# STATE OF NEW JERSEY

## DEPARTMENT OF INSTITUTIONS AND AGENCIES

## DIVISION OF MEDICAL ASSISTANCE

## AND

## HEALTH SERVICES

# HEALTH SERVICES PROGRAM



# PODIATRY MANUAL

# THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

# NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332



July 26, 1974

TO: ALL PODIATRISTS

SUBJECT: REVISION TO PODIATRY MANUAL – CHAPTER II
REMOVAL OF PRIOR AUTHORIZATION

It has been brought to our attention that some providers did not receive these revisions to the Podiatry Manual with our letter dated June 14, 1974. In the event you did receive the original mailing, please discard this package.

Attached is the revised Chaper ~~III~~ II of the Podiatry Manual. Please remove and destroy the old Chapter II and replace it with the new material.

We strongly urge you to read the attached material. There have been significant changes in Medicaid policy regarding podiatric services in that all requirements for prior authorization have been removed with the exception of molded shoes and arch supports (see Section 205.1 and 205.2).

Contact your Local Medical Assistance Unit or Central Office Podiatry Consultant if you have any questions.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

# NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

July 26, 1971

PODIATRY SERVICES

Sections in your New Jersey Health Services Program Podiatry Manual have been revised.

These changes involve nearly all of Chapters II and III, so both sections were reprinted. Please remove and destroy pages 11 through 27 and replace with the attached pages.

LATER REVISION:

3/1/72 PAGES 18, 19, + 20

Central Files

# THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

# NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

February 1, 1971

PODIATRY SERVICES

Sections in your New Jersey Health Services Program Podiatry Manual pertaining to routine foot care, prescription policies, medications, prosthetic and orthotic services have been revised.

These changes involve nearly all of Chapter II, so the entire section has been revised. Please remove and destroy pages 11 through 19 and replace with the attached Chapter II.



NEWSLETTER 11

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

# NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

Volume P - 197 September 26, 1977

TO: ALL PODIATRISTS

SUBJECT: NEW JERSEY MEDICAID INJECTION POLICY – CHAPTER II

Enclosed are Manual page revisions to your Podiatry Manual which affects Chapter II. Please remove and destroy page 14 REV 6/15/74 from your existing Podiatry Manual and insert the attached new pages 14 and 14.1.

The changes become effective October 1, 1977 and affect the reimbursement policy on injections in that the New Jersey Medicaid Program will now make payment for injections (Intradermal, Subcutaneous, Intramuscular, Intravenous) in an office or home setting.

All changes are bracketed on the new manual pages.

## FOREWORD

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

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

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

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

## CHAPTER I

## GENERAL INFORMATION ABOUT THE PROGRAM





Rev. 12/01/70

## 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.

## 101. HOW TO IDENTIFY A COVERED PERSON

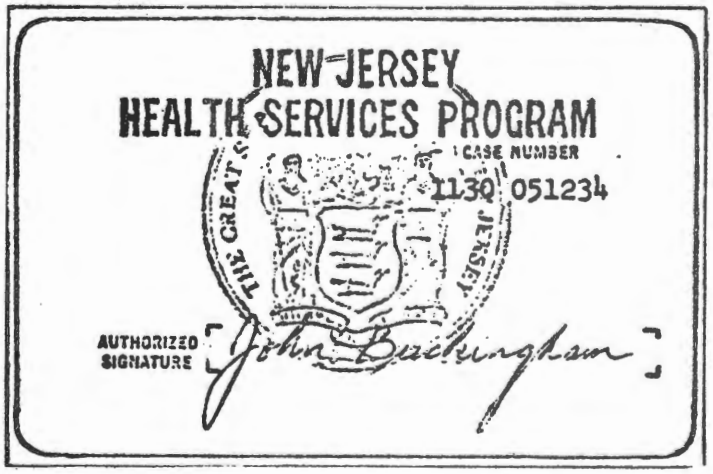
### 101.1 Plastic Identification Card (Exhibit I)

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 OF THE STATE OF NEW JERSEY (SEE SECTION 101.2).

A plastic identification card must be retained by the person to whom it is issued, and no provider shall retain an identification card for the purpose of rendering a service in the future.

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 validation form must be retained by the person to whom it is issued, and no provider shall retain the form for the purpose of rendering a service in the future.

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.

Exhibit II

_____ COUNTY WELFARE BOARD

VALIDATION FOR HEALTH SERVICES PROGRAM

Valid Only for Month of Jan. 1970

BUCKINGHAM 11 30 051234

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

## 101.3 Temporary Identification and Validation Form (Exhibit III)

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

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

TEMPORARY IDENTIFICATION AND VALIDATION OF ELIGIBILITY

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

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

NOTICE TO PROVIDER OF HEALTH SERVICES:

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

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

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

NOTICE TO CLIENT:

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

Signature _____

Prepared By _____ Date _____

Approved By _____ Date _____

MAP-16(11/69) TEMP. FORM

EXHIBIT III

## 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.

## 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.

## 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.

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, 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;

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.

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.

116. NEW JERSEY SALES TAX EXEMPTION

All items and services provided to covered persons under this program are exempt from the New Jersey Sales Tax, by virtue of N.J.S.A. 54:32B-9.

CHAPTER II

PODIATRY SERVICES MANUAL

## CHAPTER II

## PODIATRY SERVICES

### 200. PODIATRY SERVICES

### 201. DEFINITIONS

#### 201.1 Podiatrist

Any person licensed as a podiatrist by the New Jersey State Board of Medical Examiners, or similarly by a comparable agency of the State in which he practices.

#### 201.2 Podiatry Services

"Podiatry services" means those services performed by a licensed podiatrist within the scope of his practice as defined by the laws of New Jersey (NJSA 45:5) and which are within the scope of services covered by the New Jersey Health Services Program.

### 202. STANDARDS

Podiatry care furnished covered persons shall be in conformity with the Professional and Ethical Standards of the American Podiatry Association as defined by the Laws of New Jersey 45:5 et al.

### 203. SCOPE OF SERVICES

Podiatry care under the Health Services Program is allowable to covered persons if such services are essential. Essential podiatry care includes those services which require the professional knowledge and skill of a licensed podiatrist.

### 204. NON-COVERED SERVICES

The following foot care services are not covered:

#### 204.1 Treatment of Flat Foot Conditions

As herein defined, treatment of "flat foot conditions" means treatment of the local condition of flattened arches regardless of the underlying etiology and encompasses all phases of services in connection with flat feet.

Exceptions: (covered services)

A. Where treatment is an integral part of post fracture or post-operative treatment plan.

B. Where supportive devices (i.e., arch supports, specific additions to shoes, etc.) are prescribed to palliate pain and other symptoms associated with the condition.

C. Where the talo-crural joint is involved.

D. Where there may be attachment of a supportive device to a brace or bar.

204.2 Treatment of Subluxations of the Foot

Definition: As herein defined, "subluxation" is the structural misalignment of the joints of the feet which do not require surgical methods of treatment and/or correction, with the exceptions of fractures and complete dislocations.

Inclusions (not a covered service) - Structural misalignments of the feet in which the normal relationship of the bones, tendons, ligaments, and supporting muscles is disturbed and which, regardless of underlying etiology, requires treatment by mechanical methods (i.e., whirlpool, paraffin baths, casting, strapping, splinting, padding, shortwave or low voltage currents, physical therapy, exercise manipulation, massage, etc.).

Exceptions: (covered services)

A. Where treatment is an integral part of post fracture or post-operative treatment plan.

B. Where the talo-crural joint is involved.

C. Where there may be attachment of a supportive device to a brace or bar.

204.3 Routine Foot Care

Routine foot care includes the cutting or removal of corns, warts or calluses, the trimming of nails, routine hygienic care, and any other routine-type care of the feet. "Routine hygienic care" includes hygienic and preventive maintenance care of the feet, of the type which is ordinarily within the realm of self-care, such as observation and cleansing of the feet, use of skin creams to maintain skin tone of both ambulatory and bedfast patients,

prevention and reduction of corns, calluses and warts, and any services performed in the absence of localized illness, injury or symptoms involving the foot. "Other routine-type care" includes any other part of foot care, in addition to those examples of non-covered routine hygienic care specified above, which are ordinarily expected to be within the realm of self-care.

