



## CHAPTER II

## PHYSICIAN'S SERVICES

[Feb. 1971]

at the Health Services  
Program.**DO NOT CIRCULATE**

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CHAPTER II  
PHYSICIANS' SERVICES

200. PHYSICIANS' SERVICES

201. DEFINITIONS

201.1 Physician

"Physician" means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the State in which he practices.

201.2 Physician's Services

"Physicians Services" means those services provided within the scope of practice of his profession as defined by the Laws of New Jersey, or if in practice in another State by the Laws of that State, by or under the direct personal supervision of an individual licensed by the State of New Jersey to practice medicine or osteopathy. It includes services furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere. (Exception - See Section 202.4).

Note: Direct personal supervision means that the services must be rendered in the physician's presence.

201.3 Specialist

For purposes of the Health Services Program, a Specialist is a fully licensed physician who limits his practice to his specialty and who:

1. is a diplomate of the appropriate American Board, or Osteopathic Board; or
2. is a fellow of the appropriate American Specialty College, or a member of an Osteopathic Specialty College; or
3. has been notified of admissibility to examination by the appropriate American Board, or Osteopathic Board, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association, or American Osteopathic Association; or
4. holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or
5. is recognized in the community as a specialist by his peers.

Note: Specialists rendering services outside their field of specialization will not be reimbursed as a specialist.

#### 201.4 Consultation

A consultation is advice or counsel of a qualified specialist as requested by the attending physician. This requires a personal examination of the patient with a written notation of the history, physical findings, diagnosis and recommendations of the consultant.

When the consultant assumes the continuing care of the patient any subsequent services rendered by him will no longer be considered as consultation. (See Section 201.5).

Except where medical necessity dictates, or where hospital policy (therapeutic abortion) or State Law (commitment to a mental institution) dictates otherwise, multiple and simultaneous consultations in the same specialty for the same disease, illness, or condition, whether in or out of a hospital, is not reimbursable. Reimbursement for consultations will be limited to one per specialty per hospital admission.

Consultation services can be paid only when they meet the three criteria of eligible consultation services under the Medicaid Program. To be paid, a consultation must:

- a. Be a professional service furnished to a patient by a second physician or consultant at the request of the attending physician;
- b. Include a history and examination of the patient;
- c. Include a written report.

When consultation services are performed in the doctor's office or the patient's home, the name of the referring physician must be included on the claim form. The name may be listed in section 7C of that form.

When reporting consultation services, be sure to specify whether they were limited or comprehensive.

#### 201.5 Concurrent Care

In the case of consultation, each physician is entitled to payment for services rendered, subject to limitations under Section 201.4. However, once transfer is made, reimbursement for services can only be made to the current attending physician. Concurrent care will be covered only in an emergency or a significant illness or injury status for which the medical necessity for concurrent care can be clearly established.

#### 201.6 Transfer

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

## 202. SCOPE OF SERVICE

Payment will be made for necessary medical and surgical services, subject to the following limitations.

### 202.1 Injections and Drugs Dispensed by the Physician are not Eligible

No additional payment will be made for injections or drugs dispensed by a physician.

### 202.2 Clinical Laboratory Services

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

1. Independent clinical laboratories, including physician operated out-of-hospital laboratories which perform primarily diagnostic work referred by other physicians or practitioners, and which meet the above qualifications.
2. Hospital laboratories holding valid certifications from the New Jersey Department of Health, and which provide laboratory services to ambulatory patients as requested by a practitioner.

Where laboratory service has been provided by a certified laboratory, payment shall be made only to the laboratory.

Note: A physician cannot include in his claim any charges for laboratory services when the procedures have been performed by an independent clinical laboratory.

Exception: A physician may claim reimbursement for laboratory services performed for his own patients in his own office, but these must be standard laboratory procedure. Dip tests, paper tests and tablet tests will be disallowed as reimbursable items.

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

### 202.3 Hospital-Based Physicians' Services

In the hospital setting, specific physicians' services for which the physician is reimbursed directly by the provider under contractual or other arrangements (e.g. EKG interpretations, radiological or pathological services, etc.), are considered reimbursable provider costs and must be billed to the Program by the provider and not by the physician.

### 202.4 Hospital Out-Patient Services

All services rendered to a patient registered in the hospital out-patient department are considered hospital costs, including costs of physician services, whether or not the physician receives compensation from the hospital. Services to eligible recipients who are not registered out-patients and obtain a single service on a private ambulatory basis may be billed to the Program by the treating practitioner if he is not reimbursed by the hospital for the service.

### 202.5 Services to Persons in Skilled Nursing Homes

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

### 202.6 Diagnostic and Therapeutic Radiology Services

Radiological (X-ray) services shall ordinarily be provided only by a physician who is a specialist in Radiology. However, a physician other than a radiologist may provide radiological services which are related and limited to his own special field.

Reimbursement for radiological services by physician(s), other than those covered in the preceding paragraph, will be limited to routine diagnostic chest x-rays and/or diagnostic x-rays of long bones in emergency situations.

## 203. GENERAL POLICY

### 203.1 Record Keeping

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

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

1. Date of Service.
2. Chief complaint(s)
3. Pertinent historical and physical data
4. Reports of diagnostic procedures ordered
5. Diagnoses
6. Prescription (including medication) and treatment.

Subsequent progress notes may be brief, but must include date, specific medications and/or other treatment as a minimum.

#### 204. POLICIES RELATED TO INPATIENT CARE

##### 204.1 Hospital Designated Attending Physician

If the patient is admitted to a hospital and does not have a private physician, a physician may, in accordance with regulations of the hospital's medical and governing boards, be assigned as the private physician and be reimbursed as such, provided:

1. The patient is allowed free choice of physician.
2. The physician chosen accepts the professional responsibility for the patient and provides for any required aftercare by himself or appropriate referral.

##### 204.2 Certification and Utilization Review- AID Program

Patients will be admitted to a hospital only on the direction of a physician. Under the Health Services Program, the hospital record of admission will serve as the physician's certification of need. The physician's certification and recertification and Utilization Committee's approval and reapproval must be on file at the hospital and must be kept available for audit. Certification is not required for outpatient services.

The AID Program (Approval by Individual Diagnosis) is a system whereby the initial number of days of hospitalization approved depends on the diagnosed condition for which the patient is treated.

The regulations of the New Jersey Health Services Program require that the attending physician sign a statement on or before the expiration of AID days (recertification form) certifying the medical necessity of continued hospitalization beyond the AID days.

### 204.3 Physician Responsibility for Discharge Planning

When an inpatient is to be discharged from the hospital and continuing medical care is required either in another medical facility (i.e., E.C.F., Skilled Nursing Home, etc.), or by a community health agency (e.g., Home Health Agency), a legible abstract or summary must be prepared by either the attending physician or the hospital and signed by the attending physician, covering the patient's care in the hospital with recommendations for further medical care, and made available to the institution or agency to which the patient has been referred.

### 205. PRIOR AUTHORIZATION

Definition - Prior authorization means approval before a service is rendered by a medical consultant with the New Jersey Health Services Program.

#### 205.1 Prior authorization for certain services rendered by physicians is required as follows:

a. Elective Cosmetic Surgery

Prior authorization is required from the Local Medical Assistance Unit serving the area. (See Section 305.)

b. Psychiatric Services

Prior authorization is required for psychiatric services exceeding \$300 in any 12 month period commencing with the patient's initial visit when provided in the out-patient setting and is accumulative within that period (Prior authorization is not required for out-patient psychiatric services not exceeding \$300 under same conditions listed above).

