STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES

HEALTH SERVICES PROGRAM

DO NOT CIRCULATE

PROSTHETIC AND ORTHOTIC
MANUAL

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THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

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

August, 1974

TO: APPROVED PROSTHETIC AND ORTHOTIC PROVIDERS

SUBJECT: CHAPTER IV, MANUAL REVISIONS – INCLUSION OF FEE SCHEDULES

Enclosed is revised Chapter IV, which now reflects an updated listing of procedure codes and maximum fees for Prosthetics, Orthotics, shoes, shoe appliances and repairs.

The New Jersey Health Services (Medicaid) Program, in recognition of the substantial increases in costs of materials and labor, is pleased to advise you that we have increased our maximum allowable reimbursement for shoes, shoe appliances and repairs effective August 19, 1974. This means that claims processed for eligibles subsequent to August 19, 1974 will be reimbursed in accordance with the revised schedule of allowances.

Please remove the current Chapter IV from your Prosthetic and Orthotic Manual and insert enclosed Chapter IV.

We wish to take this opportunity to thank you for your continued participation in the Medicaid program. Your dedication to the health needs of the people of the State of New Jersey is recognized and appreciated.

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

New Jersey Health Services Program **NEWSLETTER**

Volume P-205 November 1, 1977

TO: PROSTHETIC AND ORTHOTIC APPLIANCE PROVIDERS

SUBJECT: REVISED PROSTHETIC AND ORTHOTIC APPLIANCE CLAIM FORM (MC-15-C1), EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorpate federally required MMIS information, the MC-15 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-15 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-15-C1 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form (items 10, 11, 12 and 15) are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-15 CLAIM FORM

Item 10: Indicate whether this claim is related to an injury which resulted from an automobile accident, by che the appropriate block.

Item 11: Diagnosis

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

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

Item 12: EPSDT Program Referral - Complete this item for recipients under age 21.

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

It is essential that the Medicaid Program be able to relate diagnostic and/or treatment services to the original screening. Therefore, when a patient under 21 visits your office, a reasonable effort should be

(continued)

made to determine whether it is as a result of an EPSDT Program referral by asking the referring physician or clinic or the patient. If you are unable to obtain the information, check "NO".

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by and Individual Medicaid Practitioner (IMP) Number. Item 15 on the revised claim refers to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers.

Item 15: Prescribing Practitioner

Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the prosthetic and/or orthotic appliance(s).

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

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

Continue to follow the procedures for submitting claims as outlined in Chapter III of your Medicaid Prosthetic and Orthotic Manual.

PROSTHETIC AND ORTHOTIC APPLIANCE BILLING PROCEDURES

Instructions for Completion of Form MC-15

1. - 4. -Copy the Patient's Name, Health Services Program (HSP) Case Number, and Person Number EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card.
   -For additional information, see Section 101. of your Medicaid Prosthetic and Orthotic Manual.

5. -Indicate patient's age.

6. -Check appropriate block, to identify patient's sex.

7. -Check appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage.
   -If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from the carrier.
   -When the recipient is covered by both Medicare and Medicaid, see Section 304. of your Medicaid Prosthetic and Orthotic Manual.

8. -Check as appropriate.
   -If patient's illness or injury is work related, enter name and address of employer.

9. -This information is usually preprinted.
   -If not preprinted, write in provider name, address, and provider number.
   -Enter telephone number.

10. -Indicate whether injury resulted from an automobile accident.

11. -Enter diagnosis.

12. -Complete this item for recipients under 21 years of age.
    -Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening.
    Indicate if this patient is such a referral by checking the appropriate block.

13.A. -Enter date(s) service was provided.
13.B. -Identify appliance provided by code number as listed in Chapter IV of your Medicaid Prosthetic and Orthotic Manual.
13.C. -If appliance includes shoes, check column C.
13.D. -Describe appliance(s) furnished, repairs, and/or parts replaced, using nomenclature from Chapter IV of your Medicaid Prosthetic and Orthotic Manual.
13.E. -Enter quantity.
13.F. -Enter your usual and customary charge.

14. -Do not write in this space; for Division use only.
-When prior authorization is required, obtain authorizing signature from Local Medical Assistance Unit.

15. -Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the prosthetic and/or orthotic appliance(s).

16. -Indicate whether the patient is currently in a Long Term Care Facility.
-If yes, give the name and address of the Long Term Care Facility.

17. -Under ordinary circumstances, the patient must sign the claim form when services have been received.
-The claim form must indicate services rendered, prior to presenting it to the patient for signature.
-If the patient's signature is unobtainable, see the Billing Chapter in your Medicaid Prosthetic and Orthotic Manual for procedures to follow.

18. -Read the Provider Certification carefully.
-The provider must sign item 17 before the claim can be considered for payment.
-Indicate the billing date which is the date the claim is mailed.

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

13

PROSTHETIC AND ORTHOTIC APPLIANCE CLAIM

1 Patient's Last Name — First Name

2 Patient's Street Address — Telephone Number

City — State — ZIP Code

3 Health Services Program Case No.

4 Patient Person No.

5 Age

6 Sex ☐ Male ☐ Female

7 Other Health Insurance or Liability Coverage? ☐Yes ☐No
If Yes, attach a copy of Decline Notice or Explanation of Payment from Carrier.
No Fault Auto Coverage? ☐Yes ☐No
(If Medicare – See Section 304 of Manual).

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

10 Did Injury result from automobile accident? ☐Yes ☐No

9 PROVIDER OF SERVICE INFORMATION

Telephone Number

Medicaid Provider Number (Enter only when not printed below)

Name and Address

11 Primary Diagnosis — Secondary Diagnosis

12 Was this service performed as a result of an EPSDT Program Referral? ☐ Yes ☐ No

FOR CONTRACTOR'S USE ONLY

TOTAL AMOUNT A	TOTAL AMOUNT B	CODE	PRESCRIBING PRACTITIONER	AUTH	JAM	3rd PLC
47 48 49 50 51 52	53 54 55 56 57 58	59	60 61 62 63 64 65 66 67 68	69	70	71

13 REPORT OF SERVICES

A DATE PROVIDED	B APPLIANCE CODE NO.	C SHOES	D DESCRIPTION OF APPLIANCE, REPAIRS, OR REPLACEMENTS USING NOMENCLATURE AS LISTED IN CHAPTER IV.	E QUAN.	F CHARGES
					$

14 AUTHORIZING SIGNATURE (MEDICAL CONSULTANT) (For Division Use Only)

Date

TOTAL CHARGES $

15 Name and Number of Prescribing Practitioner

Name — Individual Medicaid Practitioner Number

16 Is Patient in a Long Term Care Facility? ☐Yes ☐No
If Yes, give the Name and Address of the Facility.

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

Signature (Patient or authorized representative) — Date Signed

18 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 payment 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 payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

Provider Signature____________________

Billing Date Mo./Day/Yr.

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 YR.	FROM MO.	FROM DAY	TO MO.	TO DAY	ITEM #	AMOUNT A	AMOUNT B	CODE	P	JAM	DATES OF SERVICE YR.	FROM MO.	FROM DAY	TO MO.	TO DAY	ITEM #	AMOUNT A	AMOUNT B	CODE	P	JAM
3																						
	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 68	69	70	71
4																						
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 68	69	70	71
5																						

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FOREWORD

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

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

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

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

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

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CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

100. WHO IS ELIGIBLE

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

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

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

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

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

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

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

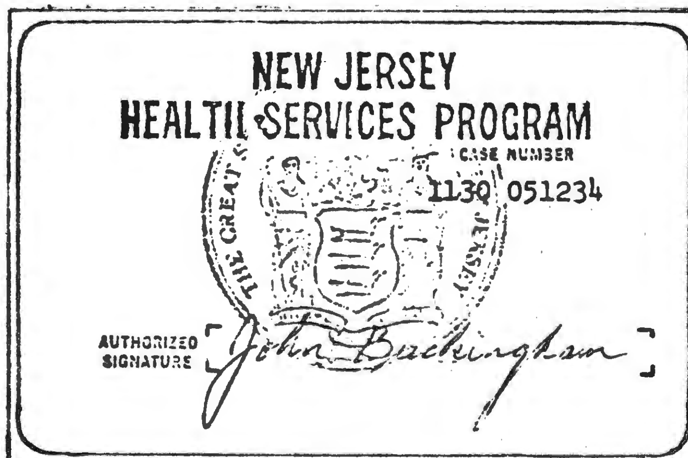
101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

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

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

Exhibit I



101.2 Validation Form (Exhibit II)

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

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

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

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

Exhibit II

______ COUNTY WELFARE BOARD

VALIDATION FOR HEALTH SERVICES PROGRAM

Valid Only for Month of Jan. 1970

BUCKINGHAM 11 30 051234

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

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

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

2. Workmen's Compensation

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

3. Other Health Insurance

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

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.