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

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

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

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

204.4 Injection Policy and Drugs Dispensed by a Podiatrist.

No additional payment will be made for drugs dispensed by a podiatrist. The following is the New Jersey Medicaid Program Injection Policy: The New Jersey Medicaid Program will make payment for injections (Intradermal, Subcutaneous, Intramuscular, Intravenous) - Office or Home Setting.

INJECTION: (Intradermal, Subcutaneous, Intramuscular, Intravenous) - Office or Home Setting.

Reimbursement for the above injections are on a flat fee basis and are all inclusive for the cost of the service and the drug or vaccine.

Note 1: A visit for the sole purpose of an injection is reimbursable as an injection and not as an office visit plus an injection. On the other hand, if the criteria of an office or home visit are met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

Note 2: Intravenous injections are reimbursable only when performed by the podiatrist.

Note 3: No reimbursement will be made for vitamins, liver or iron injections or combinations thereof except in laboratory proven deficiency states requiring parenteral therapy.

Note 4: No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.

Note 5: No reimbursement will be made for injection given as a pre-operative medication or as a local anesthetic which is part of an operative or surgical procedure since this injection would normally be included in the prescribed fee for such a procedure.

Note 6: Insert procedure code number 9072 as a separate item on physician and practitioner claim form MC-8 under Section 12D. This is to be followed by the name, dose of drug and route of administration. The complete diagnosis for which the injection was given must be inserted on the same line in Section 12C.

Note 7: Injectable prescription drugs are no longer a reimbursable item to the provider.

Exception:
1. In Long Term Care Facilities
2. Drugs to be administered to a patient by other than the podiatrist or his employee. Podiatrist's prescription must carry the legend "Medicaid authorized". Prior authorization is required.

## 205. PODIATRIC LABORATORY SERVICES - NOT CLINICAL

Payment will be allowed for laboratory services rendered by a podiatrist for his own patients with prior authorization.

Note: Services provided by an independent laboratory must be billed directly to the Program by the laboratory, and not by the referring practitioner.

prevention and reduction of corns, calluses and warts, and any services performed in the absence of localized illness, injury or symptoms involving the foot. "Other routine-type care" includes any other part of foot care, in addition to those examples of non-covered routine hygienic care specified above, which are ordinarily expected to be within the realm of self-care.

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

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

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

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

204.4 <u>Injections or Drugs Dispensed by the Podiatrist Not Reimbursable</u>

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

205. PODIATRIC LABORATORY SERVICES - NOT CLINICAL

Payment will be allowed for laboratory services rendered by a podiatrist for his own patients with prior authorization.

Note: Services provided by an independent laboratory must be billed directly to the Program by the laboratory, and not by the referring practitioner.

205.1 Molded Shoes

A. Prior authorization is required for molded shoes.

B. The podiatrist shall be allowed a service fee including casting, not to exceed Program limitations. This is to be billed on a Physicians and Practitioner Claim Form (MC-8).

C. The maximum allowable charges to the Program for the shoes will be a vendor's charge not to exceed Program limitations, and shall be billed on a Medical Suppliers Claim Form (MC-11).

D. Exceptional cases will be given individual consideration by the consultant as to fee requested.

205.2 Arch Supports

Prior authorization is required for arch supports. Casting for arch supports shall be reimbursed by a fee not to exceed Program limitations. This shall be billed on a Physicians and Practitioners Claim Form (MC-8). The actual cost of the supports shall be within the limits of the Program and must be billed by the vendor on an MC-11 Medical Suppliers Claim Form.

206. CLINICAL LABORATORY SERVICES

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

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

B. Hospital laboratories holding valid certification from the New Jersey Department of Health, and which provide laboratory services to ambulatory patients as requested by a practitioner.

207. HOSPITAL CLINIC SERVICES

All services rendered in the hospital clinic setting are considered hospital costs, including practitioners' services.

## 208. DIAGNOSTIC RADIOLOGY SERVICES

Reimbursement will be allowed for necessary radiological services by a podiatrist, subject to the limitation of his licensure. Routine x-rays for screening purposes are not reimbursable.

## 209. PRIOR AUTHORIZATION

The following services need prior approval by the Podiatry Services Unit, Division of Medical Assistance and Health Services, P. O. Box 2485, Trenton, New Jersey 08625:

1. Molded Shoes - 205.1
2. Arch Supports - 205.2

A written request for authorization (Form 33030) must be submitted, identifying the case and containing sufficient information about the problem and plan of treatment to enable the unit to make a proper evaluation.

## 210. BASIS OF PAYMENT

Reimbursement for covered services furnished under the Health Services Program 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 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.

## 211. MULTIPLE VISITS -- OUT-OF-OFFICE

Podiatry services rendered in a residential or medical facility (i.e., Hospital, Nursing Home, Extended Care Facility, etc.) must be based on referral by the attending physician.

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

## 212. RECORD KEEPING

Podiatrists are to keep individual records as are necessary to fully disclose the kind and extent of services provided and to make such information available as the Division or its agents may request. For the initial examination, the records shall show the following as a minimum:

a. Date of service
b. Chief complaint(s)
c. Pertinent historical and physical data
d. Reports of diagnostic procedures ordered or performed
e. Diagnosis
f. Prescription (including medication) and treatment

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

## 213. PHARMACEUTICAL SERVICES

### 213.1 Prescription Policies

A. This section is intended to describe the Practitioner's responsibility in the writing of prescriptions in order to maintain the traditional patient-prescriber-provider relationship and to insure the recipient free choice of provider. Practitioners are urged to familiarize themselves with all aspects of this section in order to effect economics consistent with good medical practices and to facilitate prompt payment to the pharmacist. All podiatrists licensed or authorized to prescribe by the State of New Jersey and falling as indicated within policies of New Jersey Health Services Program are eligible. Out-of-State practitioners may prescribe under this program, as herein outlined, if they meet the same requirements in their State.

B. Dosage and Directions

The practitioner must include specific directions on all drug prescriptions or the prescription will not be eligible for payment. Non-acceptable directions, e.g., "PRN", "as directed", "ad lib", etc., are not eligible for payment. This ruling does not apply to prescriptions such as topical preparations since specific directions are seldom possible in these instances. The choice of prescription drugs remains at the discretion of the

prescribing practitioner. However, the practitioner should be aware that pharmacies will not receive payment for certain prescription drugs, under specific conditions, as listed under D and E of this section. The practitioner should give preference to:

1. Drugs listed in the latest edition of the U.S. Pharmacopeia (U.S.P.), National Formulary (N.F.), New Drugs, and Accepted Dental Therapeutics.

2. Oral medications 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.

C. Quantity of Medication

The quantity 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 exceed a 60-day supply.

Any drug used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the patient for up to 60 days.

In Long Term Medical Care Facilities (that is, Skilled Nursing Facility, Intermediate Care Facility, Infirmary Section of Home for the Aged, or Public Medical Institution), 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.

D. Services Requiring Prior Authorization

Certain 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 spaces in this area.

1. Antiobesics and Anorexics.

2. Protein replacement products, such as (but not limited to) Probana, Portagen, Nutramigen, Neo-Mullsoy.

3. Preventive drugs and biologicals when not available through listed Distributing Stations.

E. 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, (for example, New Jersey State Department of Health, New Jersey Heart Association).

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).

   Exception: a. Insulin
   b. All vitamins, minerals, vitamin mineral combinations.

7. Prescriptions written and dispensed with non-specific directions.

8. Telephoned "refill" prescriptions.

9. Methadone.

   Policy

   The New Jersey Health Services Program 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.