Exceptions: Payment for all psychiatric services provided an in-patient in an acute care general hospital are excluded from calculation of the \$300 limit.

When prior authorization is required this request is to be submitted to the Chief of Mental Health Services, Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, New Jersey 08625. This request must include the age, diagnosis, treatment plan and progress report in detail, prognosis and date requested authorization is to begin. No postfacto authorization will be granted.

When a request for prior authorization is approved, the Chief of the Mental Health Services shall provide the practitioner with written confirmation for continued care. Form Medicaid #33030 (Request for Authorization) will be forwarded from the Local Medical Assistance Unit and must be attached to the Practitioner Claim Form (MC-9) when submitting a claim for payment. When a request for prior authorization is denied, the practitioner shall be notified in writing of the reason.

### 206. BASIS OF PAYMENT

Reimbursement for covered services furnished under the Health Service shall be on the basis of the customary charge prevailing in the community for the same service, not to exceed an allowance determined

reasonable by the Commissioner (Institutions and Agencies), and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community. If a patient receives care from more than one member of a partnership or corporation in the same discipline, the maximum payment allowance would be the same as that of a single attending physician.

Note 1: Allowances for surgical procedures are all inclusive and additional reimbursement will be disallowed except in unusual circumstances specifically delineated by the surgeon.

Note 2: Reimbursement for psychiatric services will be made only for periods when eligibility is current.

Note 3: Reimbursement for allergy services includes specific testing procedures and, when prepared by a specialist, allergy vaccines.

Note 4: Reimbursement is not made for, and recipients may not be asked to pay for, broken appointments.

## 210. REHABILITATION AND PHYSICAL MEDICINE

### 210.1 Scope of Service

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

### 210.2 Definitions

- (a) "Rehabilitation Services" means physical therapy, occupational therapy, speech therapy and hearing services and the use of such supplies and equipment as are necessary in the provision of such services.
- (b) A "qualified physical therapist" is a graduate of a program of physical therapy approved by the Council on Education of the American Medical Association, or its equivalent, and where applicable, is licensed or registered by the State.
- (c) A "speech therapist" is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

- (d) A "qualified occupational therapist" is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

#### 210.3 Requirements

1. The physician in communication with the physical therapist, must prescribe (authorize in writing) the specific means or methods to be used by the therapist and the frequency of therapy services.
2. Physical therapy must be related to the active treatment regimen designed by the physician to elevate the patient to his maximum level of function which has been lost or reduced by reason of injury or illness.
3. "Physical therapy as needed" or a similarly worded blanket authorization does not suffice as an accepted prescription since no specific treatment is named and the physical therapist is in effect prescribing the patient's regimen.

#### 210.4 Distinction Between Physical Therapy Services And Restorative Nursing Care

1. Restorative nursing care includes such measures as maintaining good body alignment and proper positioning of bedfast patients, keeping patients active and out of bed in accordance with the physician's orders, and developing the patient's independence in activities of daily living by teaching self-care, transfer and ambulation activities by the nursing staff.
2. Nursing personnel may also assist patients in practicing the use of prosthetic and orthotic devices and in carrying out the prescribed physical treatment if requested by the physician.
3. Restorative nursing procedures performed by licensed nurses constitute a part of skilled nursing care when they are prescribed by a physician and are designed to restore functions which have been lost or reduced by illness or injury.

#### 210.5 Procedures When Prescribing All Rehabilitation Services

1. The physician should place detailed orders on the patient's chart prior to the treatment being initiated, specifying goals or potentials.
2. The physician should instruct the physical therapist, or others of the Allied Health Professions, to file notes in the patient's chart similar to nursing notes at least weekly, reflecting the patient's response to treatment.

3. The physician should review the patient's record at least every 30 days, when in a skilled nursing home, to determine if treatment is being provided according to his orders and indicate by signing the treatment records. Treatment that is being provided but which has not been prescribed or authorized by the physician should be discontinued immediately.
4. Formal physical and occupational therapy is not indicated when evidence indicates that similar types of care could be provided on the nursing unit by rehabilitative nursing or other techniques.

#### 210.6 Where Care May Be Provided

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

#### 210.7 Prior Authorization

Except in a hospital setting, prior approval of the Local Medical Assistance Unit is required for rehabilitation services. Initial or subsequent authorization shall not exceed 60 calendar days and shall be granted only when the following conditions are met:

1. All rehabilitation services of any type shall be supported by a written recommendation of a licensed physician, including a statement covering the medical necessity for therapy, the objective of treatment, a therapy prescription, and the estimated number of treatments.
2. Therapy prescriptions must be definitive as to type and scope of procedures to be rendered. Prescriptions such as "Physical therapy 3X a week, "will not be accepted."

#### 211. ENVIRONMENTAL EQUIPMENT

Under the Program, no reimbursement is allowed.

Environmental equipment is considered to be equipment which

- (a) Can withstand repeated uses, and
- (b) is primarily and customarily not used to serve a medical purpose.
- (c) and generally is not medically useful to a person in the absence of an illness or injury.

## 212. POLICY ON SHOES

### Definition

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

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

In the New Jersey Health Services Program, shoes are reimbursable under the following conditions:

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

## 220. PRESCRIPTION POLICIES

- A. This section is intended to describe the practitioner's responsibilities in the writing of prescriptions in order to maintain the traditional patient-prescriber-provider relationship and to insure the recipient free choice of provider. Practitioners are urged to familiarize themselves with all aspects of this section in order to effect economies consistent with good medical practices and to facilitate prompt payment to the provider.

All practitioners licensed or authorized to prescribe by the State of New Jersey and falling as indicated within policies of New Jersey Health Program are eligible. Out-of-State practitioners may prescribe under this Program, as herein outlined, if they meet the same requirements in their State.

The practitioner's Social Security Number must appear on all prescriptions. The appearance of this number instead of the practitioner's name serves to expedite the mechanical aspects of processing the prescription claim. This requirement is a necessary and efficient step in computing each claim.

- B. Supplies and Equipment

Medical supplies and equipment, pre-fabricated prosthetics and orthotics, and other assistive devices that are essential for the patient's medical condition are allowable unless otherwise available at no charge from community resources (ie, The American Cancer Society, service organizations, etc.).

Prior authorization must be obtained by the provider when prescribing custom-made prosthetic and orthotic appliances required to support or strengthen the body or replace parts thereof, excluding eye, ear, and mouth. Prosthetic and orthotic devices must be provided only by certified Prosthetists and/or Orthotists.

Contact Local Medical Assistance Unit to ascertain which prosthetic and orthotic providers are eligible under the Program.

C. Dosage and Direction for Allowable Drug Items

The practitioner must include specific directions on all drug prescriptions or the prescription will not be eligible for payment. Examples of non-acceptable directions are: "prn", "as directed", "ad lib", etc. This ruling does not apply for prescriptions such as topical preparations, aerosol inhalers or Nitroglycerin tablets since specific directions are seldom possible in these instances.

D. Choice of Prescription Drug

The choice of prescription drugs remains at the discretion of the prescribing practitioner.

The practitioner should give preference to:

1. Drugs listed in the latest edition of the U.S. Pharmacopoeia (USP), National Formulary (N.F.), New Drugs, and Accepted Dental Therapeutics.
2. Oral medication when as effective as injectable preparations.
3. Non-proprietary or generic named drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brand-named drugs.
4. The practitioner should note under specific conditions as listed under F (Drug Services Requiring Prior Authorization) and G (Pharmaceutical Services Not Eligible for Payment) with restriction to payment of pharmacies under certain prescription drugs.

E. Quantity of Medication

The Quantity of Medication prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not to exceed a 60-day supply.

