

NEW YORK STATE

MEDICAID PROGRAM

PHYSICIAN – PROCEDURE CODES

SECTION 1 – GENERAL INFORMATION

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GENERAL INFORMATION

Underlined procedure codes require Prior Approval before services are rendered.

1. **OSTEOPATHIC PHYSICIANS:** The Physician Fee Schedule is applicable to services provided by osteopathic physicians.
2. **MULTIPLE CALLS:** If an individual patient is seen on more than one occasion during a single day, the fee for each visit may be allowed.
3. **CHARGES FOR DIAGNOSTIC PROCEDURES:** Charges for special diagnostic procedures which are not considered to be a routine part of an attending physician's or consultant's examination (eg, pregnancy test, diagnostic X-ray, lumbar puncture) are reimbursable in addition to the usual physician's visit fee.
4. **SEPARATE PROCEDURES:** Some of the listed procedures are commonly carried out as an integral part of a total service, and as such, do not warrant a separate identification.
5. **PROCEDURE NOT INCLUDED:** Each public agency may determine, on an individual basis, fees for services or procedures not included in the Fee Schedule. The value and appropriateness of services not specifically listed in this fee schedule will be determined "By Report". Claims for these services will be manually reviewed by medical professional staff. The MMIS procedure codes to be utilized when submitting claims for such unlisted services may be found at the end of each section.
6. **BY REPORT:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesions(s), if appropriate), diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (eg, procedure description, itemized invoices, etc.) should accompany all claims submitted.

Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

7. **MATERIALS SUPPLIED BY PHYSICIAN:** Supplies and materials provided by the physician, eg, sterile trays/drugs, **over and above** those usually included with the procedure(s), office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as 99070 or specific supply code.

When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

Reimbursement for supplies and materials (including drugs, vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the practitioner. For all items furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost, as established by invoice, to the practitioner. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the item provided.

8. **PRIOR APPROVAL:** Payment for those listed procedures where the MMIS code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.
9. **REFERRAL:** A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in LEVELS OF E/M SERVICE.
10. **CONSULTATION:** Consultation is to be distinguished from referral. REFERRAL is the transfer of the patient from one physician to another for definitive treatment. CONSULTATION is advice and opinion from an accredited physician specialist called in by the attending practitioner in regard to the further management of the patient by the attending practitioner.

Consultation fees are applicable only when examinations are provided by an accredited physician specialist within the scope of his specialty upon request of the authorizing agency or of the attending practitioner who is treating the medical problem for which consultation is required. The attending practitioner must certify that he requested such consultation and that it was incident and necessary to his further care of the patient.

When the consultant physician assumes responsibility for a portion of patient management, he will be rendering concurrent care (use appropriate level of Evaluation and Management codes). If he has had the case transferred or referred to him, he should then use the appropriate codes for services rendered (eg, visits, procedures) on and subsequent to the date of transfer.

11. **FAMILY PLANNING CARE:** In accordance with approval received by the State Director of the Budget, effective July 1, 1973 in the Medicaid Program, all family planning services are to be reported on claims using appropriate MMIS code numbers listed in this fee schedule in combination with modifier '-FP'

This reporting procedure will assure to New York State the higher level of federal reimbursement which is available when family planning services are provided to Medicaid patients (90% instead of 50% for other medical care). It will also provide the means to document conformity with mandated federal requirements on provision of family planning services.

12. **PAYMENT IN FULL:** Fees paid in accordance with the allowances in the Physician Fee Schedule shall be considered full payment for services rendered. No additional charge shall be made by a physician.
13. **FEES:** The fees are listed in the Physician-Medicine Fee Schedule, available at <http://www.emedny.org/ProviderManuals/index.html>
14. **PRESCRIBER WORKSHEET:** Enteral formula requires voice interactive telephone prior authorization from the Medicaid Program. The prescriber must initiate the authorization through this system. The worksheet specifies the questions asked on the voice interactive telephone system and must be maintained in the patient's clinical record. The worksheet can be found on the Provider Communication link. [eMedNY : Provider Manuals : Physician Provider Communications](#)

MMIS MODIFIERS

- 23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier -23 to the procedure code of the basic service. (Reimbursement will not exceed \$30 plus time for the procedure.)