10. Medication prescribed for a Title XIX (Medicaid) covered person who is receiving benefits under Part A of Title XVIII (Medicare) as a patient in an extended care facility (ECF).

11. Prescribed non-legend drugs unless specifically listed in Appendix B (allowable non-legend drugs) of the New Jersey Blue Cross Code Register.

12. Food supplements, milk modifers, infant formula and therapeutic diets. EXCEPTION: Protein replacements.

13. Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their New Drug Application (NDA).

F. Telephone Ordered Original Prescriptions

Telephone orders from the prescriber for original prescriptions, in accordance with all applicable Federal and State Laws and regulations, will be permitted.

NOTE: Telephone orders for refills are not permitted.

G. Prescription Refill

1. Refill instructions must be indicated by the practitioner.

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.

   Exception: Vitamins and vitamin-mineral combinations originally prescribed for a 100-day supply may be refilled two (2) times within one year.

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

## CHAPTER III

## PODIATRY BILLING PROCEDURES

## CHAPTER III

## PODIATRY 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 should be submitted no later than ninety (90) days after the last date items are furnished.

### 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

When submitting claims for payment, make certain all authorizations have been properly signed by the Podiatry Services Unit and are attached.

### 304. COMBINATION MEDICARE/MEDICAID CLAIMS

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

Note: In cases where prior authorization is required for the Health Services Program, it must be obtained and submitted with the Medicare Claim. Medicare Claim Form (SSA-1490) may be obtained from Prudential.

## 305. DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS

Following is a list of Local Medical Assistance Units, their identification numbers and their addresses. It should be noted that the identification number comprises the first two positions of the Health Services Program Case Number and indicates which Local Medical Assistance Unit has jurisdiction in submission of requests for authorization and other reports.

N.B. Inquiries concerning eligibility and application for eligibility are to be sent to the County Welfare Board of patient's residence.

| County Code | County | Street Address | Municipality | Zip Code | P.O. Box | Telephone |
|---|---|---|---|---|---|---|
| 01 | Atlantic | 1601 Atlantic Ave. | Atlantic City | 08404 | 1970 | 609-344-2861 |
| 05 | Cape May | " " " | " " | " | " | " " " |
| 02 | Bergen | 90 Main Street | Hackensack | 07601 | | 201-488-5667 |
| 03 | Burlington | Chesley & Alloway Bldg., Rt. 38 and Eayrestown Road | Mt. Holly | 08060 | | 609-261-0448 |
| 04 | Camden | 709 Market Street | Camden | 08101 | 19 | 609-365-3926 |
| 06 | Cumberland | 7 E. Broad Street | Bridgeton | 08302 | 440 | 609-451-6550 |
| 07 | Essex | 505 S. 15th St. | Newark | 07103 | 1576 | 201-648-3700 |
| 08 | Gloucester | 10 Harrison St. | Woodbury | 08096 | 1900 | 609-845-7185 |
| 17 | Salem | " " " | " | " | " | " " " |
| 09 | Hudson | 100 Newkirk St. | Jersey City | 07306 | | 201-792-6390 |
| 10 | Hunterdon | 6 Court Street | Flemington | 08822 | | 201-782-1130 |
| 18 | Somerset | " " | " | " | | " " " |
| 21 | Warren | " " | " | " | | " " " |
| 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 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 |

## 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).

5-6 Self-explanatory.

7. OTHER INSURANCE OR LIABILITY COVERAGE - If patient has other Health Insurance or Liability coverage, check appropriate block, and attach copy of explanation of payment from the carrier.

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

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

10. Self-explanatory.

11. Write in Name of institution, if place of service is other than doctor's office or patient's home. To be completed in addition to Questions 12B.

12. 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.
E. Self-explanatory.
F. Enter charge for each service or procedure.

13. CONSULTATION - Leave blank.

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

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

A. Illiterate Patient

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

B. Other

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

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

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

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

306.2 Medical Groups

The instructions in Section 306.1 apply also to medical groups. The individual physician rendering service should sign the form, but in lieu of the attending physician's signature, his name may be listed on the claim and the form signed by another member of the group.

306.3 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

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

EXHIBIT

03

# PHYSICIANS AND PRACTITIONERS CLAIM

1. Patient's Last Name | First Name

2. Patient's Street Address | Telephone Number

3. Health Services Program Case No. — —

4. Patient Person #

5. Age

6. Sex ☐ Male ☐ Female

City | State | ZIP Code

7. Other Health Insurance or Liability Coverage? ☐ Yes ☐ No
If Yes, attach copy of Explanation of Payment from carrier.
**(If Medicare — See Section 304 of Manual)**

8. Was Patient's Illness or Injury connected with his employment? ☐ Yes ☐ No
If Yes, give Name and Address of Employer here.

9. PROVIDER OF SERVICE INFORMATION

Telephone Number

Social Security or Employer I.D. Number (Enter only when not printed below)

Name and Address

10. Did injury result from automobile accident? ☐ Yes ☐ No

11. Give Name of Institution if Place of Service is other than Doctors Office or Patients Home.

FOR CONTRACTOR'S USE ONLY

| TOTAL AMOUNT A | | | | | | TOTAL AMOUNT B | | | | | | CODE | JAM | HOSPITAL PROVIDER NUMBER | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 |
| | | | | | | | | | | | | | | | | | | | |

## REPORT OF SERVICES

| 12. A. DATE OF EACH VISIT | B. PLACE OF SERV. | C. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES | D. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE OF SERVICE | E. CHECK (✓) IF FAMILY PLANNING | F. CHARGE |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

13. IF CONSULTATION — Give Name of Referring Physician.

TOTAL CHARGES $

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

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

Provider Signature ☐ MD ☐ DO Date Signed
Other Degree_____

1—Doctor's Office 2—Patient's Home 3—Inpatient Hospital 4— 5—Skilled Nursing Home 6—Independent Laboratory
7—Outpatient Hospital 8—Clinic **(Other than Hospital based)** 9—Other Locations **(Specify in 12C)** 0—Emergency Room

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

FOR CONTRACTOR'S USE ONLY

| CARD | DATES OF SERVICE FROM YR | FROM MO | FROM DAY | TO MO | TO DAY | PLACE | TYPE | RAP | # OF VISITS | PROC | VALUE | AMOUNT A | AMOUNT B | CODE | JAM | PROCEDURE CODE (1) | PROCEDURE CODE (2) | PROCEDURE CODE (3) | PRIMARY DX. | SECOND DX. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | | | | | | | | | | | | | | | | | | | | |
| 11 | 14 15 | 16 17 | 18 19 | 20 21 | 22 23 | 24 | 25 | 26 | 27 28 | 29 | 30 | 31 32 33 34 35 36 | 37 38 39 40 41 42 | 43 | 44 | 45 46 47 48 49 | 50 51 52 53 54 | 55 56 57 58 59 | 60 61 62 63 | 64 65 66 67 |
| 4 | | | | | | | | | | | | | | | | | | | | |

MC-B-A-C1

CONTRACTOR'S COPY



Medicaid 32917 Part I ED 6-71 (N.J.)

# PODIATRY SERVICES MANUAL

## SUBCHAPTER 3. HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURE CODING SYSTEM (HCPCS)

## INDEX

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

### 10:57-3.1 INTRODUCTION

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology - 4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. LEVEL I CODES (Narratives found in CPT=4)

   These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

   Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level 1 codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4.

2. LEVEL II CODES (Narratives found in APPENDIX A)

   These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4. Level II codes are listed in APPENDIX A of each section.

3. LEVEL III CODES (Narratives found in APPENDIX A)

   These codes are assigned by the Division and the Prudential Insurance Co. to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey. These codes are listed in Appendix A of each section.

(b) SPECIFIC ELEMENTS OF HCPCS CODES WHICH REQUIRE ATTENTION OF PROVIDER: The list of HCPCS codes in section 3.2 is arranged in tabular form with specific information for a code given under columns with the titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS", "MEDICAID DOLLAR VALUE" and "ANES BASIC UNITS". The information given under each column is summarized below:

| COLUMN TITLE | |
|---|---|
| IND | (Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or services code is used. |

Explanation of indicators and qualifiers used in this column are given below and in paragraph 1. (Alphabetic and Numeric Symbols) which follows:

"L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A. At the end of Section 3.2

"N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B. At the end of Section 3.2.