Commonly used sustaining drug, required continuously, should be prescribed in sufficient quantities to treat the patient for up to 60 days.

If the quantity of sustaining drug or maintenance medication is not indicated in writing by the prescriber, the pharmacy provider must dispense a minimum of 100 tablets or capsules, a pint, or a 30 day supply, whichever is less.

- Exceptions: (1) Oral antibiotics, oral penicillin and oral penicillin derivatives may not be prescribed for more than a ten (10) day supply.
- (2) Oral contraceptives may be prescribed for up to a three month supply.

F. Drug Services Requiring Prior Authorization

The following therapeutic classes and dosage forms require Prior Authorization obtained by the prescribing practitioner from the Local Medical Assistance Unit. If the request is approved, an authorization number will be provided and must appear on the prescriber's original prescription. The pharmacist must check the box in the space provided on the Prescription Claim Form (MC-6) identifying a prior-authorized item, and enter the authorization number in the proper space in this area.

- (1) Antiobesics and anorexics
- (2) Oral antibiotics, oral penicillin, and oral penicillin derivatives when prescribed in quantity greater than a 10-day supply.
- (3) Injectable Medication

- Exceptions: (A) Insulin
- (B) All injectable medication when prescribed for and provided to a patient in long term care facility, i.e., Skilled Nursing Home, infirmary section of a Home for the Aged or Public Medical Institution.

G. Pharmaceutical Services Not Eligible for Payment

1. Drugs for which adequate literature, i.e., package inserts, etc., and price catalogues are not readily available.
2. Experimental drugs.
3. Drugs administered or directly furnished by the practitioner. (Payment for drugs will be made only when dispensed by a registered pharmacist in a licensed pharmacy).
4. Drugs and biologicals provided without charge through programs of other public or voluntary agencies (i.e., New Jersey State Department of Health, New Jersey Heart Association, etc.).

5. Medications prescribed for use by hospital inpatients.
6. Prescribed non-legend (OTC) drugs for patients in long term medical care facilities (i.e., skilled nursing homes, infirmary sections of a home for the aged or public medical institutions).

Exceptions: (A) Insulin  
(B) All vitamins, minerals, vitamin-mineral combinations.

7. Prescriptions written and dispensed with non-specific directions.
8. Telephoned "refill" prescriptions.
9. Food supplements, milk modifiers, infant formula and therapeutic diets.
10. Methadone

#### Policy

The New Jersey Hospital Service Plan will not reimburse pharmacies for prescriptions for Methadone. This policy applies to all uses of the drug and is not limited to its uses in persons who are addicts.

#### H. Telephone Ordered Original Prescription

Telephone orders from the prescriber for original prescriptions (with the exception of Class A narcotics) will be permitted, except as incident to an office visit.

Note: Telephone orders for refills are not permitted.

#### I. Prescription Refill

1. Refill instructions must be indicated by the practitioner on his original prescription.
2. Prescription refills will be limited to two (2) times within a six month period if so indicated by the prescriber on the original prescription.

Exceptions: (1) Oral antibiotics, oral penicillin and oral penicillin derivatives may be refilled one time within ten (10) days from the original dispensing date if so indicated by the prescriber on the original prescription.

(2) Oral contraceptives originally prescribed for a three month supply may be refilled two times within a nine month period.

3. Medical-Surgical supplies and equipment, prosthetics, orthotics, and other assistive devices are renewable only on prior authorization.

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

Composite billing for each patient should be done on a monthly basis. In all cases, claims should not be withheld for longer than 90 days accumulative.

#### 302. PATIENT IDENTIFICATION

Verify that the patient is a covered person on the first visit and each visit thereafter. This is done by viewing the patient's Validation Form (see Section 101) which is issued on the first day of each month. It is especially important to review a patient's Validation Form on each visit when extended plans of treatment have been authorized. Prior authorization is no guarantee that an individual is covered.

#### 303. PRIOR AUTHORIZATION

Items or services requiring prior authorization should not be provided until the authorization is received. When submitting claims for payment make certain all authorizations have been properly signed and are attached.

#### 304. COMBINATION MEDICARE/MEDICAID CLAIMS

There will be many patients who also have Medicare Supplementary Medical Insurance benefits (Part B). In such cases the Medicare claim form SSA-1490 will also serve as the Health Services Program claim form, where possible. The patient's Program Case Number should be entered on Item 5 of the Medicare Form.

NOTE: In cases where prior authorization is required for the Health Services Program, it must be obtained and submitted with the Medicare claim.

305. DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS

Following is a list of the Local Medical Assistance Units in the State. Except for Bureau of Children's Services cases, it should be noted that the County code number comprises the first two (2) positions of the Health Services Program (HSP) Case number, and indicates which Local Medical Assistance Unit has jurisdiction.

Certain units have been combined to effect efficiencies necessary in the Program. (Presently there are 18 units located in the State). Those counties that are combined are grouped together and bracketed on this listing. There is but one mailing address for those counties that have been combined.

<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 Cape May	1601 Atlantic Ave.	Atlantic City	08404	1970	609-344-2861
05		" "				
02	Bergen	90 Main Street	Hackensack	07601	813	201-488-5667
03	Burlington	50 Rancocas Rd.	Mt. Holly	08060	607	609-261-0443
04	Camden	709 Market St.	Camden	08101	19	609-365-3926
06	Cumberland	7 E. Broad St.	Bridgeton	08302	440	609-451-6550
07	Essex	505 S. 15th St.	Newark	07103	1576	201-548-3700
08	Gloucester Salem	10 Harrison St.	Woodbury	08096	1900	609-845-7185
17		" "				
09	Hudson	100 Newkirk St.	Jersey City	07306	8216	201-792-6390
10	Hunterdon Somerset Warren	79 Main Street	Flemington	08822	19	201-782-1130
18		" "				
21		" "				
11	Mercer	205 E. State St.	Trenton	08625	2465	609-292-7315
12	Middlesex	75 Paterson St.	New Brunswick	08903	1274	201-246-0653
13	Monmouth	320 Broad St.	Red Bank	07701	778	201-842-6440
14	Morris Sussex	6 Court Street	Morristown	07960	425M	201-267-1700
19		" "				
15	Ocean	952 President Ave. Apt. #1	Toms River	08753	1005	201-341-0804
16	Passaic	152 Market St.	Paterson	07590	2863	201-523-2800
20	Union	7 Bridge Street	Elizabeth	07201	776	201-355-8860

## BILLING PROCEDURES

### 306. PHYSICIANS AND PRACTITIONERS CLAIM (MC-8)

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

NOTE: Any laboratory services rendered by the physician or practitioner to his own patients in his own office should be billed on this form. However, any laboratory services provided by an independent laboratory must be billed directly to the Program by the laboratory, and not by the physician or practitioner.

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

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.)

Note: Fee for circumcision or other services for a new born child must be

5-6. Self-explanatory. billed as a claim for the child.

7. OTHER INSURANCE OR LIABILITY COVERAGE - If patient has other Health Insurance or Liability coverage, check appropriate block, provide the name and address of the carrier(s), and indicate the amount paid.

8. EMPLOYMENT RELATED - If patient's illness or injury is work related enter name and address of employer.

9. NAME and ADDRESS OF PROVIDER - (This information may be preprinted).

10. REPORT OF SERVICES -

A. Enter date(s) of each visit or surgical procedure.

B. Place of service (see codes at bottom of claim form).

C. Enter diagnosis.

D. Enter description of services rendered. IN ADDITION TO THE DESCRIPTION, USE OF LABORATORY OR SURGICAL PROCEDURE CODES, DESCRIBED IN THE MANUAL APPENDIX FURNISHED TO THOSE ELIGIBLE TO PROVIDE SUCH SERVICES, ALSO IS RECOMMENDED.

