

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

ortho ex
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Orthotic and Prosthetic Appliances: Billing Examples

Examples in this section are to assist providers in billing for orthotic and prosthetic appliances on the *CMS-1500* claim form. Refer to the *Orthotic and Prosthetic Appliances* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Orthosis Repair

Figure 1. Orthosis Repair.

This is a sample only. Please adapt to your billing situation. Sample attachments are not illustrated in this example.

This example shows unlisted orthosis repair. The complete description of the procedure must be attached to the claim and “See attachment” entered in the *Reserved for Local Used* field (Box 19).

HCPCS codes L4205 (labor) and L4210 (materials) are entered in the *Procedures, Services or Supplies* field (Box 24D).

In this example, prior authorization is required because the orthotic repair exceeds the specified *Treatment Authorization Request* (TAR) threshold (limit), and the TAR number is entered in the *Prior Authorization Number* field (Box 23). See the *Orthotic and Prosthetic Appliances* section in this manual for more information about TAR threshold amounts of orthotic and prosthetic devices.

Since the orthosis repair was made at the patient’s home, a “12” is entered in the *Place of Service* field (Box 24B).

Labor is billed in units of time. When billing time, enter it in 15-minute increments (for example, to bill for an hour you would enter “4”). In this example, “3” is entered in the *Days or Units* field (Box 24G) to indicate that 45 minutes of labor is being billed.

Enter the usual and customary charges in the *Charges* field (Box 24F).

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 90000000A95001						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN					3. PATIENT'S BIRTH DATE MM DD YY SEX 06 21 62 M <input checked="" type="checkbox"/> <input type="checkbox"/>						
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						
CITY ANYTOWN		STATE CA			CITY STATE		7. INSURED'S ADDRESS (No., Street)				
ZIP CODE 95823		TELEPHONE (Include Area Code) (916) 555-5555			ZIP CODE TELEPHONE (Include Area Code) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:						
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED _____ DATE _____					SIGNED _____						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
17b. NPI _____					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
19. RESERVED FOR LOCAL USE UNLISTED ORTHOSIS REPAIR. SEE ATTACHMENT.											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
1. _____ 3. _____					23. PRIOR AUTHORIZATION NUMBER 01234567890						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
11 08 07		12	L4205	L4205		L4210	75 00	3	NPI	NPI	
11 08 07		12	L4210	L4210		L4210	200 00	1	NPI	NPI	
_____		_____	_____	_____		_____	_____	_____	NPI	NPI	
_____		_____	_____	_____		_____	_____	_____	NPI	NPI	
_____		_____	_____	_____		_____	_____	_____	NPI	NPI	
_____		_____	_____	_____		_____	_____	_____	NPI	NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see b3a-d) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$		
_____		_____	_____		YES <input type="checkbox"/> NO <input type="checkbox"/>		275 00	_____	275 00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <i>Jane Doe</i> DATE 11/30/07			32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____			33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555					
SIGNED <i>Jane Doe</i> DATE 11/30/07			a. NPI _____ b. _____			a. 0123456789 b. _____					

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Figure 1. Orthosis Repair.

Custom-Made Device

Figure 2. Custom-Made Device.

This is a sample only. Please adapt to your billing situation. Sample attachments are not illustrated in this example.

In this example, an orthotics manufacturer is billing for a custom-made orthotic appliance. HCPCS code L1980 (AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff, custom fabricated) is entered in the *Procedures, Services or Supplies* field (Box 24D). HCPCS code L1980 is billed with modifier LT (left side) to indicate that the appliance is for use on the left side of the body. For additional information about the use of LT or RT modifiers, see the *Orthotic and Prosthetic Appliances* section in this manual.

For a custom-made appliance, the date of service is the date the appliance was delivered to the recipient; therefore, the delivery date is entered in the *Date of Service* field (Box 24A). A copy of the invoice must be attached showing the cost of parts used in the manufacture of the custom-made item; a statement indicating this is also entered in the *Reserved for Local Use* field (Box 19).

In this example, prior authorization is not required because the orthotic device does not exceed the specified TAR threshold (limit). See the *Orthotic and Prosthetic Appliances* section in this manual for more information about TAR threshold amounts of orthotic and prosthetic devices.