CHAPTER II

PROSTHETIC AND ORTHOTIC APPLIANCES

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CHAPTER II

PROSTHETIC AND ORTHOTIC APPLIANCES

200. PROSTHETIC AND ORTHOTIC APPLIANCES

This chapter is concerned only with those prosthetic and custom-made orthotic appliances listed in Chapter IV of this Manual. It is not concerned with medical supplies and equipment, dentures, eye aids, including eyeglasses and artificial eyes and prosthetic devices used in conjunction with a surgical procedure, i.e., heart valves (et al).

201. DEFINITIONS

201.1 Prosthetic Appliances

"Prosthetic Appliances" means appliances prescribed by a physician within the scope of his practice as defined by State Law, for the purpose of artificially replacing a missing portion of the body.

201.2 Orthotic Appliances

"Orthotic Appliances" refers to custom-made braces prescribed by a physician within the scope of his practice as defined by State Law, for the purpose of providing support, increased function and overcoming physical impairments or defects.

201.3 Custom-made

For purposes of Health Services Program policies as they relate to prosthetic and orthotic appliances (excluding hearing aids, dentures, and artificial eyes), this term means a device or appliance fabricated (constructed and/or assembled) in an approved facility and designed to fit and perform a useful function solely for that specific single individual for whom it was ordered.

201.4 Certification

For purposes of Health Services Program policies as they relate to prosthetic and orthotic appliances, the term "certification" means a prosthetist, orthotist and/or facility who (which) has met the standards of qualification as established by the American Board for Certification in Orthotics and Prosthetics, Inc.

202. ELIGIBLE PROVIDERS

Reimbursement for custom-made prosthetic and orthotic appliances (excluding those in Sections 200., 204.2 and Shoes) shall be made only to providers who are eligible to participate in the New Jersey Health Services Program in accordance with the following criteria:

A. Approval for Program Participation

1. Appliances are fabricated in the facility and not jobbed out ("facility" means the area of operation of the prosthetist/orthotist).

2. Certified Facility.

3. Certified Personnel (owner and/or employee(s)).

NOTE: If the facility restricts its appliances to prosthetics, then only a certified prosthetist is required; if orthotics, a certified orthotist: if prosthetic and orthotic, a certified prosthetist and orthotist is required.

B. Provisional Approval for Program Participation (Certified Personnel)

1. Appliances are fabricated in the facility and not jobbed out.

2. Non-Certified Shop.

3. Certified Personnel (owner and/or employee(s)).

NOTE: See Part A.

C. Provisional Approval for Program Participation (Non-Certified Personnel)

1. Appliances are fabricated in the facility and not jobbed out.

2. Non-Certified Shop.

3. Non-Certified Personnel (Neither the owner nor any employee is certified).

Related to categories B (parts 2 and 3) and C (Parts 2 and 3) only, provisional approval may be granted by the Division of Medical Assistance and Health Services to those facilities and personnel whose application for facility and/or personnel certification is pending.

203. PRESCRIPTION POLICIES

203.1 Prosthetic and orthotic appliances require a personally signed and dated order (prescription) by the prescribing physician.

203.2 The prescription must include the following:

1. Patient's name, age, address, HSP Number, Patient Person Number, and

2. Relevant diagnosis supporting need for custom-made prosthetic and orthotic appliances, and

3. Detailed (meaningful) description of the prosthetic and orthotic appliances ordered. (i.e., "back brace", "leg brace", "artificial limb", "orthopedic shoe", etc., on a prescription is unacceptable).

204. PRIOR AUTHORIZATION

204.1 Prosthetic and Orthotic Appliances

The provider, upon receipt of an acceptable prescription (See Section 203.1 and 203.2 - Prescription Policies), will submit, with the prescription attached, his detailed breakdown of the appliance ordered, according to the accepted New Jersey Prosthetic and Orthotic nomenclature, to the appropriate Local Medical Assistance Unit, on Prosthetic and Orthotic Claim Form (MC-15). Upon receipt of this information at the Local Medical Assistance Unit, the local medical consultant will review the medical (prosthetic or orthotic) data and sign the MC-15 in the appropriate space, if approved. The Local Medical Assistance Unit will retain copy 3 for its files and forward the MC-15 to the provider. The provider, upon approval, fabrication and delivery of the appliance to the recipient, with recipient's signature, will forward the completed claim form (MC-15) to the contractor (See Chapter III - Billing Procedures). In the event that a physician's prescription does not conform to the prosthetic and orthotic nomenclature accepted by this Division and the approved New Jersey prosthetic and orthotic facilities, it shall be encumbent upon the facility to transform the original prescription to conform to the accepted nomenclature. This does not imply that the physician's prescription will in any way be altered.

In the case of a claim submitted by an out-of-state facility which may be unfamiliar with New Jersey nomenclature, the Division's Prosthetic and Orthotic Consultant will assume the responsibility of clarifying the claim to conform to the accepted nomenclature.

204.2 Orthotic Appliances Not Requiring Prosthetic and Orthotic Facility Approval

The following items customarily listed as orthotic appliances are reimbursable, under the conditions imposed in Section 204.1, paragraph 1, from facilities other than those with Division approval or provisional approval (i.e., pharmacies, non-approved prosthetic and orthotic facilities, etc.) and require prior authorization:

1. Cervical Collars
   a. Soft
   b. Hard
   c. Malleable Frame
2. Abdominal Belts (fashioned elastic type - not used for incisional hernia)
3. Abdominal Corsets (non-elastic type)
4. Abdominal Supports (low back - non-elastic type - size to fit patient)
5. Sacro-iliac and lumbo-sacral corsets, supports or belts (male or female)
6. Special corset, boned and reinforced with steel stays
7. Combination corset with inside abdominal belt
8. Elastic support stockings, etc.
9. Surgical weight hose

10. Trusses

11. Knee Cage (Standard)

12. Hand Orthosis

    a. Short Opponens

        (1) C-Bar

        (2) Lumbrical Bar

13. Denis Browne Splints and Fillauer Bar

14. Shoes

NOTE: See Chapter III - Billing Procedures

204.3 Shoes

A. Definition of Shoe - For the purpose of the New Jersey Health Services Program policies, an "orthopedic shoe" is defined as a shoe, with or without accompanying appliances, used to prevent or correct gross deformities of the feet and consisting of the following basic parts:

1. Correct straight last line

2. Heels with sufficient bearing surface

3. Toe with ample room for function

4. Sole with sufficient weight for foot protection

5. Rigid Shank

6. Properly fitting upper

7. Smooth and protective lining

8. Snug fitting heel counter

9. Properly fitted as to length and width

B. Shoes are reimbursable under the following conditions:

1. When attached to a brace or bar and/or

2. When part of the normal (customary, usual) post-operative or post-fracture treatment program and/or

3. When used to correct gross foot deformities and/or

4. When the talo-crural (ankle) joint is included in the shoe

C. The provider, upon receipt of an acceptable prescription (See Section 203.1 and 203.2 - Prescription Policies), must submit a copy of the prescription along with a cost estimate of the shoe (with alterations, additions, accompanying appliances, etc., where applicable) to the recipient's Local Medical Assistance Unit. This cost estimate must include a detailed cost breakdown of the basic shoe plus any additional charges for materials and/or services.

204.4 Repairs and Replacement of Parts

All repair and replacement of parts for custom-made prosthetic and orthotic appliances require a personally signed and dated order by the prescribing physician (See Section 203.1 - Prescription Policies) and must include the necessary information required in Section 203.2.

Exception: Repairs or replacement of parts involving solely the mechanical aspects of an appliance (breakage, etc.) which occurs as an emergency and are under $50.00, require no prior authorization. An amount of $50.00 or over requires prior authorization by the local medical consultant.

205. GUARANTEE/WARRANTY

205.1 Health Services Program

It is the responsibility of the provider to verify recipient eligibility. Payment cannot be made for ineligible recipients. Therefore, an authorization per se for any service(s) provided guarantees payment only if current eligibility is established (See Chapter I, Section 101., for instructions on identifying current eligibility).

Exceptions:

1. If fabrication of an appliance (including repair or replacement of parts on existing appliance) has commenced following authorization, but has not been completed, during the period of recipient's eligibility, reimbursement to the provider will be allowed.

2. If death or other circumstances (i.e., moving out of state) involving the recipient over which no one may have control, reimbursement will be made in an amount consistent with the stage of completion of the appliance or, if completed, reimbursement will be made for the completed appliance consistent with the Program's schedule of allowances.