HCPCS CODE — Lists the HCPCS procedure code numbers.

MOD — 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 are listed in Appendix C at the end of Section 3.2 (Podiatry Services HCPCS code numbers and maximum fee schedule).

DESCRIPTION — Lists the code narrative. (Narratives for Level I Codes are found in CPT-4, Narratives for Levels II and III Codes are found in Appendix A at the end of Section 3.2).

FOLLOW UP DAYS — Lists the number of days for follow-up care.

MEDICAID DOLLAR VALUE — Lists New Jersey Medicaid Program's reimbursement schedule for specialist and non-specialist. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the 1500-N.J. claim form.

ANES — B.U.V. (Basic Unit Value) + A.T. (Anesthesia Time) (units) x $6.30 (specialist) or $5.50 (non-specialist) equals reimbursement. (For more information about anesthesia service, see Policies and Procedures Regarding Use of HCPCS (c) 3.v. which follows.)

1. ALPHABETIC AND NUMERIC SYMBOLS UNDER "IND" & "MOD"

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

i. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code as written in the CPT-4. THE PROVIDER WILL

THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

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

(c) POLICIES AND PROCEDURES REGARDING USE OF HCPCS

Listed below are both some general and specific policies of the New Jersey Medicaid Program relevant to HCPCS. Additional requirements of the podiatrist when rendering services and requesting reimbursement are listed in both Subchapter 1. and Subchapter 2., (Billing procedures).

1. GENERAL REQUIREMENTS

i. When filing a claim, the HCPCS Codes, including the referenced qualifiers and modifiers, must be used in conjunction with the narratives in the CPT-4 or Appendix A, whichever is applicable.

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

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

iv. When billing, the provider must enter into the procedure code column of space 24-D of claim form 1500-N.J. a CPT/HCPCS code as listed in the CPT-4 or this Subchapter. If an appropriate code is not listed, place an "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert into space 24-D a CPT code closest to the narrative description you have written.

v. Date(s) of service(s) must be indicated on the claim form and in the practitioner's own record for each service billed.

vi. When submitting a claim, the practitioner must always use his/her usual and customary fee. The fees designated for the HCPCS procedure codes represent the New Jersey Medicaid Program's maximum payment for the given procedure.

vii. All references to time parameters shall mean the practitioner's personal time in reference to the service rendered unless it is otherwise indicated.

2. Medicine (Specific Requirements)

i. It is not the intent of the program to reimburse a podiatrist for histories and/or podiatry examination performed by physician assistants, interns, residents or other house staff.

ii. For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the podiatrist submitting the claim:

(1) Office, Hospital, Nursing Home, or Sheltered Boarding Home Visits.

(2) Any part of a history or physical examination.

iii. To qualify as documentation that the service was rendered by the podiatrist during an inpatient stay, the medical record must contain the podiatrist's notes indicating that he/she personally:

(1) Reviewed the patient's medical history with the patient and/or his family, depending upon the medical situation.

(2) Performed an examination.

(3) Confirmed or revised the diagnosis.

(4) Visited and examined the patient on the days for which a claim for reimbursement is made.

(5) Was personally responsible for discharge of the patient.

iv. The billing podiatrist's involvement must be clearly demonstrated in notes reflecting his/her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A countersignature alone is not sufficient.

3. Surgery (Specific Requirements):

i. SEPARATE PROCEDURE: Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "Separate Procedure" is applicable.

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

iii. MULTIPLE SURGICAL PROCEDURES:

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

(2) When an incidental procedure, (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the allowance will be that of the major procedure only.

iv. Listed allowances for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column titled "Follow-Up Days".

v. ANESTHESIA:

(1) Anesthesia services rendered to his/her patient by the operating surgeon are considered part of the surgical procedure and will not receive any additional reimbursement.

vi. ASSISTANT SURGEON: Reimbursement will be made for an assistant surgeon when the service is medically necessary and when a duly qualified surgical resident or house physician is unavailable, and when the primary procedure performed has a procedure code specialist fee of at least $142. The allowance permitted is a maximum of 15 percent of the listed specialist fee. The minimum payment is $27.

When billing for assistant surgical services, affix to the appropriate procedure code the modifier "80" which identifies surgical assistant services.

4. Radiology (Specific Requirements)

i. Values include contrast media, equipment and materials.

ii. Values include consultation and written report to the referring physician.

iii. S & I - Supervision and Interpretation only for the procedure given. This code is used only when a procedure is performed by more than one physician. Values include consultation and written report.

iv. Complete Procedure - Includes the Supervision and Interpretation (S & I) plus the injection services when performed by the same physician (e.g., necessary local anesthesia, placement of needle or catheter, injection of contrast media, supervision of the study and interpretation of the results). Values include usual contrast media, equipment and materials.

v. All films taken of an area which is to be subject to a contrast study will, for reimbursement purposes, be considered part of the contrast study unless stated otherwise in section 3.2 (c) (Radiology).

vi. The fee listed represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

## 10:57-3.2 PODIATRY SERVICES HCPCS CODE NUMBERS AND MAXMUM FEE SCHEDULE

(a) MEDICINE

| IND | HCPCS Code | MOD | MEDICAID DOLLAR VALUE S | $ NS | IND | HCPCS CODE | MOD | MEDICAID DOLLAR VALUE S | $ NS |
|---|---|---|---|---|---|---|---|---|---|
| N | 90015 | | 22.00 | 17.00 | N | 90320 | | 22.00 | 17.00 |
| N | 90017 | | 22.00 | 17.00 | N | 90350 | | 9.00 | 7.00 |
| N | 90020 | | 22.00 | 17.00 | N | 90360 | | 9.00 | 7.00 |
| N | 90050 | | 9.00 | 7.00 | N | 90370 | | 9.00 | 7.00 |
| N | 90060 | | 9.00 | 7.00 | N | 90415 | | 22.00 | 17.00 |
| N | 90070 | | 9.00 | 7.00 | N | 90420 | | 22.00 | 17.00 |
| N | 90150 | | 9.00 | 7.00 | N | 90450 | | 9.00 | 7.00 |
| N | 90160 | | 25.00 | 25.00 | N | 90460 | | 9.00 | 7.00 |
| N | 90170 | | 25.00 | 25.00 | N | 90470 | | 9.00 | 7.00 |
| N | 90215 | | 22.00 | 17.00 | N | 90600 | | 22.00 | - |
| N | 90220 | | 22.00 | 17.00 | N | 90605 | | 22.00 | - |
| N | 90250 | | 9.00 | 7.00 | N | 90610 | | 22.00 | - |
| N | 90260 | | 9.00 | 7.00 | N | 90620 | | 37.00 | - |
| N | 90315 | | 22.00 | 17.00 | N | 90799 | | 2.50 | 2.50 |