E. Enter charge for each service or procedure.

11-12. CERTIFICATIONS - The patient or his authorized representative and the physician or practitioner MUST sign and date their respective certifications before the claim may be considered. The statement should be read to a patient who signs by mark,

## BILLING PROCEDURES

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and witnessed by a person who knows the patient. Enter the name and address of the witness. If the patient is a minor, or cannot sign because of his physical or mental condition, a parent or guardian should sign and indicate relationship.

### 306.2 Reimbursement for Anesthesiology Services

A copy of the hospital anesthesiology record must be attached to the claim form (MC-8) when the claim is submitted to the Contractor for reimbursement.

### 306.3 Medical Groups

The instructions in Section 306.1 apply also to medical groups, but the individual physician rendering each service must be identified by name.

### 306.4 Mailing Instructions

Mail the original copy (Contractor's copy) together with any authorization forms (where appropriate) to:

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



## CHAPTER IV

### LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

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## CHAPTER IV

### LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

CODE  
NUMBER

#### SPECIAL CLINICAL TESTS

8556 Basal metabolic rate (BMR)

#### BLOOD EXAMINATIONS

8591 RH and other subgroup antibody titrations (saline agglutinations, albumin agglutinins, Coombs titration, etc.)  
8601 Acid hemolysis (Ham test)  
8605 Amylase, quantitative  
8608 Ascorbic acid  
8610 Bilirubin, total serum  
8611 Van den Bergh, Qualitative (total), Direct and Indirect  
8614 Bleeding time, skin puncture  
8617 Blood culture, aerobic and anaerobic  
8618 Blood culture, definitive (colony count)  
8620 Blood, red cell count (erythrocyte also RBC)  
8622 Blood, hemoglobin determination, Photoelectric method (HGB)  
8623 Hematocrit (macro or micro also HCT)  
8624 Blood, white cell count (WBC)  
8626 Blood, differential count (DIFF)  
8628 Complete blood count: hemoglobin, white cells, red cells and/or hematocrit, differential (CBC)  
8636 Bone marrow study--examination of smear with interpretation with collection of material--same physician  
8640 C-reactive protein (CRP)  
8641 Calcium (CA)  
8643 Carbon dioxide content or combining power  
8646 Cephalin flocculation (Ceph. Flocc.)  
8647 Carbon monoxide, spectrometric  
8650 Chloride  
8652 Cholesterol, total (Choles.)  
8658 Coagulation time (Lee and White)  
8661 Complement fixation tests (Wasserman, Kolmar, Reiter, etc.)  
8675 Flocculation tests, (Kline, Mazzini, VDRL, etc.)  
8664 Creatinine or creatine (Creat.)  
8683 Heterophile antibodies: presumptive or "mono"  
8684 Heterophile antibodies: presumptive and confirmatory

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

CODE  
NUMBER

8688 Lactic dehydrogenase (LDH)  
8689 Isocitric dehydrogenase (IDH)  
8690 Icterus index (Indies)  
8692 Lipase  
8693 Lipids, total  
8700 Phosphatase, acid  
8701 alkaline or prostatic acid  
8702 Phosphorus  
8704 Platelet count  
8706 Potassium (K)  
8707 Iodine: protein bound (PBI)  
8709 Prothrombin time (P.T.)  
8713 Reticulocyte count  
8714 Latex fixation (RA test)  
8717 Iron, serum  
8720 Sedimentation rate (Sed Rate)  
8721 Sickle cell preparation  
8724 Sodium (NA)  
8726 Glucose (sugar) quantitative  
8727 Glucose (sugar) tolerance, 3 hours - (four specimens)  
8731 Thymol turbidity  
8733 Protein, total  
8737 ABO and Rh typing  
8738 Rh (D), Rh (E), Hr (C), Hr (O)  
8739 Coombs test (direct or indirect)  
8740 Crossmatch: Compatibility tests, complete including ABO  
and Rh, Saline, Albumin and Coombs  
8741 Typing for Kell and other rare subgroups,  
(screening for atypical antibodies)  
8743 Urea clearance  
8744 Urea nitrogen (BUN)  
8746 Uric acid  
8747 Transaminase (SGO-T or SPG-T)  
8761 Triglycerides (neutral fat)

FECES EXAMINATIONS

8800 Blood, occult (stool)  
8803 Ova and parasites, (concentrated method)  
8807 Routine chemical and microscopic examination including fat,  
trypsin, occult blood  
8813 Culture, screening  
8814 definitive

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

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CODE  
NUMBER

GASTRIC OR DUODENAL CONTENTS EXAMINATIONS

8820 Gastric analysis: routine fractional without histamine  
8848 Smear and culture, (concentrated) for A.F.B.

SPINAL FLUID EXAMINATIONS

8853 Routine chemical (Pandy)  
8855 Routine microscopic (cell count)  
8861 Colloidal gold or gum mastic  
8874 Culture for bacteria screening, definitive

SPUTUM EXAMINATIONS

8881 Acid fast smear, direct  
8892 Culture, pyogenic bacteria, screening

TISSUE EXAMINATIONS

8903 Surgical gross and microscopic, (examination and report) -  
Specimen obtained out of hospital, single  
8907 Frozen section examination (with or without pre-operative  
examination)  
8911 Culture for bacteria screening  
8912 Culture for bacteria, definitive  
8917 Cytological study (papanicolaou smear or pap smear)

URINE

8925 Urobilinogen, qualitative  
8934 Complete routine (chemical and microscopic)  
8938 Phenosulfonphthalein (P.S.P.)  
8941 Smear for bacteria  
8942 Culture for bacteria screening  
8943 Culture for bacteria, definitive

MISCELLANEOUS EXAMINATIONS

8955 Sensitivity studies, bacterial: disc technique, up to  
10 antibodies  
8974 Smears for bacteria, stained, any type  
8981 Semen analysis, complete  
8986 Autogenous vaccine

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

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CODE  
NUMBER

PREGNANCY TESTS

8962	Animal (rabbit or rat)
8964	Routine prenatal: Serology, typing, Rh
8965	Amniocentesis and spectrophotometric analysis of amniotic fluid

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

SURGERY

INTEGUMENTARY SYSTEM

Excision

- 0171 Biopsy; excision of skin, subcutaneous tissue or mucous membrane for biopsy (including simple closure) (independent procedure)
- 0175 Excision (including simple closure) of BENIGN cicatricial, fibrous, inflammatory, congenital, cystic, etc., lesions of skin, subcutaneous tissue or mucous membrane; lesion diameter up to 1/4 inch (anything over indicate size)
- Excision (including simple closure) or treatment by any other method (except radiation) of MALIGNANT lesions of skin or mucous membrane (except melanoma) to include local anesthesia.
- 0188 Trunk, arms or legs: lesion diameter up to 1/4 inch (anything over indicate size)
- 0191 Face, scalp, ears, neck, hands, feet, genitalia: lesion diameter up to 1/4 inch (anything over indicate size)
- 0194 Eyelids, nose, lips, mucous membrane: lesion diameter up to 1/4 inch (anything over indicate size)
- 0238 Excision of pilonidal cyst or sinus

Repair--Simple

- 0251 Wounds, recent, up to 2 1/2 inches (anything over indicate size)

Destruction

- 0401 Electro-surgical destruction with or without surgical curettement of facial nevi, leukoplakia, actinic or senile keratoses, or keratoacanthomas, to include local anesthesia, one lesion (if more than one give number)
- 0403 Electro-surgical destruction (except 0401) or chemocautery or cryocautery of BENIGN or PRE-MALIGNANT lesions of skin or mucous membrane with or without curettement, one lesion (if more than one give number)

BREAST

Excision

- 0444 Excision of cyst, fibro-adenoma or other benign tumor, aberrant breast tissue, duct lesion (including gynecomastia) or nipple lesion (including any other partial mastectomy) male or female, unilateral

0457 Complete (simple) mastectomy

MUSCULOSKELETAL SYSTEM

Incision

0516 Removal of metal band, plate, screw or nail (independent procedure)

0537 Osteotomy cutting, division or transection of smaller bones (fibula, metacarpals, metatarsals, etc.) with or without internal fixation.