205.2 Provider

For a new appliance, the provider shall submit a unit price for each complete item in the New Jersey Prosthetic and Orthotic nomenclature and shall include:

1. Cost of all labor required to prepare the appliance for final acceptance.

2. Cost of materials.

3. Cost for home visits beyond a 10-mile radius from the prosthetic and orthotic facility (maximum allowable home visits - 3).

4. Delivery of the appliance to the recipient within 45 calendar days of receipt of authorization by the facility from the Local Medical Assistance Unit.

   If it is not possible to provide an appliance within the stated time, the facility shall notify the Local Medical Assistance Unit that such time limit cannot be met in a particular case and state the reason(s) why.

   Liability for delinquency thereupon becomes a judgmental factor within the Local Medical Assistance Unit which will act accordingly.

5. Provision that all appliances furnished by the approved facility will conform to the prescriber's prescription and the description of appliances set forth in the accepted nomenclature, will fit properly to the extent that the recipient's condition(s) permit and will provide maximum efficiency and comfort consistent with the condition(s) of the recipient for whom the appliances are prescribed.

6. Assumption of liability for material defects over which they have (or should have) control.

   Exception: Structural material defects over whose production, testing, inspection, etc., the facility has no control.

7. Agreement to accept rejection of all appliances when the prescribing physician, after appropriate evaluation of the appliance(s), determines that the appliance(s) does not conform to the prescription and description of the appliance set forth in the accepted nomenclature, do not fit properly, are not acceptable quality or do not provide maximum efficiency and comfort consistent with the conditions of the recipient(s) for whom they are prescribed.

8. Warranty against defective material and workmanship (except for parts normally worn from natural use) for a period of one year from date of delivery to and acceptance by the recipient(s). If it is found that either or both are defective then -

   a. the provider shall be allowed a reasonable opportunity to make such adjustments and/or corrections or replacement that may be necessary to allow for acceptance of the appliance as indicated in item 7 without additional charge.

      Exception: This warranty does not apply to corrections and/or conditions incidental to alterations or changes in the recipient's physical condition or misuse, abuse or alteration in an appliance not made by the original provider.

9. Agreement that any controversies arising from the preceding 8 items shall be resolved by arbitration of a special committee appointed by the Director, Division of Medical Assistance and Health Services and consisting of personnel not involved in the case originally. The opinions of the committee shall be binding on all concerned (Division, provider, prescribing physician, recipient).

10. Acceptance of any action by the Division of Medical Assistance and Health Services resulting from recommendations of the special committee appointed to resolve controversies as indicated in item 9.

206. COMMITTEE

The director, Division of Medical Assistance and Health Services, shall appoint a committee to review, alter and update prosthetic and orthotic nomenclature and this committee shall meet, at least annually, to perform its assigned responsibility.

207. BASIS OF PAYMENT

Reimbursement shall be on the basis of the customary charge, not to exceed an allowance determined reasonable by the Commissioner of the Department of Institutions and Agencies, and further limited by federal policy relative to reimbursement of practitioners and other individual providers. In no event shall the allowance exceed the charge by the provider to other governmental agencies, or other groups or individuals in the community.

CHAPTER III

BILLING PROCEDURES - PROSTHETIC AND ORTHOTIC

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CHAPTER III

PROSTHETIC AND ORTHOTIC APPLIANCES - 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

A. New Appliances (including shoes)

Claims should be submitted for payment following delivery and acceptance of the completed appliance(s) to the recipient.

B. Repair and/or Replacement of Parts

(1) Claims of $20 or less require no prior authorization and should be submitted for payment to the contractor with the physician's prescription attached.

(2) Claims over $20, except in emergencies, (See Section 204.4) require prior authorization and should be submitted for payment following the completion of the authorized repairs and/or replacement of parts and delivery and acceptance of the repaired appliance(s) to the recipient.

302. PATIENT IDENTIFICATION

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

303. PRIOR AUTHORIZATION

Items or services requiring prior authorization should not be provided until prior authorization is received (See Section 204.1). When submitting claims for payment make certain the Prosthetic and Orthotic Claim Form (MC-15) has been properly signed in the following sections:

Section 11 - Signature of Local Medical Consultant
Section 14 - Patient Certification
Section 15 - Provider's Signature

To assure prompt claim consideration, always furnish the prescribing physician's name and Social Security Number.

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.

In this instance, it will be necessary to attach to the SSA-1490, a completed MC-15 Form (See Section 204. - Prior Authorization).

> 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 applications 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 & 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 Street	Newark	07103	1576	201-648-3700
08	Gloucester	10 Harrison Street	Woodbury	08096	1900	609-845-7185
17	Salem	" " "	"	"	"	" " "
09	Hudson	100 Newkirk Street	Jersey City	07306		201-792-6390
10	Hunterdon	6 Court Street	Flemington	08822		201-782-1130
18	Somerset	" " "	"	"		" " "
21	Warren	" " "	"	"		" " "
11	Mercer	205 E. State Street	Trenton	08625	2465	609-292-7315
12	Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-246-0653
13	Monmouth	320 Broad Street	Red Bank	07701	778	201-842-6440
14	Morris	4 Court Street	Morristown	07960		201-267-1700
19	Sussex	" " "	"	"		" " "
15	Ocean	952 President Ave. Apt. #1	Toms River	08753	666	201-341-0804
16	Passaic	152 Market Street	Paterson	07590	2863	201-523-2800
20	Union	7 Bridge Street	Elizabeth	07201		201-355-8860

306. PROSTHETIC AND ORTHOTIC APPLIANCE CLAIM (MC-15)

This form is to be used for the purpose of billing for prosthetic and orthotic appliances. If the claim is for a service which does not require prior authorization as stated in this manual, A COPY OF THE ORIGINAL PRESCRIPTION MUST BE ATTACHED.

306.1 Instructions for Completion of Form MC-15 (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, provide the name and address of the carrier(s), and show amount paid.

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

9. Name and Address of Provider - (This information may be preprinted)

10. A. Enter date service was provided
    B. Enter appliance code number as listed in Chapter IV
    C. If claim includes shoes, please check
    D. Enter description of appliances furnished, repaired, or parts replaced using nomenclature as listed in Chapter IV
    E. Enter quantity (if applicable)
    F. Enter charges

11. AUTHORIZING SIGNATURE - When prior authorization is required, obtain signature from the Local Medical Assistance Unit.

12. PRESCRIBING PRACTITIONER - Give the Name and Social Security Number of the physician prescribing the prosthetic or orthotic appliance.

13. LONG TERM CARE - If the patient is confined to a long term facility such as an Extended Care Facility or a Skilled Nursing Home check the appropriate block and give the name and address of the facility in the space provided.

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

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

A. Illiterate Patient

The patient may sign by mark (X), and the signature must be witnessed by another person including the provider of 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 CERTIFICATION - The Provider must sign and date this certification before the claim for payment may be considered.

306.2 Mailing Instructions

Mail the Original Copy (Contractor's Copy) and prescriptions (where appropriate) to:

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

Retain the Provider copy for your records.

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

EXHIBIT **13**

PROSTHETIC AND ORTHOTIC APPLIANCE 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

FOR CONTRACTOR'S USE ONLY

TOTAL AMOUNT A						TOTAL AMOUNT B						CODE	PRESCRIBING PHYSICIAN									AUTH	JAM
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70

REPORT OF SERVICES

10. A. DATE PROVIDED	B. APPLIANCE CODE NO.	C. SHOES	D. DESCRIPTION OF APPLIANCE, REPAIRS, OR REPLACEMENTS USING NOMENCLATURE AS LISTED IN CHAPTER IV.	E. QUAN.	F. CHARGES
					$

11. AUTHORIZING SIGNATURE — Date — **TOTAL CHARGES** $

12. Name and Number of Prescribing Practitioner
Name — Social Security Number

13. Is Patient in a long term care Facility? ☐ Yes ☐ No
If Yes, give the Name and Address of the Facility.

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

Signature *(Patient or authorized representative)* — Date Signed

15. PROVIDER CERTIFICATION. I certify that the 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 — Date Signed

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

FOR CONTRACTOR'S USE ONLY

CARD	DATES OF SERVICE					ITEM #	AMOUNT A	AMOUNT B	CODE	P	JAM	DATES OF SERVICE					ITEM #	AMOUNT A	AMOUNT B	CODE	P	JAM
		FROM		TO									FROM		TO							
	YR.	MO.	DAY	MO.	DAY							YR.	MO.	DAY	MO.	DAY						
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 68	69	70	71
4																						
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 68	69	70	71
5																						

MC-15A — CONTRACTOR'S COPY — Medicaid 33696 Part I Ed 6-71 (N.J.) Printed in U.S.A.