(b) SURGERY

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|
| | 10000 | | 0 | 13.00 | 11.00 | | 3. |
| | 10003 | | 0 | 13.00 | 11.00 | | 3. |
| | 10060 | | 0 | 13.00 | 11.00 | | 3. |
| | 10061 | | 30 | 48.00 | 42.00 | | 4. |
| | 10100 | | 0 | 13.00 | 11.00 | | 3. |
| | 10101 | | 30 | 34.00 | 29.00 | | 3. |
| | 10120 | | 0 | 18.00 | 16.00 | | 3. |
| | 10121 | | 30 | 34.00 | 29.00 | | 4. |
| | 10140 | | 0 | 18.00 | 16.00 | | 3. |
| | 10141 | | 30 | 48.00 | 42.00 | | 3. |
| | 10160 | | 0 | 13.00 | 11.00 | | 3. |
| N | 11000 | | 0 | 13.00 | 11.00 | | 4. |
| N | 11001 | | 0 | 6.00 | 5.00 | | 3. |
| | 11040 | | 0 | 13.00 | 11.00 | | 3. |
| | 11041 | | 0 | 13.00 | 11.00 | | 3. |
| | 11042 | | 0 | 16.00 | 14.00 | | 3. |
| | 11043 | | 0 | 16.00 | 14.00 | | 3. |
| | 11044 | | 0 | 48.00 | 42.00 | | 3. |
| | 11100 | | 0 | 13.00 | 11.00 | | 4. |
| | 11400 | | 15 | 18.00 | 16.00 | | 3. |
| | 11401 | | 15 | 22.00 | 20.00 | | 3. |
| | 11402 | | 15 | 27.00 | 24.00 | | 3. |
| | 11403 | | 30 | 32.00 | 27.00 | | 3. |
| | 11404 | | 30 | 32.00 | 27.00 | | 3. |
| | 11406 | | 30 | 32.00 | 27.00 | | 3. |
| | 11420 | | 15 | 18.00 | 16.00 | | 3. |
| | 11421 | | 15 | 22.00 | 20.00 | | 3. |
| | 11422 | | 15 | 27.00 | 24.00 | | 3. |
| | 11423 | | 30 | 32.00 | 27.00 | | 3. |
| | 11424 | | 30 | 32.00 | 27.00 | | 3. |
| | 11426 | | 30 | 32.00 | 27.00 | | 3. |
| | 11600 | | 90 | 37.00 | 32.00 | | 3. |
| | 11601 | | 90 | 47.00 | 42.00 | | 3. |
| | 11602 | | 90 | 61.00 | 53.00 | | 3. |
| | 11620 | | 90 | 61.00 | 53.00 | | 4. |
| | 11621 | | 90 | 90.00 | 79.00 | | 4. |
| | 11622 | | 90 | 121.00 | 105.00 | | 4. |
| | 11700 | | 0 | 13.00 | 11.00 | | 3. |
| | 11701 | | 0 | 19.00 | 16.00 | | 3. |
| | 11710 | | 0 | 13.00 | 11.00 | | 3. |
| | 11711 | | 0 | 19.00 | 16.00 | | 3. |
| | 11730 | | 0 | 10.00 | 10.00 | | 3. |
| | 11750 | | 30 | 42.00 | 37.00 | | 3. |
| | 12001 | | 0 | 18.00 | 16.00 | | 3. |
| | 12002 | | 0 | 24.00 | 21.00 | | 3. |
| | 12004 | | 0 | 30.00 | 26.00 | | 3. |
| | 12041 | | 30 | 30.00 | 26.00 | | 3. |
| | 12042 | | 30 | 67.00 | 59.00 | | 4. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|
| | 13131 | | 30 | 67.00 | | 59.00 | 4. |
| | 13132 | | 30 | 145.00 | | 126.00 | 4. |
| | 13300 | | 30 | 242.00 | | 210.00 | 4. |
| | 14040 | | 60 | 193.00 | | 168.00 | 4. |
| | 14041 | | 60 | 242.00 | | 210.00 | 4. |
| | 17000 | | 0 | 8.00 | | 6.00 | 3. |
| | 17010 | | 0 | 11.00 | | 8.00 | 3. |
| | 17100 | | 0 | 18.00 | | 15.00 | 3. |
| | 17105 | | 0 | 27.00 | | 24.00 | 3. |
| | 17110 | | 0 | 8.00 | | 6.00 | 3. |
| | 17200 | | 0 | 8.00 | | 6.00 | 3. |
| | 17304 | | 30 | 25.00 | | 21.00 | 3. |
| | 17305 | | 30 | 8.00 | | 6.00 | 3. |
| | 17310 | | 30 | BR | | BR | 3. |
| | 20000 | | 0 | 18.00 | | 16.00 | 3. |
| | 20005 | | 0 | 45.00 | | 40.00 | 4. |
| N | 20520 | | 7 | 51.00 | | 45.00 | 3. |
| N | 20550 | | 0 | 13.00 | | 11.00 | 0. |
| | 20600 | | 0 | 13.00 | | 11.00 | 3. |
| N | 20605 | | 0 | 13.00 | | 11.00 | 3. |
| | 20650 | | 0 | 55.00 | | 47.00 | 4. |
| | 20670 | | 0 | 24.00 | | 21.00 | 3. |
| N | 20680 | | 21 | 121.00 | | 105.00 | 4. |
| N | 20680-52 | | 21 | 61.00 | | 53.00 | 4. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|
| | 27530 | | 30 | 74.00 | | 65.00 | 3. |
| | 27532 | | 90 | 121.00 | | 105.00 | 3. |
| | 27534 | | 90 | 145.00 | | 126.00 | 3. |
| | 27536 | | 90 | 242.00 | | 210.00 | 3. |
| | 27603 | | 30 | BR | | BR | 3. |
| | 27604 | | 0 | 13.00 | | 11.00 | 3. |
| | 27610 | | 60 | 182.00 | | 158.00 | 3. |
| | 27611 | | 60 | 182.00 | | 158.00 | 3. |
| | 27613 | | 0 | 13.00 | | 11.00 | 4. |
| | 27620 | | 60 | 182.00 | | 158.00 | 3. |
| | 27625 | | 90 | 211.00 | | 184.00 | 3. |
| | 27630 | | 30 | 90.00 | | 79.00 | 3. |
| | 27640 | | 60 | 211.00 | | 184.00 | 4. |
| | 27641 | | 60 | 211.00 | | 184.00 | 4. |
| | 27648 | | 0 | 61.00 | | 53.00 | 3. |
| | 27650 | | 90 | 227.00 | | 197.00 | 4. |
| | 27658 | | 90 | 121.00 | | 105.00 | 3. |
| | 27659 | | 90 | 121.00 | | 105.00 | 3. |
| | 27664 | | 90 | 90.00 | | 79.00 | 3. |
| | 27665 | | 90 | 90.00 | | 79.00 | 3. |
| | 27685 | | 90 | 151.00 | | 131.00 | 4. |
| | 27686 | | 90 | 202.00 | | 175.00 | 3. |
| | 27695 | | 90 | 302.00 | | 263.00 | 3. |
| | 27698 | | 90 | 227.00 | | 197.00 | 3. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|
| | 27700 | | 90 | 249.00 | 216.00 | | 3. |
| | 27705 | | 90 | 272.00 | 236.00 | | 3. |
| | 27707 | | 90 | 113.00 | 100.00 | | 3. |
| | 27752 | | 90 | 121.00 | 105.00 | | 3. |
| | 27754 | | 90 | 145.00 | 126.00 | | 3. |
| | 27756 | | 90 | 211.00 | 184.00 | | 3. |
| | 27760 | | 90 | 79.00 | 68.00 | | 3. |
| | 27762 | | 90 | 79.00 | 68.00 | | 3. |
| | 27764 | | 90 | 105.00 | 91.00 | | 3. |
| | 27766 | | 90 | 151.00 | 131.00 | | 3. |
| | 27781 | | 30 | 45.00 | 39.00 | | 3. |
| | 27782 | | 90 | 61.00 | 53.00 | | 3. |
| | 27784 | | 90 | 121.00 | 105.00 | | 3. |
| | 27788 | | 90 | 79.00 | 68.00 | | 3. |
| | 27790 | | 90 | 105.00 | 91.00 | | 3. |
| | 27792 | | 90 | 151.00 | 131.00 | | 3. |
| | 27802 | | 90 | 121.00 | 105.00 | | 3. |
| | 27804 | | 90 | 161.00 | 140.00 | | 3. |
| | 27806 | | 90 | 161.00 | 140.00 | | 3. |
| | 27810 | | 90 | 121.00 | 105.00 | | 3. |
| | 27812 | | 90 | 145.00 | 126.00 | | 3. |
| | 27814 | | 90 | 211.00 | 184.00 | | 3. |
| | 27818 | | 90 | 121.00 | 105.00 | | 3. |
| | 27820 | | 90 | 141.00 | 123.00 | | 3. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|