Excision

0561 Patellectomy or hemipatellectomy

0563 Metatarsectomy

0567 Excision of chondroma, osteochondroma, or exostosis; humerus, pelvis, femur, tibia, radius, fibula, ulna small bones

0577 Partial ostectomy; partial excision of bone, craterization, guttering or saucerization of bone; diaphysectomy; small bones

Introduction

0598 Removal buried wire or pin (independent procedure)

Spinal Fusion

0639 Spinal fusion with removal of intervertebral disc, cervical region, posterior, technique

Fractures

Facial Bones

0686 Nasal, uncomplicated (digital) closed reduction

0688 Nasal, open reduction, uncomplicated

0699 Maxilla, closed reduction, with wiring of teeth

0704 Mandible, closed reduction and wiring of teeth

Spine and Trunk

0722 Vertebral body, one or more requiring reduction

0741 Clavicle, simple, closed reduction

0761 Ribs, simple

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Upper Extremity

- 0780 Humerus, surgical neck simple, requiring manipulative reduction
- 0784 shaft, simple, closed reduction
- 0789 supracondylar or dicondylar, closed reduction
- 0793 medial or lateral condyle, simple, closed reduction
- 0799 Radius, head, simple, closed reduction
- 0803 shaft, simple, closed reduction
- 0807 distal end (e.g. Colles type), simple, closed reduction
- 0815 Ulna, proximal end, shaft, simple, closed reduction
- 0821 Radius and ulna shaft, simple, closed reduction
- 0827 Carpal bones, one or more, simple reduction
- 0842 Metacarpal, simple or compound, one, closed reduction with uncomplicated soft tissue closure
- 0943 more than one, simple or compound, closed reduction, with uncomplicated soft tissue closure
- 0853 Phalanx or phalanges, finger, proximal, middle or thumb, simple, closed reduction

Lower Extremity

- 0872 Femur, intertrochanteric, simple, no reduction
- 0873 intertrochanteric, with fixation or traction
- 0874 intertrochanteric, simple or compound, open reduction
- 0881 shaft, including supracondylar, simple, closed reduction
- 0894 Tibia, proximal end, tibial plateaus, condyle, condyles or intercondylar spines, simple, closed reduction
- 0902 shaft closed reduction
- 0921 Fibula, distal end, malleolus, simple, closed reduction
- 0926 Tibia and fibula, shafts, simple, closed reduction

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

- 0933 Ankle, bimalleolar (including Potts) simple, closed reduction
- 0938           trimalleolar, simple, closed reduction
- 0944 Tarsal (except astragalus and os calcis) one or more, simple, closed reduction
- 0955 Astragalus, simple, closed reduction
- 0961 Os calcis, simple, closed reduction
- 0967 Metatarsal, simple, closed reduction
- 0976 Phalanx or phalanges, great toe, simple, closed reduction
- 0981           other than great toe, simple, closed reduction

Joints

Incision

- 1001 Arthrotomy or capsulotomy with exploration, drainage, or removal of loose body, e.g., osteochondritis or foreign body; shoulder
- 1007           hip
- 1008           knee
- 1044           arthrocentesis; puncture for aspiration of hemarthrosis, initial

Excision

- 1082 Arthrectomy, Meniscectomy: excision of semilunar cartilage of knee joint
- 1102           Synovectomy knee

Repair

- 1149 Arthroplasty, hip, cup replacement prosthesis, primary for fracture
- 1176 Arthrodesis, knee
- 1179           hammer toe operation, one toe (e.g., inter-phalangectomy)

Manipulation

- 1221 Shoulder
- 1227 Knee

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Dislocations

- 1285 Shoulder (humerus), simple, closed reduction, with anesthesia  
1315 Finger, one, one or more joints, simple, closed reduction  
1350 Patella, simple, closed reduction

Bursae

Incision

- 1413 Needle puncture of bursa, with or without aspiration, injection or irrigation, initial or subsequent

Excision

- 1435 Excision of bursa, subacromial (subdeltoid)

Muscles

Incision

- 1460 Muscle biopsy, superficial

Suture

- 1496 Suture of ruptured diaphragm, transthoracic or combined

Tendons, Tendon Sheaths and Fascia

Tenotomy

- 1535 Tenotomy, subcutaneous, corrective, single digit

Excision

- 1550 Excision of lesion of tendon or fibrous sheath, or ganglion, in other locations

Repair

- 1583 Repair or suture of a flexor tendon, primary or late, finger, hand or forearm, foot or leg  
1589 Tenolysis, single  
1591 Lengthening or shortening of tendon, (e.g. Achilles' tendon)

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Extremities

Amputation

- 1737 Digit (finger or thumb), any joint or phalanx, one, with or without split or Wolff graft, or skin-plasty and / or tenodesis, with or without resection of digital nerves
- 1760 Thigh, through femur, including supracondylar open (guillotine)
- 1771 Leg, through tibia and fibula open (Guillotine)
- 1785 Foot, transmetatarsal
- 1802 Toe, one, with or without split or Wolff graft, or skin-plasty and/or tenodesis, with or without resection of digital nerves

Plaster Casts (Independent Procedure Only)  
(Excluding Cost of Materials)

- 1865 Ankle (foot to midleg) (short leg)
- 1867 Knee (foot to thigh) (long leg)
- 1891 Unna boot

RESPIRATORY SYSTEM

Nose

Excision

- 1916 Excision of nasal polyp (s) one or more, unilateral or bilateral, one or more stages, office
- 1928 Submucous resection, classic, nasal septum

Repair

- 1950 Rhinoplasty, lateral and alar cartilages and/or elevation of nasal tip
- 1959 Repair, choanal atresia, intranasal

Destruction

- 1966 Cauterization of turbinates, unilateral or bilateral (independent procedure)
- 1971 Nasal hemorrhage, anterior, control of unilateral or bilateral, with or without cauterization or anterior packs

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Accessory Sinuses

Incision

- 1981 Antrum lavage, puncture or natural ostium, unilateral  
1985 Antrotomy, intranasal, unilateral

Excision

- 2006 Ethmoidectomy, intranasal or external, unilateral

Larynx

Excision

- 2055 Hemilaryngectomy

Introduction

- 2062 Endotracheal intubation, emergency procedure

Endoscopy

- 2070 Laryngoscopy, indirect with biopsy  
2071 direct, diagnostic (independent procedure)  
2073 operative including foreign body removal with biopsy  
2074 operative, including foreign body removal including excision of tumor

Trachea and Bronchi

Incision

- 2101 Tracheotomy (independent procedure)

Endoscopy

- 2111 Bronchoscopy, diagnostic  
2113 with biopsy  
2120 with excision of tumor

Suture

- 2144 Closure of tracheostomy or tracheal fistula

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Incision

- 2151 Thoracotomy, exploratory, including biopsy
- 2157           with closed drainage of empyema cavity; tube drainage with negative pressure (independent procedure), in hospital
- 2170 Pneumonotomy, with open drainage of pulmonary abscess or cyst
- 2180 Pneumonocentesis: puncture of lung for aspiration biopsy
- 2183 Thoracentesis: puncture of pleural cavity for aspiration, initial or subsequent