PROSTHETIC AND ORTHOTIC SERVICES MANUAL

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

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3.4 HCPCS CODES FOR PROSTHETIC SERVICES

(a) Lower Limb

(b) Upper Limb

(c) General

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:55-3.1 Introduction

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

1. Alphabetic or numeric symbols are used to modify the HCPCS codes and require consideration by the provider for proper evaluation. These symbols are discussed in section 3.2.

2. The responsibility of the prosthetic and orthotic services provider when rendering services and requesting reimbursement is listed in Subchapter 1. and Subchapter 2. of the Prosthetic and Orthotic Services Manual.

10:55-3.2 Elements of HCPCS Coding System Which Require Attention of Provider

(a) The lists of HCPCS codes in section 3.3 and section 3.4 are arranged in tabular form with specific information for each code given under columns with titles such as "HCPCS Codes", "Description", and "Medicaid Dollar Value".

(b) The column titled "Medicaid Dollar Value" indicates the amount of reimbursement or one of the following symbols:

1. "C.P." means Current Price less 10 percent.

2. "B.R." (By Report) is 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 MC-15 claim form.

3. "B.I." (By Invoice) means that the invoice must be attached to the MC-15 claim form. Payment will be made by adding 50 percent to the invoice cost. If the invoice cost is excessive in comparison to invoice costs submitted by other providers, the provider may be required to supply additional information.

(c) Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The modifier is reported by alphabetic and/or numeric characters placed after the usual procedure code numbers. The New Jersey Medicaid Program's recognized modifier codes for prosthetic and orthotic services is as follows:

1. "RP" (Replacement and Repair) is used to indicate replacement of orthotic and prosthetic devices which have been in use for sometime. The claim shows the code for the part, followed by the "RP" modifier and the charge for the part.

10:55-3.3 HCPCS Codes For Orthotic Services

(a) ORTHOTIC DEVICES - SPINAL

(SPINAL - CERVICAL)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L0120	Cervical, Flexible, Non-Adjustable (Foam Collar)	15.00
L0130	Cervical, Flexible Thermoplastic Molded to Patient	39.00
L0140	Cervical, Semi-Rigid, Adjustable (Plastic Collar)	32.00
L0150	Cervical, Semi-Rigid, Adjustable Molded Chin Cup (Plastic Collar with Mandibular/Occipital Piece)	43.00
L0160	Cervical, Semi-Rigid, Wire Frame Occipital/Mandibular Support	32.00
L0170	Cervical, Collar, Molded to Patient Model	100.00
	(MULTIPLE POST COLLAR)	
L0180	Cervical, Multiple Post Collar, Occipital/Mandibular Supports, Adjustable	85.00
L0190	Cervical, Multiple Post Collar, Occipital/Mandibular Supports, Adjustable Cervical Bars (Somi, Guilford, Taylor Types)	265.00
L0200	Cervical, Multiple Post Collar, Occipital/Mandibular Supports, Adjustable Cervical Bars, and Thoracic Extension	175.00
	(THORACIC)	
L0210	Thoracic, Rib Belt, Custom Fitted	22.00
L0220	Thoracic, Rib Belt, Custom Fabricated	34.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(SPINAL - THORACIC - LUMBAR - SACRAL)	
L0300	Thoracic-Lumbar-Sacral-Orthoses (TLSO), Flexible (Dorso-Lumbar Surgical Support), Custom Fitted	100.00
L0310	TLSO, Flexible (Dorso - Lumbar Surgical Support), Custom Fabricated	198.00
	(ANTERIOR-POSTERIOR CONTROL)	
L0320	TLSO, Anterior-Posterior control Taylor Type, with Apron Front	170.00
L0330	TLSO, Anterior-Posterior-Lateral Control (Knight-Taylor Type), with Apron Front	208.00
	(ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL)	
L0340	TLSO, Anterior-Posterior-Lateral-Rotary Control, Arnold, Magnuson, Steindler Types), with Apron Front	245.00
L0350	TLSO, Anterior-Posterior-Lateral-Rotary Control, Flexion Compression Jacket, Custom Fitted	854.00
L0360	TLSO, Anterior-Posterior-Lateral-Rotary Control, Flexion Compression Jacket Molded to Patient Model	854.00
L0370	TLSO, Anterior-Posterior-Lateral-Rotary Control, Hyperextension (Jewett, Lennox, Baker, Cash Types)	185.00
L0380	TLSO, Anterior-Posterior-Lateral-Rotary Control, with Posterior Extensions	245.00
L0390	TLSO, Anterior-Posterior-Lateral Control (Body Jacket) Molded to Patient Model	854.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(SPINAL - LUMBAR - SACRAL)	
L0500	Lumbar-Sacral-Orthoses (LSO), Flexible, (Lumbo-Sacral Surgical Supports), Custom Fitted	83.00
L0510	LSO, Flexible (Lumbo - Sacral Surgical Support), Custom Fabricated	117.00
	(ANTERIOR-POSTERIOR-LATERAL CONTROL)	
L0520	LSO, Anterior-Posterior-Lateral Control (Knight, Wilcox Types), with Apron Front	179.00
	(ANTERIOR-POSTERIOR CONTROL)	
L0530	LSO, Anterior-Posterior Control (Macausland Type) with Apron Front	175.00
	(LUMBAR FLEXION)	
L0540	LSO, Lumbar Flexion (Williams Flexion Type) Anterior-Posterior-Lateral Control (Body Jacket)	160.00
	(ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET)	
L0550	LSO, Anterior-Posterior-Lateral Control (Body Jacket), Molded to Patient Model	854.00
	(SPINAL - SACROILIAC)	
L0600	Sacroiliac, Flexible (Sacroiliac Surgical Support), Custom Fitted	45.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L0610	Sacroiliac, Flexible (Sacroiliac Surgical Support), Custom Fabricated Semi-Rigid	75.00

SPINAL - TORSO SUPPORTS

(POST SURGICAL SUPPORT)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L0940	Torso Supports, Post Surgical Support, Custom Fitted	*C.P.
L0950	Torso Supports, Post Surgical Support, Custom Fabricated	C.P.
L0960	Torso Supports, Post Surgical Support, Pads for Post Surgical Support	C.P.
X4070	Apron Front Replacement	25.00
L0970	TLSO, Corset Front	40.00
L0972	LSO, Corset Front	40.00
L0974	TLSO, Full Corset	72.00
L0976	LSO, Full Corset	72.00
L0978	Axillary Crutch Extension	10.00
L0980	Peroneal Straps, Pair	3.00

(b) ORTHOTIC DEVICES - SCOLIOSIS PROCEDURES

NOTE: Scoliosis Procedures

The Orthotic care of Scoliosis differs from other Orthotic care in that the treatment is more dynamic in nature and utilizes ongoing, continual modification of the orthosis to the patient's changing condition.

*C.P. - Current Price Less 10%

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE

This coding structure uses the proper names - or eponyms - of the procedures because they have historic and universal acceptance in the profession. It should be recognized that variations to the basic procedures described by the founders/developers are accepted in various medical and orthotic practices throughout the country. All procedures include model of patient when indicated.

