (Bird Port. with Nebulizer)
2280	IPPB (Bird with Mark 7)
2290	IPPB (Hand E Vent)
2300	IPPB (Monaghan M500)
2310	IPPB (Monagham M510)
2320	IPPB (Monaghan M520)
2350	Respirators (Emerson Series 4AJ Tank 4A0 Wall)
2370	Respirators (4AF Port Compressor)
2380	Respirators (P-B Series Model PR-1)
2390	Respirators (Model PR2)
2420	Oxygen (Standard or K Cylinder)
2430	Oxygen (H Cylinder)
2440	Oxygen (G Cylinder)
2450	Oxygen (M Cylinder)
2460	Oxygen (S Cylinder)
2470	Oxygen (LC3-3000 cubic feet)
2480	Oxygen (With Cascade Aerosol)
2510	Oxygen Tents (With daily oxygen)
2540	Oxygen Regulator & Mask
2560	Oxygen Regulator
2590	Oxygen Cannula
2610	Nebulizers (Pocket Size)
2620	Nebulizers (With Oxygen Regulator)
2630	Nebulizers (Mistogen)
2640	Nebulizers (DeVilbiss Ultrasonic)
2650	Nebulizers (DeVilbiss Compressor)
2660	Nebulizers (DeVilbiss Steam)
2690	Vaporizer (Croupaire)
2720	Humidifier (Cool mist with oxygen equipment)

MEDICAL SUPPLY CODES

<u>CODE</u>	<u>ITEM</u>
2730	Humidifier (Microtherm)
2760	Emergency Oxygen (Lif O Gen)
2770	Emergency Oxygen (Lif O Gen Refill)
2780	Emergency Oxygen (E Cylinder)
2790	Emergency Oxygen (E Cylinder Refills)
2800	Emergency Oxygen (Breath O Life)
2810	Emergency Oxygen (Breath O Life Refills)
2820	Emergency Oxygen (Port a Gen)
2880	Ileal Bladder Sets (#800)
2890	Ileal Bladder Sets
2920	Ureterostomy Set (Single)
2930	Ureterostomy Set (Double)
3030	Irrigation Equipment
3100	Colostomy Belts
3110	Colostomy Belts
3120	Colostomy Belts
3140	Colostomy Clamps
3290	Slings (Ranch Armsling)
3370	Traction Sets (Cervical)
3380	Traction Sets (Pelvic)
3390	Traction Sets (Pelvic with Bucks)
3400	Traction Sets (Camp Pelvic)
3410	Traction Sets (Zimmer)
3420	Traction Sets (Overhead Pulley)
3430	Traction Sets (Shoulder, overdoor)
3440	Traction Sets (Camp-Varco Pelvic)
3460	Traction Sets (Electric, leg)
3490	Sand Bags (4)
3510	Exercise Boot
3530	Laryngectomy Tubes
3550	I.V. Stand

SUPPORTS

<u>CODE</u>	<u>ITEM</u>
3600	Supports (Misc.)
3601	Molded Leather Wrist Support
3602	Molded Leather Ankle Support
3603	Abdominal or Surgical Support
3604	Dorso-Lumbar Spinal Support
3605	Lumbar-Sacral Spinal Support
3606	Sacro-Iliac Spinal Support
3607	Orthopedic Corset with Steel Stays
3608	Rib or Abdominal Belt
3609	Hernia Support, Unilateral
3610	Hernia Support, Bilateral
3611	Scrotal Truss, Unilateral
3612	Scrotal Truss, Bilateral