- 24 Unrelated Evaluation and Management Service by the Same Practitioner During a Postoperative Period:
The practitioner may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier -24 to the appropriate level of E/M service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Practitioner on the Day of a Procedure: (Effective 10/1/92) The practitioner may need to indicate that on the day a procedure or service identified by an MMIS code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier -25 to the appropriate level of E/M service. **NOTE:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- 26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier –26 to the usual procedure number. (Reimbursement will not exceed 40% of the maximum State Medical Fee Schedule amount.)
- 47 Anesthesia By Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier -47 to the basic service. (This does not include local anesthesia.) (Reimbursement will not exceed 50% of the basic value plus time for the procedure.)
- 50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral medical procedures and surgical procedures requiring a separate incision that are performed at the same operative session, or bilateral x-ray examinations should be identified by the appropriate procedure code describing the first procedure. To indicate a bilateral procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum State Medical Fee Schedule amount for medicine and surgery services or 160% of the maximum State Medical Fee Schedule amount for radiology services. One claim line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)

- 54 Surgical care only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management (or postoperative management is to be provided in an outpatient department when physician services are included in the rate) , surgical services may be identified by adding the modifier -54 to the usual procedure number. (Reimbursement will not exceed 80% of the maximum State Medical Fee Schedule amount.)
- 62 Two Surgeons: When two surgeons (usually of different skills) work together as primary surgeons performing distinct part(s) of a single reportable procedure, add the modifier – 62 to the single definitive procedure code. [One surgeon should file one claim line representing the procedure performed by the two surgeons. Reimbursement will not exceed 125% of the maximum State Medical Fee Schedule amount.] If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported without the modifier –62 added as appropriate. **NOTE**: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier –80 added, as appropriate.
- 63 Procedure Performed on Infants Less Than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier –63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier –63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections. (Reimbursement will not exceed 100% of the maximum Fee Schedule amount.)
- 66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier -66 to the basic procedure number used for reporting services. (Reimbursement will not exceed 20% of the maximum Fee Schedule amount.)
- 76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. (When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it will be identified by adding modifier -76.) (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

- 77 Repeat Procedure By Another Physician (or Practitioner): The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier -77 to the repeated service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

- 78 Return to the Operating Room for a Related Procedure During the Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier -78 to the related procedure. (Reimbursement will not exceed 100% of the maximum Fee Schedule amount.)

- 79 Unrelated Procedure or Service by the Same Practitioner During the Postoperative Period: The practitioner may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier -79 to the related procedure. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

- 80 Assistant Surgeon: Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number(s). (Reimbursement will not exceed 20% of the maximum Fee Schedule amount.)

- 82 Assistant Surgeon: (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier -82 appended to the usual procedure code number(s). (Reimbursement will not exceed 20% of the maximum Fee Schedule amount.)

- AA Anesthesia Services Performed Personally By Anesthesiologist: All anesthesia services not reported with modifiers –23 or -47 will be identified by adding the modifier -AA to the procedure number of the surgical procedure. (Reimbursement will not exceed the basic value plus time for the procedure.)

- AJ Clinical Social Worker: To report services of a Certified Social Worker (CSW) under the direct supervision of an employing psychiatrist, modifier –AJ should be added to the appropriate procedure code listed below. (Reimbursement will not exceed the indicated amount.) 90804 (\$13.50), 90806 (\$27.00), 90846 (\$7.20), 90847 (\$7.20), 90849 (\$7.20), 90853 (\$7.20), 90857 (\$7.20).

- AS Physician Assistant, Nurse Practitioner, or Registered Nurse Assistant Services for Assist at Surgery: When the physician requests that a Physician Assistant, Nurse Practitioner, or Registered Nurse Assistant assist at surgery in lieu of another physician, Modifier -AS

should be added to the appropriate code describing the procedure. One claim is to be filed. (Reimbursement will not exceed 120% of the maximum Fee Schedule amount.)