SCOLIOSIS - CERVICAL - THORACIC - LUMBAR - SACRAL (MILWAUKEE)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L1000	Cervical-Thoracic-Lumbar-Sacral (CTLSO) (Milwaukee), inclusive of Furnishing Initial Orthoses, including Model	857.00
	(CORRECTION PADS)	
L1010	Additions to Cervical-Thoracic-Lumbar-Sacral Orthoses (CTLSO) or Scoliosis Orthoses, Axilla Sling	39.00
L1020	Additions to CTLSO or Scoliosis Orthoses, Kyphosis Pad	25.00
L1030	Additions to CTLSO or Scoliosis Orthoses, Lumbar Bolster Pad	25.00
L1040	Additions to CTLSO or Scloiosis Orthoses, Lumbar or Lumbar Rib Pad	39.00
L1050	Additions to CTLSO or Scoliosis Orthoses, Sternal Pad	39.00
L1060	Additions to CTLSO or Scoliosis Orthoses, Thoracic Pad	39.00
L1070	Additions to CTLSO or Scoliosis Orthoses, Trapeze Sling	51.00
L1080	Additions to CTLSO or Scoliosis Orthoses Outrigger	45.00
L1090	Additions to CTLSO or Scoliosis Orthoses, Lumbar Sling	51.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L1100	Additions to CTLSO or Scoliosis Orthoses, Ring Flange, Plastic or Leather	66.00
L1110	Additions to CTLSO or Scoliosis Orthoses, Ring Flange, Plastic or Leather, Molded to Patient Model	90.00
L1120	Additions to CTLSO or SIO, Scoliosis Orthoses, Covers for Upright, Each	45.00
	(SCOLIOSIS - THORACIC - LUMBAR - SACRAL) (LOW PROFILE)	
L1210	Additions to TLSO, (Low Profile) Lateral Thoracic Extension	175.00
L1220	Additions to TLSO, (Low Profile) Anterior Thoracic Extension	175.00
L1230	Additions to TLSO, (Low Profile) Milwaukee type Super Structure	340.00
	(LOWER LIMB HIP)	
L1600	Hip (HO), Abduction Cont_ol of Hip Joints, Flexible, Frejka Type with Cover	52.00
L1610	HO, Abduction Control of Hip Joints Flexible, Frejka Cover only	21.00
L1620	HO, Abduction Control of Hip Joints Flexible, Pavlik Harness	67.00
L1640	HO, Abduction Control of Hip Joints, Static, Pelvic Band or Spreader Bar, Thigh Cuffs	280.00
L1650	HO, Abduction Control of Hip Joints, Static, Adjustable Custom Fitted (ILFLED TYPE)	105.00
L1660	HO, Abduction Control of Hip Joints Static, Plastic, Custom Fitted	105.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
(c)	ORTHOTIC DEVICES - LOWER LIMB	
	(LOWER LIMB-PERTHES)	
L1700	Legg Perthes Orthosis, Toronto Type	221.00
	(LOWER LIMB - KNEE)	
L1800	Knee Orthoses (KO), Elastic with Stays	36.00
L1810	KO, Elastic with Joints	50.00
L1820	KO, Elastic with Condyle Pads and Joints	65.00
L1825	KO, Elastic Knee Cap	50.00
L1830	KO, Immobilizer; Canvas Longitudinal	55.00
L1850	KO, Swedish Type	175.00
L1860	KO, Modification of Supracondylar Prosthetic Socket, Molded to Patient Model (SK)	400.00
L1870	KO, Double Upright, Thigh and Calf Lacers, Molded to Patient Model with Knee Joints	550.00
L1880	KO, Double Upright, Non-Molded Thigh and Calf Cuffs/Lacers with Knee Joints	420.00
	(LOWER LIMB - ANKLE - FOOT)	
L1900	Ankle-Foot Orthoses (AFO), Spring Wire, Dorsiflexion Assist Calf Band	150.00
L1910	AFO, Posterior, Single Bar, Clasp Attachment to Shoe Counter	55.00
L1920	AFO, Single Upright with Static or Adjustable Stop (Phelps or Perlstein type)	150.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
X4450	AFO, Posterior Leaf Spring Molded to Patient Model (Tirr, Rancho) includes Casting	330.00
L1940	AFO, Molded to Patient Model, Plastic	1120.00
L1960	AFO, Posterior Solid Ankle Molded to Patient Model, Plastic	330.00
L1980	AFO, Single Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Single Bar "BK" Orthosis)	189.00
L1990	AFO, Double Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Double Bar "BK" Orthosis)	550.00

(LOWER LIMB-HIP-KNEE-ANKLE-FOOT (OR ANY COMBINATION)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2000	Knee-Ankle-Foot-Orthoses (KAFO) Single Upright Free Knee, Free Ankle, Solid Stirrup, Thigh and Calf Bands/Cuffs (Single Bar "AK" Orthosis)	221.00
L2010	KAFO, Single Upright, Free Knee, Free Ankle, Solid Stirrup, Thigh and Calf Bands/Cuffs (Single Bar "AK" Orthosis), without Knee Joint	221.00
L2020	KAFO, Double Upright Free Knee, Free Ankle, Solid Stirrup, Thigh and Calf Bands/Cuffs (Double Bar "AK" Orthosis)	450.00
L2035	KAFO, Full Plastic, Molded to Patient Model (SKA, Floor Reaction Types) Torsion Control	710.00

(TORSION CONTROL)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2050	HKAFO, Torsion Control, Bilateral Torsion Cables, Hip Joint, Pelvic Band/Belt	161.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2060	HKAFO, Torsion Control, Bilateral Torsion Cables, Ball Bearing Hip Joint, Pelvic Band/Belt	120.00
L2080	HKAFO, Torsion Control, Unilateral, Torsion Cable, Hip Joint, Pelvic Band/Belt	123.00
L2090	HKAFO, Torsion Control Unilateral Torsion Cable, Ball Bearing Hip Joint, Pelvic Band/Belt	82.00
	(FRACTURE ORTHOSIS)	
L2120	AFO, Fracture Orthoses, Tibial Fracture Orthosis, with Plastic Construction	420.00
L2150	KAFO, Fracture Orthoses, Femoral Fracture Cast Orthoses, Plaster of Paris, Knee Joints, Solid Ankle, with Adjustable Femoral Section	650.00

(d) ADDITIONS TO LOWER EXTREMITY ORTHOSES

	(ADDITIONS - SHOE - ANKLE - SHIN)	
L2200	Additions to Lower Extremity, Limited Ankle Motion, Each Joint	32.00
L2210	Additions to Lower Extremity, Dorsiflexion Assist (Plantar Flexion Resist)	40.00
L2220	Additions to Lower Extremity, Dorsiflexion and Plantar Flexion Assist/Resist	77.00
L2230	Additions to Lower Extremity, Split Flat Caliper Stirrups, and Plate Attachment	56.00
L2240	Additions to Lower Extremity, Round Caliper and Plate Attachment	45.00
L2250	Additions to Lower Extremity, Foot Plate, Molded to Patient Model, Stirrup Attachment	188.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2260	Additions to Lower Extremity, Reinforced Solid Stirrup (Scott-Craig Type)	14.00
L2270	Additions to Lower Extremity, Varus/Valgus Correction ("T") Strap, Padded/Lined or Malleolus Pad	32.00
L2280	Additions to Lower Extremity, Molded Inner Boot	87.00
L2300	Additions to Lower Extremity, Abductions Bar (Bilateral Hip Involvement), Jointed, Adjustable	105.00
L2310	Additions to Lower Extremity, Abductions Bar-Straight	60.00
L2320	Additions to Lower Extremity, Non-Molded Lacer	110.00
L2340	Additions to Lower Extremity, Pre-Tibial Shell, Molded to Patient Model	315.00
L2350	Additions to Lower Extremity, Prosthetic Type, (BK) Socket, Molded to Patient Model, (Used for 'PTB' 'AFO' Orthoses)	420.00
L2360	Additions to Lower Extremity, Extended Steel Shank	30.00

ADDITIONS - KNEE

(STRAIGHT KNEE JOINT)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2400	Additions to Lower Extremity, Knee, Straight Knee Joint Drop Lock, Each Joint	70.00
L2410	Additions to Lower Extremity, Knee, Straight Knee Joint, Cam Lock (Swiss, French, Bail Types), Each Joint	75.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2420	Additions to Lower Extremity, Knee, Straight Knee Joint, Disc or Dial Lock for Adjustable Knee Flexion, Each Joint	120.00
L2450	Additions to Lower Extremity, Offset Knee Joint, Free, Each Joint	67.00
L2490	Additions to Lower Extremity, Offset Knee Joint, Lift Loop, for Drop Lock Ring	74.00
L2495	Additions to Lower Extremity Offset Knee Joint, Knee Control, Strap or Pad	54.00
X4350	Knee Pad, Standard	45.00
X4355	Knee Pad, Pull	65.00

ADDITIONS - THIGH/WEIGHT BEARING

(GLUTEAL/ISCHIAL WEIGHT)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2500	Additions to Lower Extremity, Thigh/Weight Bearing, Gulteal/ Ischial Weight Bearing, Ring	106.00
L2510	Additions to Lower Extremity, Thigh/Weight Bearing, Quadrilateral Brim, Molded to Patient Model	560.00
L2520	Additions to Lower Extremity, Thigh/Weight Bearing, Quadrilateral Brim, Custom Fitted	375.00
L2530	Additions to Lower Extremity, Thigh/Weight Bearing, Lacer, Non-Molded	120.00
L2540	Additions to Lower Extremity, Thigh/Weight Bearing, Lacer, Molded to Patient Model	210.00
L2550	Additions to Lower Extremity, Thigh/Weight Bearing, High Roll Cuff	50.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2560	Additions to Lower Extremity, Gluteal/Ischial Weight Bearing	63.00
L2580	Additions to Lower Extremity, Gluteal/Ischial Weight Bearing, Pelvic Sling	113.00
	ADDITIONS - PELVIC CONTROL	
L2600	Additions to Lower Extremity, Pelvic Control, Hip Joint, Clevis Type, or Thrust Bearing, Free, Each	78.00
L2610	Additions to Lower Extremity, Pelvic Control, Hip Joint, Clevis or Thrust Bearing, Lock, Each	78.00
L2630	Additions to Lower Extremity, Pelvic Control, Band and Belt Unilateral	50.00
L2640	Additions to Lower Extremity, Pelvic Control, Band and Belt Bilateral	72.00
L2650	Additions to Lower Extremity, Pelvic and Thoracic Control, Gluteal Pad, Each	55.00
L2660	Additions to Lower Extremity, Thoracic Control, Thoracic Band	18.00
L2670	Additions to Lower Extremity, Thoracic Control, Paraspinal Uprights	32.00
L2680	Additions to Lower Extremity, Thoracic Control, Lateral Support Uprights	32.00
X3610	"D" Rings	11.00
X3620	Bullet (Spring Loaded) Retentions	25.00
	(ADDITIONS - GENERAL)	
L2760	Additions to Lower Extremity Orthoses, Extension, per Extension, per Bar (For Lineal Adjustment for Growth)	30.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2770	Additions to Lower Extremity Orthoses, Stainless Steel-Per Bar or Joint	30.00
X3680	Travel Time per Hour (Specify Time Involved)	30.00