| | 27822 | | 90 | 242.00 | 210.00 | | 3. |
| | 27823 | | 90 | 242.00 | 210.00 | | 3. |
| | 27832 | | 90 | 164.00 | 142.00 | | 3. |
| | 27840 | | 45 | 61.00 | 53.00 | | 0. |
| | 27842 | | 45 | 61.00 | 53.00 | | 3. |
| | 27844 | | 45 | 152.00 | 131.00 | | 3. |
| | 27846 | | 90 | 305.00 | 263.00 | | 3. |
| | 27850 | | 0 | 61.00 | 53.00 | | 3. |
| | 27852 | | 60 | 284.00 | 247.00 | | 4. |
| | 27860 | | 0 | 61.00 | 53.00 | | 3. |
| | 27870 | | 90 | 302.00 | 263.00 | | 3. |
| | 28001 | | 0 | 13.00 | 11.00 | | 3. |
| | 28002 | | 0 | 24.00 | 21.00 | | 3. |
| | 28008 | | 60 | 61.00 | 53.00 | | 3. |
| | 28010 | | 0 | 24.00 | 21.00 | | 3. |
| | 28011 | | 0 | 37.00 | 32.00 | | 3. |
| | 28020 | | 60 | 109.00 | 95.00 | | 3. |
| | 28022 | | 60 | 109.00 | 95.00 | | 3. |
| | 28024 | | 60 | 37.00 | 32.00 | | 3. |
| | 28080 | | 30 | 121.00 | 105.00 | | 3. |
| | 28090 | | 30 | 90.00 | 79.00 | | 3. |
| | 28092 | | 30 | 61.00 | 53.00 | | 3. |
| | 28100 | | 60 | 121.00 | 105.00 | | 4. |
| | 28108 | | 60 | 121.00 | 105.00 | | 4. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|
| | 28114 | | 90 | 242.00 | 210.00 | | 3. |
| | 28120 | | 60 | 90.00 | 79.00 | | 4. |
| | 28121 | | 60 | 90.00 | 79.00 | | 4. |
| | 28122 | | 60 | 90.00 | 79.00 | | 4. |
| | 28123 | | 60 | 90.00 | 79.00 | | 4. |
| | 28124 | | 60 | 90.00 | 79.00 | | 4. |
| | 28140 | | 60 | 121.00 | 105.00 | | 3. |
| | 28150 | | 90 | 90.00 | 79.00 | | 3. |
| | 28160 | | 90 | 90.00 | 79.00 | | 3. |
| | 28190 | | 0 | 18.00 | 16.00 | | 3. |
| | 28192 | | 30 | 34.00 | 29.00 | | 4. |
| | 28193 | | 30 | 34.00 | 29.00 | | 4. |
| | 28200 | | 90 | 121.00 | 105.00 | | 3. |
| | 28208 | | 90 | 61.00 | 53.00 | | 3. |
| | 28220 | | 60 | 113.00 | 99.00 | | 3. |
| | 28222 | | 60 | 139.00 | 119.00 | | 3. |
| | 28225 | | 60 | 113.00 | 99.00 | | 3. |
| | 28226 | | 60 | 139.00 | 119.00 | | 3. |
| | 28230 | | 30 | 42.00 | 37.00 | | 3. |
| | 28232 | | 60 | 139.00 | 119.00 | | 3. |
| | 28234 | | 60 | 139.00 | 119.00 | | 3. |
| | 28240 | | 30 | 61.00 | 53.00 | | 3. |
| | 28262 | | 90 | 121.00 | 105.00 | | 3. |
| | 28280 | | 45 | 61.00 | 53.00 | | 3. |
| N | 28285 | | 90 | 90.00 | 79.00 | | 3. |
| N | 28288 | | 21 | 72.00 | 63.00 | | 3. |
| | 28290 | | 60 | 90.00 | 79.00 | | 3. |
| | 28292 | | 90 | 139.00 | 121.00 | | 3. |
| | 28294 | | 90 | 141.00 | 123.00 | | 3. |
| | 28306 | | 90 | 113.00 | 100.00 | | 3. |
| | 28308 | | 90 | 113.00 | 100.00 | | 3. |
| | 28315 | | 60 | 55.00 | 47.00 | | 3. |
| | 28400 | | 30 | 68.00 | 59.00 | | 3. |
| | 28405 | | 90 | 90.00 | 79.00 | | 3. |
| | 28410 | | 90 | 113.00 | 99.00 | | 3. |
| | 28415 | | 90 | 151.00 | 131.00 | | 3. |
| | 28430 | | 30 | 82.00 | 72.00 | | 3. |
| | 28435 | | 90 | 90.00 | 79.00 | | 3. |
| | 28440 | | 90 | 113.00 | 99.00 | | 3. |
| | 28450 | | 30 | 41.00 | 36.00 | | 3. |
| | 28455 | | 90 | 61.00 | 53.00 | | 3. |
| | 28460 | | 90 | 90.00 | 79.00 | | 3. |
| | 28465 | | 90 | 121.00 | 105.00 | | 3. |
| | 28470 | | 30 | 18.00 | 16.00 | | 3. |
| | 28475 | | 90 | 42.00 | 37.00 | | 3. |
| | 28480 | | 90 | 63.00 | 56.00 | | 3. |
| | 28485 | | 90 | 90.00 | 79.00 | | 3. |
| N | 28490 | | 30 | 18.00 | 16.00 | | 3. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S $ | MEDICAID DOLLAR VALUE NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|
| | 28495 | | 30 | 30.00 | 26.00 | 3. |
| | 28500 | | 45 | 90.00 | 79.00 | 3. |
| | 28510 | | 30 | 18.00 | 16.00 | 3. |
| | 28515 | | 30 | 30.00 | 26.00 | 3. |
| | 28520 | | 45 | 79.00 | 63.00 | 3. |
| | 28540 | | 45 | 61.00 | 53.00 | 0. |
| | 28545 | | 45 | 61.00 | 53.00 | 3. |
| | 28550 | | 45 | 107.00 | 92.00 | 3. |
| | 28555 | | 90 | 211.00 | 184.00 | 3. |
| | 28570 | | 45 | 61.00 | 53.00 | 0. |
| | 28575 | | 45 | 61.00 | 53.00 | 3. |
| | 28580 | | 45 | 107.00 | 92.00 | 3. |
| | 28585 | | 90 | 211.00 | 184.00 | 3. |
| | 28600 | | 45 | 61.00 | 53.00 | 0. |
| | 28605 | | 45 | 61.00 | 53.00 | 3. |
| | 28610 | | 45 | 104.00 | 91.00 | 3. |
| | 28630 | | 45 | 61.00 | 53.00 | 0. |
| | 28640 | | 45 | 104.00 | 91.00 | 3. |
| | 28645 | | 90 | 121.00 | 105.00 | 3. |
| | 28660 | | 0 | 13.00 | 11.00 | 0. |
| | 28670 | | 45 | 18.00 | 16.00 | 3. |
| | 28675 | | 60 | 47.00 | 40.00 | 3. |
| | 28715 | | 90 | 272.00 | 236.00 | 3. |
| | 28725 | | 90 | 182.00 | 158.00 | 3. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S $ | MEDICAID DOLLAR VALUE NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|
| | 28740 | | 90 | 166.00 | 126.00 | 3. |
| N | 28750 | | 90 | 90.00 | 79.00 | 3. |
| N | 28755 | | 90 | 90.00 | 79.00 | 3. |
| | 28760 | | 90 | 200.00 | 173.00 | 3. |
| | 28800 | | 90 | 211.00 | 184.00 | 3. |
| | 28805 | | 90 | 211.00 | 184.00 | 3. |
| | 28810 | | 90 | 121.00 | 105.00 | 3. |
| | 28820 | | 45 | 42.00 | 37.00 | 3. |
| | 28820-51 | | 45 | 63.00 | 56.00 | 3. |
| | 28825 | | 45 | 42.00 | 37.00 | 3. |
| | 28825-51 | | 45 | 63.00 | 56.00 | 3. |
| | 29405 | | 0 | 42.00 | 37.00 | 3. |
| | 29425 | | 0 | 47.00 | 42.00 | 3. |
| | 29450 | | 0 | 24.00 | 21.00 | 3. |
| | 29455 | | 0 | 37.00 | 32.00 | 3. |
| | 29515 | | 0 | 42.00 | 37.00 | 3. |
| N | 29580 | | 0 | 18.00 | 16.00 | 3. |
| | 29700 | | 0 | 14.00 | 12.00 | 3. |
| | 29730 | | 0 | 9.00 | 8.00 | 3. |
| | 29740 | | 0 | 9.00 | 8.00 | 3. |
| | 29750 | | 0 | 9.00 | 8.00 | 3. |
| | 29751 | | 0 | 15.00 | 13.00 | 3. |
| N | 36415 | | 0 | 1.80 | 1.80 | 0. |
| | 64450 | | 0 | 13.00 | 11.00 | 0. |