Excision

- 2191 Pneumonectomy, total
- 2193 Lobectomy, total, subtotal or segmental
- 2195 Wedge resection, single or multiple
- 2197 Pleurectomy, any type (independent procedure)

Surgical Collapse Therapy

- 2221 Pneumothorax: intrapleural injection of air, initial

CARDIOVASCULAR SYSTEM

Heart and Pericardium

Introduction

- 2331 Catheterization of heart, including recording of intra-cardiac pressures where indicated (independent procedure left, percutaneouw

Repair

- 2356 Insert internal pacemaker with myocardial electrodes, initial

Arteries and Veins

Incision

- 2375 Arteriotomy, extremity
- 2381 Phlebotomy, extremity

Excision

- 2392 Thromboendarterectomy, abdominal aorta and iliac arteries and/or femoral and/or popliteal arteries

2412 Excision and graft, thoracic aorta, extremity

Introduction

2443 Exposure of and incision into vein ("cutdown") for fluid therapy or indirect transfusion, under one year of age

2444 over one year of age

2445 Blood transfusion, indirect method

2446 replacement type, infant, initial or subsequent

Suture

2516 Phleborrhaphy: suture of wound or injury of vein (independent procedure), trunk extremity

2561 Ligation and division and complete stripping of long or short saphenous veins, unilateral

2562 bilateral

2563 long and short saphenous veins, unilateral

2565 bilateral

2576 Ligation and division of short saphenous vein at saphenopopliteal junction

2581 minor varicose vein of leg, initial

HEMIC AND LYMPHATIC SYSTEMS

Lymph Nodes and Lymphatic Channels

Excision

2658 Radical Lymphadenectomy, Axilla

MEDIASTINUM

Incision

2691 Excision of mediastinal cyst

DIGESTIVE SYSTEM

Lips

Repair

2754 Plastic repair of cleft lip, primary, unilateral

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Tongue

Excision (Glossectomy)

- 2781 Biopsy of tongue, anterior third
- 2785 Partial glossectomy or hemiglossectomy

Palate and Uvula

Repair

- 2890 Palatoplasty: plastic operation for cleft palate, partial

Salivary Glands and Ducts

Incision

- 2914 Sialolithotomy, submaxillary or parotid, uncomplicated

Manipulation

- 2961 Dilation of salivary duct; ptyalectasis

Pharynx, Adenoids and Tonsils

Incision

- 2970 Drainage of peritonsillar abscess

Excision

- 2990 Excision branchial cleft syst or vestige, extending beneath subcutaneous tissues
- 2992 Tonsillectomy, with or without adenoidectomy, under age 18 years
- 2993 18 years or over
- 3000 Excision of tonsil tag (s), hospital.

Esophagus

Excision

- 3043 Esophagectomy: resection of esophagus, transpleural or extrapleural (upper two-thirds)
- 3045 Esophagogastrectomy, combined thoraco-abdominal
- 3046 Local excision, end-to-end anastomosis

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Endoscopy

3051 Esophagoscopy, diagnostic

3055 with biopsy

Repair

3073 Esophagomyotomy (Heller type)

Stomach

Excision

3111 Biopsy by laparotomy

3114 Total gastrectomy

3115 Subtotal or hemi-gastrectomy, without vagotomy

3116 with vagotomy

Endoscopy (independent procedure)

3121 Gastroscopy, diagnostic

Intestines (Except Rectum)

Excision

3171 Excision of one or more lesions of small or large bowel not requiring anastomosis, exteriorization or fistulization, single enterotomy

3174 Enterectomy: resection of small intestine with anastomosis

3178 Colectomy, partial resection of large intestine in two stages, including first stage colostomy or cecostomy

3179 Colectomy, partial, with anastomosis, with or without concomitant proximal colostomy

3193 Enterostomy, small bowel (ileostomy or jejunostomy)

3195 large bowel, (colostomy or cecostomy)

3200 Reduction of volvulus, intussusception, internal hernia, by laparotomy

3204 Revision of colostomy, complicated (reconstruction in depth)

Destruction

3211 Enterolysis (freeing of intestinal adhesion)

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

3212 Enterolysis with acute bowel obstruction

Suture

3225 Closure of enterostomy, large or small intestine

Meckel's Diverticulum and the Mesentery

Excision

2331 Excision of Meckel's diverticulum (diverticulectomy)

Suture

3241 Suture of Mesentery

Appendix

Excision

3261 Appendectomy

Rectum

Incision

3283 Incision and drainage of deep supralevator, pelvirectal or retrorectal abscess

Excision

3291 Complete proctectomy, combined abdomino-perineal, one or two stages

3295 Excision of rectal procidentia, with anastomosis, abdominal and perineal approach

Endoscopy (independent procedure)

3310 Proctosigmoidoscopy, diagnostic, initial

Repair

3323 Proctopexy for prolapse, abdominal approach

Anus

Incision

3351 Fistulostomy or fistulectomy, subcutaneous

3356 Incision and drainage of ischiorectal abscess (independent procedure)

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

- 3357 Incision and drainage, perianal abscess
- 3364 Sphincterotomy, anal: division of anal sphincter (independent procedure)

Excision

- 3371 Fissurectomy; with or without sphincterotomy
- 3372 Cryptectomy, single, office
- 3377 Hemorrhoidectomy, external, complete
- 3380           internal and external

Introduction

- 3401 Hemorrhoids, injection of sclerosing solution

Endoscopy (independent procedure)

- 3411 Anoscopy, diagnostic with or without biopsy

Repair

- 3427 Sphincteroplasty, anal, for incontinence, Thiersch procedure for incontinence and/or prolapse

Liver

Incision

- 3456 Aspiration biopsy of liver

Excision

- 3464 Hepatectomy, partial: resection of liver

Biliary Tract

- 3495 Choledochotomy or choledochostomy with exploration, drainage or removal of calculus, with or without cholecystotomy
- 3504 Cholecystotomy or cholecystostomy with exploration, drainage or removal of calculus

Excision

- 3515 Cholecystectomy
- 3517           with open exploration of common duct

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Repair

3519 Direct anastomosis of gallbladder and gastro-intestinal tract

Pancreas

Excision

3550 Pancreatectomy, subtotal

Repair

3565 Marsupialization of cyst of pancreas

Abdomen, Peritoneum and Omentum

Incision

3571 Exploratory laparotomy; exploratory celiotomy

3578 Retroperitoneal abscess

3588 Peritoneocentesis: abdominal paracentesis, initial

Introduction

3611 Pneumoperitoneum: intraperitoneal injection of air, initial

Repair

Hernioplasty, Herniorrhaphy, Herniotomy:

3631 Inguinal, unilateral

3633           with orchietomy

3634           with excision of hydrocele

3635           recurrent

3646 Femoral, unilateral

3661 Ventral, incisional

3663 Epigastric

3665 Umbilical, under age five years

3667 Omphalocele, in new born, one stage

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Suture

3734 Secondary suture of abdominal wall for evisceration or disruption

URINARY SYSTEM

Kidney

Incision

3811 Nephrolithotomy, removal of calculus

3815 Pyelotomy with exploration

3817 Pyelotomy with removal of calculus; pyelolithotomy; pelviolithotomy

Excision

3820 Renal biopsy, trochar or needle

3821 Nephrectomy, including partial ureterectomy

3824 Heminephrectomy

3827 Excision of cyst of kidney

Repair

3831 Pyeloplasty: plastic operation on renal pelvis with or without plastic operation on ureter or nephropexy

3835 Nephropexy: fixation or suspension of kidney (independent procedure)

Ureter

Incision

3851 Ureterotomy with exploration or drainage (independent procedure)

3857 Ureterolithotomy, upper three quarters of ureter

Excision

3861 Ureterectomy, with bladder cuff (independent Procedure)

Repair

3871 Ureteroplasty: plastic operation on ureter (stricture)

3875 Ureteroureterostomy

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

- 3876 Ureteronecystostomy: anastomosis of ureter to bladder, unilateral  
3884 Ureterostomy: transplantation of ureter to skin, unilateral

Bladder

Incision

- 3900 Aspiration of bladder by needle or trochar  
3904 Cystotomy or cystostomy with fulguration  
3906 Cystotomy with drainage; cystostomy  
3907 Cystotomy with removal of calculus (cystolithotomy) without vesical neck resection

Excision

- 3911 Cystectomy, partial  
3913           complete  
3918 Transurethral resection, vesical neck, female or child  
3920 Excision of bladder diverticulum (independent procedure)  
3922 Excision of bladder tumor  
3924 Transurethral resection of bladder tumors, large

Introduction

- 3926 Bladder irrigation, simple, lavage and/or instillation  
Cystoscopy:  
3930 Diagnostic, office, initial  
3932           with ureteral catheterization  
3933 Diagnostic, hospital  
3934           with ureteral catheterization  
3935 With biopsy  
3937 With fulguration of small bladder tumors (0.5 cm. to 2 cm.)  
3940 With dilatation of bladder, for interstitial cystitis, general anesthesia

- 3942 With ureteral meatotomy
- 3943 With resection or fulguration of ureterocele
- 3944 With removal of foreign body from urethra or bladder
- 3945 With removal of calculus from ureter
- 3946 With manipulation of ureteral calculus, primary

Destruction

- 3951 Litholapaxy: crushing of calculus in bladder and removal of fragments

Suture

- 3963 Closure of cystostomy (independent procedure)
- 3965 Closure of vesicovaginal, vesicouterine, or vesicoenteric fistula

Urethra

Incision

- 3971 Urethrotomy, external (independent procedure) anterior
- 3977 Meatotomy: cutting of meatus (independent procedure)

Excision

- 3991 Excision of diverticulum of urethra (independent procedure)

Endoscopy

- 4000 Urethroscopy, diagnostic
- 4001 with removal of calculus or foreign body
- 4004 with internal urethrotomy
- 4006 with fulguration of posterior urethra

Repair

- 4011 Urethroplasty: plastic operation on urethra

Suture

- 4023 Closure of urethrostomy or fistula of urethra (independent procedure)
- 4025 Closure of urethrovaginal fistula

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Manipulation

- 4031 Dilation of urethral stricture by passage of sound, initial, male
- 4033 Dilation of urethral stricture by passage of filiform and follower, male
- 4035 Passage of filiform and follower for acute vesical retention, male
- 4036 Dilation of female urethra including suppository and/or installation
- 4037 subsequent within 30 days

MALE GENITAL SYSTEM

Penis

Incision

- 4101 Dorsal or lateral "slit" of prepuce (independent procedure)

Excision

- 4111 Biopsy of penis (independent procedure)
- 4122 Circumcision, clamp procedure, newborn

Repair

- 4131 Plastic operation on penis for hypospadias, straightening of chordee

Testis

Excision

- 4140 Biopsy, needle (independent procedure)
- 4143 Orchiectomy, simple unilateral
- 4144 bilateral

Repair

- 4156 Orchiopexy, any type, with or without hernia repair

Epididymis

Excision

- 4171 Biopsy of epididymis, needle
- 4174 Excision of spermatocele with or without epididymectomy

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

4176 Epididymectomy, unilateral

Tunica Vaginalis

Incision

4191 Puncture aspiration of hydrocele with or without injection of medication

4200 Repair of hydrocele (Bottle type)

4201 Excision of hydrocele, unilateral

Vas Deferens

Incision

4231 Vasotomy: incision or transection of vas, unilateral or bilateral  
(independent procedure)

Excision

4241 Vasectomy, unilateral or bilateral (independent procedure)

Repair

4251 Vasovasostomy, unilateral

Spermatic Cord

Excision

4271 Excision of hydrocele of spermatic cord (independent procedure), unilateral

4275 Excision of varicocele (independent procedure), unilateral

4278 with hernia repair

Seminal Vesicles

Excision

4291 Vesiculectomy

Prostate

Incision

4300 Biopsy, prostate, needle, single or multiple

4303 Prostatotomy: external drainage of prostatic abscess

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Excision

- 4316 Prostatectomy, perineal, suprapubic, one or two stages  
4318 Prostatectomy, retropubic

Endoscopy

- 4321 Transurethral resection of prostate, including control of postoperative bleeding, complete

FEMALE GENITAL SYSTEM

Vulva and Introitus

Incision

- 4403 Incision and drainage, abscess of vulva  
4405 Incision and drainage of Bartholin's gland abscess, unilateral

Excision

- 4433 Excision of Bartholin's gland or cyst  
4436 Excision or fulguration of Skene's glands  
4437 Excision or fulguration of urethral caruncle

Repair

- 4447 Plastic repair of urethrocele (independent procedure)

Vagina

Incision

- 4462 Colpocentesis (independent procedure)  
4463 Puncture and aspiration of cul de sac  
4471 Biopsy of vaginal mucosa (independent procedure)  
4473 Colpocleisis, complete obliteration of vagina  
4475           Le Fort type

Repair

- 4479 Colporrhaphy: suture of injury of vagina (non-obstetrical)

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

- 4480 Colpoperineorrhaphy: suture of injury of vagina and/or perineum (non-obstetrical)
- 4481 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele (independent procedure)
- 4484 Posterior colporrhaphy, repair of rectocele (independent procedure)
- 4485         with perineoplasty or perineorrhaphy
- 4488 Combined anterior-posterior colporrhaphy
- 4492 Urethral suspension, abdominal approach (Marshall-Marchetti type)
- 4494 Repair of enterocele vaginal approach

Oviduct

Incision

- 4531 Transection of Fallopian tube, unilateral or bilateral, abdominal or vaginal approach

Excision

- 4541 Salpingectomy, complete or partial, unilateral or bilateral (independent procedure)
- 4545 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (independent procedure)
- 4551 Salpingoplasty, unilateral or bilateral (independent procedure)

Ovary

Incision

- 4562 Drainage of ovarian cyst, abdominal approach, unilateral or bilateral
- 4565 Drainage of ovarian abscess, abdominal approach

Cervix Uteri

Excision

- 4571 Biopsy or local excision of lesion, with or without fulguration, quadrant biopsy (independent procedure)
- 4572 Cauterization of cervix, office

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

4573 Biopsy of cervix, circumferential (cone) with or without dilation and curettage, with or without Sturmdorff type repair

4575 Trachelectomy: cervicectomy: amputation of cervix (independent procedure)

Introduction

4583 Insertion of intra-cervical or intra-uterine device

Repair

4586 Tracheloplasty: surgical repair of incompetent cervix, Shirodkar type

Manipulation

4589 Dilation and curettement of cervical canal

Corpus Uteri

Excision

4610 Endometrial biopsy (independent procedure)

4612 Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical)