(e) ORTHOPEDIC SHOES, SHOE MODIFICATIONS AND TRANSFERS

FOOT

(INSERT, REMOVABLE, MOLDED TO PATIENT MODEL)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L3000	Foot, Insert, Removable, Molded to Patient Model, "UCB" Type, Berkeley Shell, Each	45.00
L3010	Foot, Insert, Removable, Molded to Patient Model, Longitudinal Arch Support, Each	45.00
L3020	Foot, Insert, Removable, Molded to Patient Model, Longitudinal/ Metatarsal Supports, Each	45.00
X4290	Filler for Amputee Toes	16.00
L3030	Foot, Insert, Removable, Formed to Patient Foot, Each-Arch Supports, Removable, Premolded, Each	45.00
X4800	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Whitman Ordinary	37.00
X4801	Arch Support, Foot Plate: (Plaster cast taken by Vendor) Leather - Mayer	27.00
X4802	Arch Support, Foot Plate: (Plaster cast taken by Vendor) Leather - Schaffer	27.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
X4803	Arch Support, Foot Plate: (Plaster cast taken by Vendor) Leather - Schaffer with metatarsal pad	30.00
X4804	Arch Support, Foot Plate: (Plaster cast taken by Vendor), Leather - Whitman Combination	43.00
X4805	Arch Support, Foot Plate: (Plaster cast taken by Vendor), Leather-Rohadur Plastic	36.00
X4810	Velcro Straps, Attached to a pair of Shoes	10.00
L3100	Hallus-Valgus Night Dynamic Splint	11.50
	(ABDUCTION AND ROTATION BARS)	
L3140	Foot, Abduction Rotation Bars (Dennis Browne Type), attached to Shoe	11.50
L3150	Foot, Abduction Rotation Bars (Dennis Browne Type), clamped to Shoe	11.50
L3160	Foot-Torque Heels	7.00
	(SPACE SHOES)	
X4850	Space Shoe Rubber Raise for Shoe: 1/4 " Raise	6.00
X4851	Space Shoe Rubber Raise for Shoe: 1/2" Raise	7.00
X4852	Space Shoe Rubber Raise for Shoe: 3/4" Raise	10.00
X4853	Space Shoe Rubber Raise for Shoe: 1" Raise	20.00
X4854	Space Shoe Rubber Raise for Shoe: Each additional 1/2" Raise	8.00
	(CASTINGS)	
X4890	Foot	50.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
X4891	Foot, Ankle	65.00
X4892	Foot, Ankle, Shin	70.00
	(ORTHOPEDIC FOOTWEAR)	
L3201	Orthopedic Shoe, Oxford with Supinator or Pronator-Infant	* B.I.
L3202	Orthopedic Shoe, Oxford with Supinator or Pronator-Child	B.I.
L3203	Orthopedic Shoe, Oxford with Supinator or Pronator-Junior	B.I.
L3204	Orthopedic Shoe, Hightop with Supinator or Pronator-Infant	B.I.
L3206	Orthopedic Shoe, Hightop with Supinator or Pronator-Child	B.I.
L3207	Orthopedic Shoe, Hightop with Supinator or Pronator-Junior	B.I.
L3208	Surgical Boot, Each-Infant	B.I.
L3209	Surgical Boot, Each-Child	B.I.
L3211	Surgical Boot, Each-Junior	B.I.
L3212	Benesch Boot, Pair-Infant	B.I.
L3213	Benesch Boot, Pair-Child	B.I.
L3214	Benesch Boot, Pair-Junior	B.I.
L3215	Orthopedic Footwear, Ladies Shoes, Oxford	B.I.
L3217	Orthopedic Footwear, Ladies Shoes, Hightop-Depth Inlay	B.I.
L3222	Orthopedic Footwear, Mens Shoes-Hightop-Depth Inlay	B.I.
L3223	Orthopedic Footwear, Mens Surgical Boot-Each	B.I.

*B.I. - By Invoice Plus 50%

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L3230	Orthopedic Footwear, Custom Shoes Depth Inlay	B.I.
L3250	Orthopedic Footwear, Custom Molded Shoe, Removable Inner Mold, Prosthetic Shoe, Each	111.00
	SHOE MODIFICATION	
	(LIFTS)	
L3310	Lifts-Elevation, Heel and Sole, Neoprene, per Inch	17.50
L3320	Lifts-Elevation, Heel and Sole, Cork, per Inch	42.00
	(WEDGES)	
L3340	Heel Wedge, Sach	3.00
L3350	Heel Wedge	3.00
L3360	Sole Wedge-Outside Sole	4.00
L3370	Sole Wedge-Between Sole	4.00
L3390	Outflare Wedge	12.00
L3400	Metatarsal Bar Wedge-Rocker	4.00
L3410	Metatarsal Bar Wedge-Between Sole	4.00
L3420	Full Sole and Heel Wedge * Between Sole*	8.00
	(HEELS)	
L3460	Heel-New Rubber, Standard	3.00
L3470	Heel-Thomas Extended to Ball	6.00
L3480	Heel-Pad and Depression for Spur	6.00
L3485	Heel-Pad, Removable for Spur	3.00

*B.I. - By Invoice Plus 50%

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(MISCELLANEOUS SHOE ADDITIONS)	
L3510	Miscellaneous Shoe Additions, Insole Rubber	2.00
L3530	Miscellaneous Shoe Additions, Sole-Half	4.00
L3540	Miscellaneous Shoe Additions, Sole-Full	8.00
	TRANSFERS OR REPLACEMENT	
L3600	Transfers of an Orthosis From One Shoe To Another, Caliper Plate Existing	35.00
L3610	Transfers of an Orthosis From One Shoe To Another, Caliper Plate New	35.00
L3620	Transfers of an Orthosis From One Shoe To Another, Solid Stirrup Existing	35.00
L3630	Transfers of an Orthosis From One Shoe To Another, Solid Stirrup New	35.00
L3640	Transfers of an Orthosis From One Shoe To Another, Dennis Browne Splint (Riveton), Both Shoes	7.00
X4280	Velcro Straps used with Orthoses	18.00

(f) Upper Limb

NOTE: The procedures in this section are considered as 'Base' or 'Basic Procedures' and may be modified by listing procedures from the 'Additions Section' and adding them to the base procedure.