| IND | HCPCS CODE | MOD | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|
| | 64702 | | 90 | 79.00 | 68.00 | | 3. |
| | 64704 | | 90 | 105.00 | 91.00 | | 3. |
| | 64708 | | 90 | 242.00 | 210.00 | | 3. |
| | 64774 | | 30 | 42.00 | 37.00 | | 3. |
| | 64776 | | 30 | 53.00 | 45.00 | | 3. |
| | 64782 | | 30 | 79.00 | 68.00 | | 3. |
| | 64784 | | 30 | 131.00 | 114.00 | | 4. |
| | 64834 | | 90 | 105.00 | 91.00 | | 3. |
| | 64856 | | 90 | 210.00 | 183.00 | | 3. |
| L | W1250 | | 0 | 18.00 | 16.00 | | 3. |
| L | W1650 | | 0 | 24.00 | 21.00 | | 3. |
| L | W1650 | 22 | 0 | 37.00 | 32.00 | | 3. |
| L | W2600 | | 90 | 151.00 | 131.00 | | 3. |
| L | W2610 | | 90 | 242.00 | 210.00 | | 3. |
| L | W2620 | | 90 | 90.00 | 79.00 | | 3. |
| L | W2650 | | 0 | 21.00 | 21.00 | | 0. |
| L | W2655 | | 0 | 5.00 | 5.00 | | 0. |

(c) RADIOLOGY

| IND | HCPCS Code | MOD | MEDICAID DOLLAR VALUE S | $ | NS |
|---|---|---|---|---|---|
| | 73560 | | 15.00 | | 15.00 |
| | 73562 | | 15.00 | | 15.00 |
| | 73590 | | 15.00 | | 15.00 |
| | 73600 | | 10.00 | | 10.00 |
| | 73610 | | 13.00 | | 13.00 |

| IND | HCPCS CODE | MOD | MEDICAID DOLLAR VALUE S | $ | NS |
|---|---|---|---|---|---|
| | 73620 | | 10.00 | | 10.00 |
| | 73630 | | 13.00 | | 13.00 |
| | 73650 | | 10.00 | | 10.00 |
| | 73660 | | 5.00 | | 5.00 |
| L | W7200 | | 20.00 | | 20.00 |

(d) PATHOLOGY & LABORATORY SERVICES

| IND | HCPCS Code | MOD | MEDICAID DOLLAR VALUE S | $ | NS |
|---|---|---|---|---|---|
| N | 81000 | | 1.20 | | 1.20 |
| | 82947 | | 3.00 | | 3.00 |
| | 83051 | | 1.20 | | 1.20 |
| | 83053 | | 1.20 | | 1.20 |
| | 86595 | | 6.00 | | 6.00 |
| N | 87040 | | 9.00 | | 9.00 |
| N | 87070 | | 9.00 | | 9.00 |
| | 87076 | | 6.00 | | 6.00 |

| IND | HCPCS CODE | MOD | MEDICAID DOLLAR VALUE S | $ | NS |
|---|---|---|---|---|---|
| | 87081 | | 12.00 | | 12.00 |
| | 87101 | | 8.00 | | 8.00 |
| | 87102 | | 8.00 | | 8.00 |
| | 87106 | | 8.00 | | 8.00 |
| N | 87184 | | 9.00 | | 9.00 |
| | 87210 | | 2.40 | | 2.40 |
| | 87220 | | 2.40 | | 2.40 |

APPENDIX A

PODIATRY SERVICES

CODES AND NARRATIVES NOT FOUND IN CPT-4 (Level II and Level III Codes)

SURGERY CODES

| IND | HCPCS CODE | MOD | DESCRIPTION | FOLLOW UP DAYS | MEDICAID DOLLAR VALUE S | $ | NS | ANES BASIC UNITS |
|---|---|---|---|---|---|---|---|---|
| | W1250 | | Excision of nail, partial or complete, including nail bed or nail fold, with or without excision of subungual exostosis e.g. for fungus infection or chronic paronychia. | 0 | 18.00 | | 16.00 | 3. |
| | W1650 | | Excision of plantar verruca, single site unilateral | 0 | 24.00 | | 21.00 | 3. |
| | W1650 | 22 | Excision of plantar verruca, multiple sites unilateral | 0 | 37.00 | | 32.00 | 3. |
| | W2600 | | Arthroplasty, lesser toes, with or without tendon transfer | 90 | 151.00 | | 131.00 | 3. |
| | W2610 | | Arthroplasty - Hallux Valgus with implant (Swanson or see Burger) | 90 | 242.00 | | 210.00 | 3. |
| | W2620 | | Plastic or reconstructive surgery, toe, one joint | 90 | 90.00 | | 79.00 | 3. |
| | W2650 | | Casting for molded shoes | 0 | 21.00 | | 21.00 | 0. |
| | | | Prior authorization is required. Attach to your 1500-N.J. claim form. | | | | | |
| | W2655 | | Casting for arch support | 0 | 5.00 | | 5.00 | 0. |
| | | | Prior authorization is required. Attach to your 1500 N.J. claim form. | | | | | |

RADIOLOGY CODE

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | W7200 | | Radiologic examination; foot, complete including special os calcis view | | 20.00 | | 20.00 | |

## QUALIFIERS

| HCPCS CODE | QUALIFIERS |
|---|---|
| | INITIAL VISITS - NEW PATIENT |
| 90015<br>90017<br>90020<br>90215<br>90220<br>90315<br>90320<br>90415<br>90420 | When reference is made in your CPT manual to New Patient or Initial Care, the intent of Medicaid is to consider this service as the Initial Visit.<br><br>If the setting for this Initial Visit is an Office, or Sheltered Boarding Home, then for reimbursement purposes, it is limited to a single visit with the future use of this code then reimbursed as a Routine or Follow-Up visit. This is applicable if this examination of the recipient is by the same physician, group of physicians, involves a shared health care facility or group of physicians sharing a common record. Reimbursement for an Initial Office Visit also precludes subsequent reimbursement for an Initial Sheltered Boarding Home Visit and vice versa.<br><br>Reimbursement for an Initial Office Visit or Sheltered Boarding Home Visit will be disallowed and the fee downgraded to a routine visit, if an annual examination or EPSDT examination were billed within a twelve month period, by the same physician, group, shared health care facility, or practitioners sharing a common record.<br><br>If the setting is Skilled Nursing, Intermediate Care, Long Term Care Facility or Hospital, the Initial Visit concept will still apply when considered for reimbursement purposes despite CPT reference to the terms Initial Care or Initial Hospital Care as applying to a new or established patient.<br><br>Subsequent readmissions to the same facility may be designated as Initial Visits as long as a time interval of 30 days or more has elapsed between admissions.<br><br>It is also to be understood that in order to receive reimbursement for an Initial Visit, the following minimal documentation must be on the record regardless of the setting where the examination was performed.<br><br>Example:<br><br>1. Chief complaint(s). |

2. Complete history of the present illness and related systemic review - including recordings of pertinent negative findings.