The referring physician's name and NPI are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription by a licensed practitioner is required for all orthotic and prosthetic appliances.

Enter the usual and customary charges in the *Charges* field. Also, a "12" has been entered in the *Place of Service* field (Box 24B) to indicate that the device was delivered to the patient's home.

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IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i></td> <td colspan="3">d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</td> </tr> <tr> <td colspan="12"> <p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> </td> </tr> <tr> <td colspan="6">12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</td> <td colspan="6">13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</td> <td colspan="6">13. 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AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. EMPLOYER'S NAME OR SCHOOL NAME			b. EMPLOYER'S NAME OR SCHOOL NAME			c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			c. INSURANCE PLAN NAME OR PROGRAM NAME			d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p>												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. 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14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. BOB SMITH			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																																											
17a. NPI			17b. NPI 0123456789			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																																																																																																																											
19. RESERVED FOR LOCAL USE SEE ATTACHED INVOICE.						23. PRIOR AUTHORIZATION NUMBER			24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE																																																																																																																																																																																																																																																																																																											
C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/PCS			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS																																																																																																																																																																																																																																																																																																											
H. EPOSIT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #			25. FEDERAL TAX I.D. NUMBER			SSN EIN																																																																																																																																																																																																																																																																																																											
26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (If or gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 249.00			29. AMOUNT PAID \$			30. BALANCE DUE \$ 249.00																																																																																																																																																																																																																																																																																																											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Jane Doe</i>						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.						33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 1234567890 b.																																																																																																																																																																																																																																																																																																											
SIGNED _____ DATE 11/30/07						NUCC Instruction Manual available at: www.nucc.org						APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)																																																																																																																																																																																																																																																																																																											

Figure 2. Custom-Made Device.

Bilateral Appliances

Figure 3. Bilateral Appliances.

This is a sample only. Please adapt to your billing situation. Sample attachments are not illustrated in this example.

This example shows billing for bilateral appliances. HCPCS code L1820 (knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment) is entered in the *Procedures, Services or Supplies* field (Box 24D) on two separate claim lines with appropriate modifiers LT (left side) and RT (right side). A quantity of "1" is entered in the *Days or Units* field (Box 24G) for each claim line.

In this example, modifiers LT and RT are billed on separate claim lines because they are National Correct Coding Initiative (NCCI)-associated modifiers that must not be billed on the same line. Refer to the *Orthotic and Prosthetic Appliances* and *Correct Coding Initiative: National* sections in the appropriate Part 2 manuals for more information about bilateral orthotic and prosthetic devices.

Because the custom fabricated orthotic devices were provided at the office, an "11" is entered in the *Place of Service* field (Box 24B).

Enter the usual and customary charges in the *Charges* field (Box 24F).

<div style="border: 1px solid black; border-radius: 5px; padding: 2px; display: inline-block;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>											
<small>PICA</small> <input type="checkbox"/> <small>PICA</small> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9000000A95001					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN						3. PATIENT'S BIRTH DATE MM DD YY 06 21 62			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		
6. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)		
CITY ANYTOWN			STATE CA			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY STATE		
ZIP CODE 95823			TELEPHONE (Include Area Code) (916) 555-5555			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						c. EMPLOYER'S NAME OR SCHOOL NAME			c. INSURANCE PLAN NAME OR PROGRAM NAME		
c. EMPLOYER'S NAME OR SCHOOL NAME						d. INSURANCE PLAN NAME OR PROGRAM NAME			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____ 17b. NPI _____			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____		
19. RESERVED FOR LOCAL USE											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											
1. _____ 3. _____ 2. _____ 4. _____											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER		
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (If not gov't claims, see 9930) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 200.00		
29. AMOUNT PAID \$ _____			30. BALANCE DUE \$ 200.00			29. AMOUNT PAID \$ _____			30. BALANCE DUE \$ _____		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <i>Jane Doe</i> DATE 4/13/11						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____			33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b. _____		
NUCC Instruction Manual available at: www.nucc.org											
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)											

Figure 3. Bilateral Appliances.