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	UPPER LIMB - ELBOW	
	(DOUBLE UPRIGHT WITH FOREARM/ARM CUFF)	
L3720	EO, Double Upright with Forearm/Arm Cuffs, Free Motion	80.00
	(UPPER LIMB - WRIST - HAND - FINGER)	
L3800	Wrist-Hand-Finger-Orthoses (WHFO), Short Opponens, No Attachments	43.00
L3805	WHFO, Long Opponens, No Attachment	55.00
	ADDITIONS	
L3820	WHFO, Addition to Short and Long Opponens, I.P. Extension Assist with M.O. Extension Stop	30.00
L3825	WHFO, Additions to Short and Long Opponens, M.P. Extension	17.00
L3830	WHFO, Additions to Short and Long Opponens, M.P. Extension Assist	17.00
L3835	WHFO, Additions to Short and Long Opponens, M.P. Spring Extension, Assist	23.00
L3840	WHFO, Additions to Short and Long Opponens, Spring Swivel Thumb	15.00
L3900	WHFO, Dynamic Flexor Hinge; Reciprocal Wrist Extension/ Flexion, Finger Flexion/ Extension, Wrist or Finger Driven	246.00
L3901	WHFO, Dynamic Flexor Hinge; Reciprocal Wrist Extension/ Flexion, Finger Flexion/ Extension, Cable Driven	276.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(EXTERNAL POWER)	
L3902	WHFO, External Powered, Compressed Gas	369.00
L3904	WHFO, External Powered, Electric	369.00
	OTHER WRIST-HAND-FINGER ORTHOSES-CUSTOM FITTED	
L3908	WHFO, Wrist Extension Control (Cock-Up), Canvas or Leather Design, Non-Molded	40.00
L3914	WHFO, Wrist Extension (Cock-Up)	40.00
L3916	WHFO, Wrist Extension (Cock-Up), With Outrigger	40.00
	UPPER LIMB - SHOULDER - ELBOW - WRIST - HAND	
	(MOBILE ARM SUPPORTS-CUSTOM FITTED)	
L3964	SEWHO, Mobile Arm Supports (Attached to Wheelchair, Balanced and Fitted to Patient), Adjustable	105.00
L3966	SEWHO, Mobile Arm Supports (Attached to Wheelchair, Balanced and Fitted to Patient) Reclining	105.00
L3968	SEWHO, Mobile Arm Supports (Attached to Wheelchair, Balanced and Fitted to Patient), Friction Arm Support (Friction Dampening to Proximal and Distal Joints)	105.00
	(SPECIFIC REPAIR)	
L4000	Replace Girdle for Milwaukee Orthosis	455.00
L4010	Replace Trilateral Socket Brim	560.00
L4020	Replace Quadrilateral Socket Brim, Molded to Patient Model	560.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L4030	Replace Quadrilateral Socket Brim Custom Fitted	560.00
L4040	Replace Molded Thigh Lacer	210.00
L4050	Replace Molded Calf Lacer	87.00
L4060	Replace High Roll Cuff	50.00
L4070	Replace Proximal and Distal Upright for AKO	19.00
L4080	Replace Metal Bands KAFO-AFO, Proximal Thigh	42.00
L4090	Replace Metal Bands KAFO-AFO, Calf or Distal Thigh	42.00
L4100	Replace Leather Bands KAFO-AFO, Proximal Thigh	42.00
L4110	Replace Leather Cuff KAFO-AFO, Calf or Distal Thigh	80.00
X4375	Calf Band	34.00
X4370	Calf Cuff	52.00
	(REPAIRS)	
L4200	Repair of Orthotic Device, Hourly Rate	35.00

10:55-3.4 HCPCS CODES FOR PROSTHETIC SERVICES

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE

(a) LOWER LIMB (PARTIAL FOOT)

NOTE: Lower Limb

The procedures in this section are considered as 'Base' or 'Basic Procedures' and may be modified by listing items/procedures from the 'Additions Section' and adding them to the base procedure.

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L5000	Partial Foot, Shoe Insert with Longitudinal Arch, Toe Filler	418.00
L5010	Partial Foot, Molded Socket, Ankle Height, with Toe Filler	450.00
L5020	Partial Foot, Molded Socket, Tibial Tubercle Height, with Toe Filler	450.00
	(ANKLE)	
L5050	Ankle, Symes, Molded Socket, Sach Foot	85.00
L5060	Ankle, Symes, Metal Frame, Molded Leather Socket, Articulated Ankle/Foot	600.00
	(BELOW KNEE)	
L5100	Below Knee, Molded Socket, Shin, Sach Foot	753.00
L5110	Below Knee, Wood Socket, Joints and Thigh Lacer, Sach Foot	1050.00
	(KNEE DISARTICULATION)	
L5150	Knee Disarticulation (or Through Knee), Molded Socket, External Knee Joints, Shin, Sach Foot	1400.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(ABOVE KNEE)	
L5200	Above Knee, Molded Socket, Single Axis Constant Friction Knee, Shin, Sach Foot	1100.00
	(HIP DISARTICULATION)	
L5250	Hip Disarticulation, Canadian Type; Molded Socket, Hip Joint, Single Axis Constant Friction Knee, Shin, Sach Foot	1875.00
L5270	Hip Disarticulation tilt Table Type, Molded Pelvic Socket, Metal Frame, Hip lock, single Axis Constant Friction Knee, Standard Shin Assembly, Sach Foot	1850.00
	(HEMIPELVECTOMY)	
L5280	Hemipelvectomy, Canadian Type; Molded Socket, Hip Joint, Single Axis Constant Friction Knee, Shin, Sach Foot	1875.00
	(ENDOSKELETAL - BELOW KNEE)	
L5300	Below Knee, Molded Socket, Sach Foot, Endoskeletal System, including Soft Cover and Finishing	1200.00
L5320	Above Knee, Molded Socket, Open End, Sach Foot, Endoskeletal System, Single Axis Knee; including Soft Cover and Finishing	1520.00
L5330	Hip Disarticulation, Canadian type; Molded Socket, Endoskeletal system, Hip Joint, Single Axis Knee, Sach Foot	B.R.

*B.R. - By Report

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(INITIAL PROSTHESIS)	
L5500	Preparatory, Below Knee ("PTB" (Type) Socket, Supracondylar Strap Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Plaster Socket, Direct Formed	350.00
L5505	Preparatory Above Knee-Knee Disarticulation (Ischial Level Socket, Pelvic Suspension, 'USMC' or Equal Pylon, No Cover, Sach Foot) Plaster Socket, Direct Formed	325.00
L5510	Preparatory, Below Knee ("PTB" (Type) Socket, Supracondylar Strap Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Plaster Socket, Molded to Model	350.00
L5520	Preparatory, Below Knee, ("PTB" (Type) Socket, Supracondylar Strap Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Thermoplastic, or Equal, Direct Formed	341.00
L5530	Preparatory, Below Knee ("PTB" (Type) Socket, Supracondylar Strap Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Thermoplastic, or Equal, Molded to Model	341.00
L5540	Preparatory, Below Knee ("PTB" (Type) Socket, Supracondylar Strap Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Laminated Socket, Molded to Model	341.00
L5560	Preparatory, Above Knee-Knee Disarticulation (Ischial Level Socket, Pelvic Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Plaster Socket, Molded to Model	325.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L5570	Preparatory, Above Knee-Knee Disarticulation (Ischial Level Socket, Pelvic Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Thermoplastic or Equal, Direct Formed	315.00
L5580	Preparatory, Above Knee-Knee Disarticulation (Ischial Level Socket, Pelvic Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Thermoplastic or Equal, Molded to Model	315.00
L5590	Preparatory, Above Knee-Knee Disarticulation (Ischial Level Socket, Pelvic Suspension, "USMC" or Equal Pylon, No Cover, Sach Foot), Laminated Socket, Molded to Model	315.00
L5614	Additions to Lower Extremity, Above Knee, Lawrence Polycentric	200.00
	(ADDITIONS - TEST SOCKETS)	
L5626	Additions to Lower Extremity, Test Socket, Hip Disarticulation	713.00
L5628	Additions to Lower Extremity, Test Socket, Hemipelvectomy	845.00
	(ADDITIONS - SOCKET VARIATIONS)	
L5634	Additions to Lower Extremity, Symes Type, Posterior Opening (Canadian) Socket	455.00
L5636	Additions to Lower Extremity, Symes Type, Medial Opening Socket	455.00
L5644	Additions to Lower Extremity, Above Knee, Wood Socket	306.00
L5650	Additions to Lower Extremity, Total Contact, Above Knee or Knee Disarticulation Socket	320.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L5652	Additions to Lower Extremity, Suction Suspension, Above Knee or Knee Disarticulation Socket	475.00
X3435	Socket-Thigh Component, Total Contact Above Knee	607.00
	(ADDITIONS - SOCKET INSERT AND SUSPENSION)	
L5654	Additions to Lower Extremity, Socket Insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or Equal)	200.00
L5655	Additions to Lower Extremity, Socket Insert, Below Knee (Kemblo, Pelite, Aliplast Plastazote or Equal)	200.00
X3540	Suction Socket Valve	60.00
L5666	Additions to Lower Extremity, Below Knee, Cuff Suspension	25.00
L5670	Additions to Lower Extremity, Below Knee, Molded Supreconduar Suspension ("PTS" or Similar)	123.00
L5672	Additions to Lower Extremity, Below Knee Removable Medial	B.R.
L5676	Additions to Lower Extremity, Below Knee, Knee Joints, Pair	65.00
L5678	Additions to Lower Extremity, Below Knee, Joint Covers, Pair	20.00
L5680	Additions to Lower Extremity, Below Knee, Thigh Lacer, Non-Molded	85.00
L5682	Additions to Lower Extremity, Below Knee, Thigh Lacer, Gluteal/Ischial, Molded	300.00
L5684	Additions to Lower Extremity, Below Knee, Fork Strap	35.00