MEDICAL SUPPLY CODES

<u>CODE</u>	<u>ITEM</u>
1900	Heat Lamps (Hanova-Neptune)
1910	Heat Lamps (Infra Red)
1940	Diathermy (Sanitex)
1950	Diathermy
1960	Diathermy
1970	Diathermy
2000	Mastectomy Sleeve
2010	Jobst Lymph Sleeve
2020	Lymphedema Sleeve
2060	Surgical Stockings (Bauer & Black)
2070	Surgical Stockings (Jobst)
2080	Single Leg Leotard
2130	Stump Shrinker
2160	Therabath
2210	IPPB (P-B Series Mod. TV2P-330 or PV3P330)
2230	IPPB (Model TV4)
2240	IPPB (AP4-440)
2250	IPPB (AP5)
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2270	IPPB (Bird Port. with Nebulizer)
2280	IPPB (Bird with Mark 7)
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2310	IPPB (Monaghan M510)
2320	IPPB (Monaghan M520)
2350	Respirators (Emerson Series 4AJ Tank 4AO Wall)
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2430	Oxygen (H Cylinder)
2440	Oxygen (G Cylinder)
2450	Oxygen (M Cylinder)
2460	Oxygen (S Cylinder)
2470	Oxygen (LC3-3000 cubic feet)
2480	Oxygen (With Cascade Aerosol)
2510	Oxygen Tents (With daily oxygen)
2540	Oxygen Regulator & Mask
2560	Oxygen Regulator
2590	Oxygen Cannula
2610	Nebulizers (Pocket Size)
2620	Nebulizers (With Oxygen Regulator)
2630	Nebulizers (Mistogen)
2640	Nebulizers (DeVilbiss Ultrasonic)
2650	Nebulizers (DeVilbiss Compressor)
2660	Nebulizers (DeVilbiss Steam)
2690	Vaporizer (Croupaire)
2720	Humidifier (Cool mist with oxygen equipment)

MEDICAL SUPPLY CODES

<u>CODE</u>	<u>ITEM</u>
2730	Humidifier (Microtherm)
2760	Emergency Oxygen (Lif O Gen)
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3110	Colostomy Belts
3120	Colostomy Belts
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3390	Traction Sets (Pelvic with Bucks)
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3430	Traction Sets (Shoulder, overdoor)
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3460	Traction Sets (Electric, leg)
3490	Sand Bags (4)
3510	Exercise Boot
3530	Laryngectomy Tubes
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SUPPORTS

<u>CODE</u>	<u>ITEM</u>
3600	Supports (Misc.)
3601	Molded Leather Wrist Support
3602	Molded Leather Ankle Support
3603	Abdominal or Surgical Support
3604	Dorso-Lumbar Spinal Support
3605	Lumbar-Sacral Spinal Support
3606	Sacro-Iliac Spinal Support
3607	Orthopedic Corset with Steel Stays
3608	Rib or Abdominal Belt
3609	Hernia Support, Unilateral
3610	Hernia Support, Bilateral
3611	Scrotal Truss, Unilateral
3612	Scrotal Truss, Bilateral

MEDICAL SUPPLY CODES

HEARING AIDS

<u>CODE</u>	<u>ITEM</u>
3625	Behind the Ear
3626	In the Ear
3627	Eyeglass, Binaural
3628	Eyeglass, Uninaural (With dummy)
3629	Body

CERTIFIED PROSTHETISTS AND ORTHOTISTS

Nu-Way Limb & Brace, Inc.
1412 Haddon Avenue
Camden, N.J. 08101

Kessler Associates, Inc.
10 South Harrison St.
East Orange, N.J. 07018

Ernst Orthopedics
625 Pennsylvania Avenue
Elizabeth, N.J. 07201

Cosmevo Surgical &
Orthopedic Corp.
236 River St.
Hackensack, N.J. 07602

Amsterdam Brothers, Inc.
1060 Broad Street
Newark, N.J. 07102

Arthur A. Beitman, Inc.
44 William Street
Newark, N.J. 07102

Ace Orthopedic Appliance Co.
34 French Street
New Brunswick, N.J. 08901

North Jersey Orthopedic Co.
39-43 Broad Avenue
Palisades Park, N.J. 07650

John R. Cocco, Inc.
333 Chambers Street
Trenton, N.J. 08609

Vineland Surgical Co.
516 Landis Avenue
Vineland, N.J. 08360