3. Pertinent past medical history.

4. Pertinent family history.

5. A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings.

6. Working diagnoses and treatment plan including ancillary service and drugs ordered.

NOTE: (1) Home and Boarding Home records should be part of the office records.

(2) If the history and physical examination noted above is not personally performed by the billing physician in a hospital or health care facility, then reimbursement will be downgraded to a routine visit if that criteria is met, e.g., daily hospital care, subsequent skilled nursing visit, etc.

ROUTINE VISIT OR FOLLOW-UP CARE VISIT

Routine visit or Follow-Up Visit is defined as the care and treatment by a physician, which includes those procedures ordinarily performed during a health care visit, which is dependent upon the setting and the physician's discipline.

90050
90060
90070
90250
90260
90270
90350
90360
90370
90450
90460
90470

The setting could be office, hospital, skilled nursing, intermediate care, long term care facilities, nursing home or boarding home. Prior authorization is required where more than one visit a month would be necessary for routine foot care.

In order to document the record for reimbursement purposes, a progress note for the noted visits should include the following:

1. In an Office, or Boarding Home setting.

a) Purpose of visit;

b) Pertinent history obtained

c) Pertinent physical findings including pertinent negative findings based on the above.

HOME VISITS

90150
90160
90170

Home Visit (House Call) - does not apply to Sheltered Boarding Home or Nursing Home setting.

A Physician visit limited to care and treatment of an individual who by contemporary standards would be too ill to go to a physician's office and/or is "home bound" due to his/her physical disability. If more than one patient is seen on the visit, the fee for the additional visit will be as if it were performed in the office. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a 90150.

The record and documentation of a home visit shall become part of the office progress notes and shall include, as appropriate, the following instructions:

1. Purpose of visit;

2. Pertinent history obtained;

3. Pertinent physical findings, including pertinent negative physical findings based on 1. and 2.;

4. Procedures, if any performed, with results;

5. Lab, x-ray, ECG, etc, ordered with results;

6. Diagnosis(s) plus treatment plan status relative to present or pre-existing illness(s) plus pertinent recommendations and actions.

NOTE: The new "Home Visit (House Call)" code does not distinguish between specialist and non-specialist. Also, the Initial Home Visit is being dropped as a separate entity.

CONSULTATIONS

A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice. Two types of consultation are recognized for reimbursement - one limited in extent and one comprehensive in scope.

| HCPCS CODE | QUALIFIERS |
|---|---|
| | Limited Consultation: |
| 90600<br>90605<br>90610 | Appropriate CPT codes which are presently compatible are Codes 90600, 90605 and 90610. The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as "comprehensive" as noted below. |
| | Comprehensive Consultation: |
| 90620 | In order to receive reimbursement for CPT Code 90620 which replaces the discontinued Code 9030 (consultation comprehensive), the same criteria must be met that had been previously required, namely, the performance of a total systems evaluation by history and physical examination including a total systems review and total system physical examination. The alternative to that would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation. |

Reimbursement for Code 90620 (Comprehensive Consultation) requires the following applicable statements or language essentially similar to those statements to be inserted into Item 34 of the 1500 N.J. Claim Form. The form is to be signed by the provider who performed the consultation.

1. I personally performed a total (all) systems evaluation by history and physical examination, or

2. This consultation utilized 60 or more minutes of my personal time.

Failure to comply with the above will result in the consultation being downgraded to the reimbursement of Code 90610.

The following rules regarding consultations should also be recognized:

1. If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness then the provider may not, in addition, bill for an Initial Visit if he has or intends to bill for the consultation.

2. If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.

3. If the patient is seen for the same illness on repeated visits, by the same consultant, then these visits are considered as routine visits or follow-up care visits and not as consultations. In addition, the criteria for concurrent care would need to be met to warrant reimbursement.

4. Consultation codes 90600, 90605, 90610 and 90620 will be declined in an Office or Boarding home setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A routine visit code is applicable under these circumstances.

5. If a prior claim for code 90620 has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the same physician, physician group, shared health care facility or physicians using a common record except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be 90600, 90605, or 90610 if their criteria are met.

90799

Injection policy and drugs dispensed by a podiatrist. Payment will be made for intradermal, subcutaneous, intramuscular, or intravenous injections in the office or home (not nursing home).

1. The drug administration must be consistent with the diagnosis.

2. Injections before a surgery or nerve blocks are ineligible.

3. Sclerosing solution or anything injected into a neuroma or tumor would be considered as a visit.

4. PRV 20600 or 20605 can only be given when the injection is into a joint.

   (Ankle can be considered a joint).

5. An injection into the bursa or an injection for bursitis would be coded PRV 20600 or 20505.

6. Cortisone or steroid injections would be eligible as long as they were injected into the foot. PRV 90799 should be used.

| HCPCS CODE | QUALIFIERS |
|---|---|
| 11000<br>11001 | Porcine Pigskin Grafts will be considered as debridement of eczematous or infected skin. |
| [redacted] | Removal of foreign body in muscle, with anesthesia (Includes hematoma) (other than by needle aspiration). |
| 20550 | If office visit is performed in addition must be documented and not included in time spent for PRV 20550. |
| 20600<br>20605 | One or more joints same visit include medication. If office visit is performed in addition, must be documented on the record and may not include time spent for PRV 20600 and 20605. |
| 2068052 | Removal of metal band, plate, screw, or nail - Use only when done in outpatient setting. |
| 20680 | Removal of metal band, plate, screw or nail - Use only when done in inpatient hospital setting. |
| 28285 | Hammer toe surgery is reimbursable at 100% of the allowance for the first toe surgically corrected and 50% of the allowance for each toe thereafter up to a maximum of 200%. |
| 28288 | Rasping technique (ostectomy) with or without tenotomy. |
| 28490 | Phalanx, or phalanges, great toe, simple, closed reduction (Use of shoe, plaster or metal mold, strapping, casting, bandaging). |
| 28750<br>28755 | Toe, one or more joints. |
| 29580 | An unna paste boot is comparable to this procedure. |
| 36415 | For reimbursement purposes, reference is to collection of blood by venapuncture only and limited to office, home or nursing home. Payment is once per patient visit and will not be applicable if the laboratory study is to be done by the physician's own office. |
| 81000 | URINALYSIS<br><br>Stick, dip or tablet tests done on urine are considered part of the urinalysis, and therefore, are not eligible for separate reimbursement. Microscopy is required for reimbursement. |

| HCPCS CODE | QUALIFIERS |
|---|---|
| 87040<br>87840<br>87184 | CULTURES |

NOTE: These codes may only be billed when a pathogenic micro-organism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture.

## APPENDIX C (Podiatry Services)

| MODIFIER CODE | DESCRIPTION |
|---|---|
| LT | Left Side: Used to identify procedures performed on the left side of the body. |
| RT | Right Side: Used to identify procedures performed on the right side of the body. |
| 20 | Microsurgery: Service is performed using the techniques of microsurgery, including the aid of an operating microscope, modifier '20' may be added to the surgical procedure. |
| 22 | Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. |
| 47 | Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '47' to the basic service. |
| 50 | Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number. |
| 51 | Multiple Procedures: When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary, additional or lesser procedure(s) may be identified by adding the modifier '51' to the secondary procedure number(s). |
| 52 | Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. |
| 62 | Two Surgeons: Under certain circumstances the skill of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances the separate services may be identified by adding the modifier '62' to the procedure number used by each surgeon for reporting his/her services. |

66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier '66' to the basic procedure number used for reporting services.

75 Concurrent Care Services Rendered by More than One Physician: When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier '75' to the procedure code for the basic service performed.

76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.

77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier '77' to the repeated service.

80 Assistant Surgeon: Surgical assistant services are identified by adding this modifier '80' to the usual procedure number(s).