*B.R. - By Report

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L5686	Additions to Lower Extremity, Below Knee, Back Check (Extension Control)	21.00
L5688	Additions to Lower Extremity, Below Knee, Waist Belt, Webbing	60.00
L5690	Additions to Lower Extremity, Below Knee, Waist Belt, Padded and Lined	40.00
L5692	Additions to Lower Extremity, Above Knee, Pelvic Control Belt, Light	40.00
L5694	Additions to Lower Extremity, Above Knee, Pelvic Control Belt, Padded and Lined	40.00
L5697	Additions to Lower Extremity, Above Knee or Knee Disarticulation, Pelvic Band	37.00
L5698	Additions to Lower Extremity, Above Knee or Knee Disarticulation, Silesian Bandage	43.00
L5699	All Lower Extremity Prosthesis, Shoulder Harness	25.00
L5700	All Lower Extremity Prosthesis, Feet, External Heel, Sach Foot	78.00
L5702	All Lower Extremity Prosthesis, Feet, Single Axis Ankle/Foot	85.00
L5704	All Lower Extremity Prosthesis, Feet, Multiaxial Ankle/Foot (Greissinger or Equal)	110.00
L5709	All Lower Extremity Prosthesis, Multiaxial Rotation Unit ('MCP' or Equal)	160.00
L5710	Additions, Knee-Shin System Single Axis, Manual Lock	110.00
L5712	Additions, Knee-Shin System, Single Axis, Friction Swing and Stance Phase Control (Safety Knee)	110.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
X3610	"D" Rings	11.00
L5716	Additions, Knee-Shin System, Polycentric, Mechanical Stance Phase Lock	200.00
L5718	Additions, Knee-Shin System, Polycentric, Friction Swing and Stance Phase Control	200.00
X3480	Realistic Leg cover (B/K)	165.00

(b) UPPER LIMB

(WRIST DISARTICULATION)

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L6050	Wrist Disarticulation, Molded Socket Flexible Elbow Hinges, Triceps Pad	585.00
	(BELOW ELBOW)	
L6110	Below Elbow, Molded Socket, (Muenster or Northwestern Suspension types)	525.00
L6130	Below Elbow, Stump Activated Locking Hinge, Half Cuff	170.00
	(ELBOW DISARTICULATION)	
L6200	Elbow Disarticulation, Molded Socket, Outside Locking Hinge, Forearm	616.00
	(SHOULDER DISARTICULATION)	
L6300	Shoulder Disarticulation, Molded Socket, Shoulder Bulkhead, Humeral Section, Internal Locking Elbow, Forearm	1040.00
	(ENDOSKELETAL - ABOVE ELBOW)	
L6500	Above Elbow, Molded Socket, Endoskeletal System, including Soft Prosthetic Tissue Shaping	700.00
	(ENDOSKELETAL - SHOULDER DISARTICULATION)	
L6550	Shoulder Disarticulation, Molded Socket, Endoskeletal System, including Soft Prosthetic Tissue Shaping	1040.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE

(ADDITIONS - UPPER LIMB)

NOTE: The following procedures/modifications/components may be added to other base procedures. The items in this section should reflect the additional complexity of each modification procedure in addition to base procedure, at the time of the original order.

L6600	Upper Extremity Additions; Polycentric Hinge, Pair	52.00
L6610	Upper Extremity Additions, Flexible Metal Hinge, Pair	46.00
L6615	Upper Extremity Additions, Disconnect Locking Wrist Unit	70.00
L6620	Upper Extremity Additions, Flexion-Friction Wrist Unit	175.00
L6635	Upper Extremity Additions, Lift Assist for Elbow	190.00
L6645	Upper Extremity Additions, Shoulder Flexion-Abduction Joint, Each	65.00
L6660	Upper Extremity Additions, Heavy Duty Control Cable	35.00
L6672	Upper Extremity Additions, Harness, Chest or Shoulder, Saddle Type	60.00
L6675	Upper Extremity Additions, Harness, Figure of ("8") Eight Type, for Single Control	35.00
L6676	Upper Extremity Additions, Harness, Figure ("8") Eight Type, for Dual Control	50.00

TERMINAL DEVICES

(HANDS, DORRANCE OR EQUAL)

L6700	Terminal Devices, Hooks, Dorrance, or Equal, Model #3	165.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L6705	Terminal Devices, Hooks, Dorrance, or Equal, Model #5	126.00
L6710	Terminal Devices, Hooks, Dorrance, or Equal, Model #5X	128.00
L6715	Terminal Devices, Hooks, Dorrance, or Equal, Model #5XA	126.00
L6720	Terminal Devices, Hooks, Dorrance, or Equal, Model #6	298.00
L6725	Terminal Devices, Hooks, Dorrance, or Equal, Model #7	150.00
L6730	Terminal Devices, Hooks, Dorrance, or Equal, Model #7LO	150.00
L6735	Terminal Devices, Hooks, Dorrance, or Equal, Model #8	126.00
L6745	Terminal Devices, Hooks, Dorrance, or Equal, Model #88X	140.00
L6755	Terminal Devices, Hooks, Dorrance, or Equal, Model #10X	140.00
L6770	Terminal Devices, Hooks, Dorrance, or Equal, Model #99X	140.00
L6775	Terminal Devices, Hooks, Dorrance, or Equal, Model #555	90.00
L6795	Terminal Devices, Hooks-2 Load or Equal	500.00
L6800	Terminal Devices, Hooks-APRL VC or Equal	400.00
	(HANDS)	
L6825	Terminal Devices, Hands, Dorrance, VO	325.00
L6830	Terminal Devices, Hands, APRL, VC	325.00
L6835	Terminal Devices, Hands, Sierra, VO	325.00
L6840	Terminal Devices, Hands, Becker Imperial	325.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L6845	Terminal Devices, Hands, Becker Lock Grip	325.00
L6850	Terminal Devices, Hands, Becker Plylite	325.00
L6855	Terminal Devices, Hands, Robin-Aids, VO	325.00
L6865	Terminal Devices, Hands, Passive Hand	490.00
L6875	Terminal Devices, Hands, Bock, VC	325.00
L6880	Terminal Devices, Hands, Bock, VO	325.00
	(GLOVES FOR ABOVE HAND)	
L6890	Terminal Device, Gloves for Above Hands, Production Glove	40.00
L6895	Terminal Devices, Gloves for Above Hands, Custom Glove	117.00
	(OTHER SERVICES)	
L7500	Repair of Prosthetic Device, Hourly Rate	35.00
	NOTE: Payable in conjunction with repair. Not payable for new article provided	
X3680	Travel Time, Per Hour	30.00

(c) GENERAL

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(BREAST PROSTHESES)	
L8010	Breast Prostheses, Mastectomy Sleeve	*B.R.

*B.R. - By Report

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(ELASTIC SUPPORTS)	
L8100	Elastic Supports, Elastic Stockings, Below Knee, Medium Weight, Each	B.R.
L8110	Elastic Supports, Elastic Stockings, Below Knee, Heavy Weight, Each	B.R.
L8120	Elastic Supports, Elastic Stockings, Below Knee, Surgical Weight, (Linton Type or Equal), Each	B.R.
L8130	Elastic Supports, Elastic Stockings, Above Knee, Medium Weight, Each	B.R.
L8140	Elastic Supports, Elastic Stockings, Above Knee, Heavy Weight, Each	B.R.
L8150	Elastic Supports, Elastic Stockings, Above Knee, Surgical Weight, (Linton Type or Equal), Each	B.R.
L8160	Elastic Supports, Elastic Stockings, Full Length, Medium Weight, Each	B.R.
L8170	Elastic Supports, Elastic Stockings, Full Length, Heavy Weight, Each	B.R.
L8180	Elastic Supports, Elastic Stockings, Full Length, Heavy Surgical Weight (Linton Type or Equal), Each	B.R.
L8190	Elastic Supports, Elastic Stockings, Leotards, Medium Weight, Each	B.R.
L8200	Elastic Supports, Elastic Stockings, Leotards, Surgical Weight (Linton Type), Each	B.R.

*B.R. - By Report

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L8210	Elastic Supports, Elastic Stockings, Custom Made	*B.R.
L8220	Elastic Supports, Elastic Stockings, Lymphedema	B.R.
L8230	Elastic Supports, Elastic Stockings, Garter Belt	B.R.
	(TRUSSES)	
L8300	Trusses, Single with Standard Pad	55.00
L8310	Trusses, Double with Standard Pads	65.00
L8330	Trusses, Addition to Standard Pads, Scrotal Pad	45.00
	(PROSTHETIC SOCKS)	
L8420	Prosthetic Sock, Wool, Below Knee, Each	11.00
L8430	Prosthetic Sock, Wool, Above Knee, Each	11.00
L8470	Stump Sock, Single Ply, Fitting, Below Knee, Each	11.00
L8480	Stump Sock, Single Ply, Fitting, Above Knee, Each	11.00

*C.P. - Current Price Less 10%

*B.R. - By Report

*B.I. - By Invoice Plus 50%