4613 Myomectomy: excision of fibroid tumor of uterus (independent procedure, non-obstetrical)

4614 Total hysterectomy (corpus and cervix) with or without tubes, and/or ovaries, one or both

4620 Radical hysterectomy for cancer including regional lymph nodes

4631 Vaginal hysterectomy

4632 with plastic repair of vagina, anterior and/or posterior colporrhaphy

Repair

4683 Uterine suspension with or without shortening of round ligaments (independent procedure)

Perineum

Incision

4720 Incision and drainage of perineal abscess (non-obstetrical)

Repair

4742 Perineorrhaphy, post-partum, by other than delivering physician

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

MATERNITY

Incision

4801 Classic cesarean section

Excision

4811 Ectopic pregnancy, tubal, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach

Manipulation

4822 Obstetrical delivery (with or without low forceps, and/or episiotomy) and including hospital postpartum care

4851 Abortion, first trimester, incomplete, completed surgically, (dilatation and curettage)

4854 Abortion, second trimester, (incomplete) completed surgically, (dilatation and curettage)

4870 Dilatation and curettage of uterus for post-partum bleeding

ENDOCRINE SYSTEM

Thyroid Gland

Incision

4904 Incision and drainage of thyroglossal cyst (infected)

Excision

4911 Local excision of small cyst or adenoma of thyroid

4912 Total thyroid lobectomy, unilateral

4914 Thyroidectomy, total or complete

4917 subtotal or partial

4924 total or subtotal for malignancy with radical neck dissection

4941 Excision of thyroglossal duct, cyst or sinus

Parathyroid, Thymus, Pituitary, Pineal,  
Adrenal Glands and Carotid Body

Excision

4971 Parathyroidectomy or exploration of parathyroid

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

NERVOUS SYSTEM

Skull, Meninges and Brain

Craniotomy following Trauma:

Incision

- 5001 Burr holes, unilateral, exploratory for subdural puncture, not followed by surgery
- 5003 Evacuation of hematoma, subdural, extradural, or intracerebral by burr holes only
- 5004 requiring craniotomy

Repair

- 5018 Elevation of depressed skull fracture, simple
- 5022 Cranioplasty for skull defect, bone, metal or plastic

Craniotomy for Non-Traumatic causes:

Incision

- 5101 Burr holes, exploratory or ventricular puncture, not followed by surgery
- 5106 Craniotomy for drainage of brain abscess
- 5112 Sub-occipital craniectomy for tractotomy or section of 5th, 8th, 9th, or other cranial nerves
- 5116 Craniotomy for lobotomy, unilateral
- 5122 Subdural tap through fontanelle (infant)

Excision

- 5130 Osteoplastic craniotomy for excision of brain tumor, abscess, or cyst, supratentorial
- 5132 Sub-occipital craniectomy for brain tumor

Introduction

- 5152 Burr holes with ventriculography, not followed by surgery
- 5155 Ventricular puncture with introduction of dye and recovery
- 5159 Injection procedure for pneumoencephalography

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Repair

5162 Repair of encephalocele

Spine and Spinal Cord

Incision

5198 Spinal puncture, lumbar, simple (independent procedure)

Excision

5208 Laminotomy for removal of intervertebral discs, cervical

5209 thoracic

5210 lumbar

5211 Excision of intervertebral discs, anterior approach, cervical

Introduction

5214 Injection procedure for myelography

Repair

5225 Laminectomy for spondylolisthesis

5227 Repair of meningocele

5229 Repair of meningomyelocele

Peripheral Nerves

Other Extracranial Nerves, and Ganglia

Incision

5252 Phrenic nerve transection or avulsion

Excision

5273 Excision of surgically identifiable neuroma of cutaneous nerve

5274 digital nerve, one or both, same digit

5282 Obturator neurectomy

Introduction

5294 Alcohol injection, 2nd or 3rd branch of trigeminal nerve

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Nerve Block

- 5298 Paravertebral block, lumbar or thoracic
- 5300 Sympathetic block (cervical)
- 5302 Stellate ganglion
- 5311 Brachial plexus block
- 5312 Intercostal nerves
- 5313 Lumbar, sacral and coccygeal nerves
- 5317 Sciatic nerve
- 5318 Phrenic nerve
- 5319 Other peripheral nerves

Repair

Neurorrhaphy:

- 5320 Digital, one

Neuroplasties:

- 5347 Median nerve decompression at carpal tunnel, simple

Vegetative Nervous System

Excision

Sympathectomies:

- 5371 Cervical, unilateral
- 5381 Lumbar, unilateral
- 5382           bilateral
- 5385 Splanchnicectomy (Peet type) unilateral
- 5390 Presacral neurectomy, hypogastric plexus

EYE

Diagnostic and Manipulative Procedures

- 5404 Refraction without cycloplegic or mydriatic

5406 Orthoptic evaluation

Eyeball

Excision

5421 Enucleation of eyeball with or without sphere implant

5427 Evisceration of eyeball

5431 Suture of eyeball for wound or injury

Cornea

Incision

5441 Keratotomy, any type

5443 Paracentesis of cornea

5445 Removal of foreign body from surface of cornea

5448 under slit lamp

Excision

5451 Keratectomy, partial

5457 Pterygium

Sclera

Excision

5501 Sclerectomy for glaucoma, with scissors, punch or trephination

Iris and Ciliary Body

Incision

5531 Iridotomy

5534 Iridotomy - performed with photocoagulator

Excision

5544 Iridectomy; basal, optical or preliminary

5546 peripheral

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Crystalline Lens

Incision

5601 Discission (needling of lens), initial

Excision

5611 Extraction of lens, intracapsular, extracapsular or linear, unilateral

Retina

Repair

5630 Reattachment of retina, electrocoagulation, scleral resection, buckling or partial tubing

5634 Reattachment of retina, light coagulation of retinal break(s), one or more stages during same period of hospitalization

5636 Light coagulation of retina for tumor, Eales disease, etc., initial

Ocular Muscles

Incision, Excision and Repair

5641 Any type of muscle operation involving one or more muscles in one or both eyes done in one stage

Eyelids

Excision

5702 Excision or incision of Meibomian gland (chalazion), single

Repair

5731 Ectropion repair (e.g., Kuhnt-Szymanowski type)

5732 Entropion repair (e.g., Wheeler type)

Lacrimal Tract

Incision

5801 Drainage of lacrimal gland (abscess)

Excision

5811 Excision of lacrimal gland (dacryoadenectomy)

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

Introduction

5821 Catheterization of nasolacrimal duct with implantation of tube or stent

Repair

5833 Dacryo-ystorrhinostomy: fistulization of lacrimal sac into nasal cavity, with or without anterior ethmoidectomy

Manipulation

5841 Dilation of punctum

5843 Probing of nasolacrimal duct

EAR

External Ear

Endoscopy

5931 Otoscopy with removal of foreign body in external auditory canal

Middle Ear

Incision

5961 Myringotomy; tympanotomy; plicotomy, with or without Eustachian inflation and/or aspiration

5963 Tympanotomy, diagnostic, exploratory for middle ear exposure with insertion of tube for serous otitis media, unilateral

Excision

5971 Mastoidectomy, simple

5982 Removal of middle ear polyp

Repair

5993 Tympanoplasty without mastoidectomy (may include change in contours of external auditory canal and be combined with middle ear, including ossicular chain construction and/or attic surgery), post auricular or endaural approach

5994 Tympanoplasty with mastoidectomy

5997 Stapes mobilization, primary or secondary

LABORATORY AND SURGICAL PROCEDURE AND CODE LIST

5998 Stapedectomy with insertion of prosthetic stapes with fenestration of the oval window

Internal Ear

Incision

6012 Fenestration of semicircular canal

Excision

6021 Labyrinthectomy