- EP Child/Teen Health Program (EPSDT Program): Service provided as part of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program or Child/Teen Health Program will be identified by adding the modifier -EP to the usual procedure number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- FP Service Provided as Part of Family Planning Program: All Family Planning Services will be identified by adding the modifier -FP to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- LT Left Side: (Used to identify procedures performed on the left side of the body). Add modifier –LT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.) **(Use modifier –50 when both sides done at same operative session.)**
- RT Right Side: (Used to identify procedures performed on the right side.) Add modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed). **(Use modifier –50 when both sides done at same operative session.)**
- SL State Supplied Vaccine: (Used to identify administration of vaccine supplied by the Vaccine for Children's Program (VFC) for children under 19 years of age). When administering vaccine supplied by the state (VFC program), you **must** append modifier –SL State Supplied Vaccine to the procedure code number representing the vaccine administered. Omission of this modifier on claims for recipients under 19 years of age will cause your claim to deny. (Reimbursement will not exceed \$17.85, the administration fee for the VFC program.)
- TC Technical Component: Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier -TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. (Reimbursement will not exceed 60% of the maximum State Medical Fee Schedule amount.)

PHYSICIAN SERVICES PROVIDED IN ARTICLE 28 FACILITIES

Physicians can bill for services provided in Article 28 hospital inpatient and outpatient settings for Medicaid fee-for-service patients. This policy became effective on February 1, 2010.

Previously, if a physician was salaried by a hospital facility and his/her salary was included in the facility cost report, the clinic or inpatient payment to the hospital was considered payment in full for the service. The physician was prohibited from submitting a fee-for-service claim to Medicaid.

The physician's professional services are carved-out of APG or APR-DRG payments and may be billed in addition to the APG or APR-DRG facility payment for services provided in the following settings:

- Hospital-Based Ambulatory Surgery Settings
- Emergency Departments
- Hospital Outpatient Clinics
- Free-standing Ambulatory Surgery Centers
- Inpatient Settings (including exempt, per-diem inpatient rates)

When hospital emergency department, ambulatory surgery (hospital-based and free-standing) and hospital outpatient clinic rate codes for APGs or inpatient rate codes for APR-DRGs are billed, the physician may also submit a separate claim to Medicaid for his/her professional services. This includes physicians who are on staff and salaried by the hospital.

In order to bill, physicians providing services in these settings must be enrolled in New York State Medicaid. The HIPAA 837P billing format must be used. Physicians should bill Medicaid using the fee schedule published in the Physician Provider Manual.

The above noted physician carve-out policy for hospital-based services does not apply to diagnostic and treatment centers (D&TCs). Physicians providing services in D&TCs may not bill Medicaid. The practitioner professional component for all D&TCs is included in the APG payment to the clinic.

The professional component for all services provided by a physician assistant (PA) in an Article 28 hospital outpatient department, hospital inpatient setting, emergency department, ambulatory surgery setting and diagnostic and treatment center (D&TC) for Medicaid fee-for-service patients is included in the APG or APR-DRG payment to the facility. Supervising physicians and physician groups may not bill Medicaid separately for PA services provided in these settings.

There will be no change to current Medicaid policy, which disallows payment of interns and/or residents, yet permits payments for supervising and/or teaching physicians under certain specified conditions (see Conditions for Payment).

STATE DEPARTMENT OF HEALTH CONDITIONS FOR PAYMENTS

CONDITION FOR PAYMENT: Teaching physicians may bill for direct patient care services rendered while supervising a resident, provided that personal and identifiable services are provided to the patient in connection with the supervisory services and that the appropriate degree of documented supervision was provided.

MAXIMUM REIMBURSABLE FEE SCHEDULE: Payment for in-hospital surgical care will be limited to 80% of the fees as listed in the Surgery Section of the State Medical Fee Schedule when after-care is provided in the outpatient department. Payment for such after-care will be made on a per-visit basis to the hospital and to the outpatient physician (or to the hospital in his behalf) in accordance with prescribed procedures. (See modifier -54.)