NEW YORK STATE
MEDICAID PROGRAM

NURSE PRACTITIONER

PROCEDURE CODES

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GENERAL INFORMATION

1. **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.

2. **CHARGES FOR DIAGNOSTIC PROCEDURES:** Charges for special diagnostic procedures which are not considered to be a routine part of an examination (eg, ECG) are reimbursable in addition to the usual visit fee.

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

4. **REFERRAL:** A referral is the transfer of the total or specific care of a patient from one physician or nurse practitioner to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in LEVELS OF E/M SERVICE. **Referral** is to be distinguished from consultation. REFERRAL is the transfer of the patient from one practitioner to another for definitive treatment.

5. **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.

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.

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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 PRACTITIONER:** Supplies and materials provided, 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.

   Reimbursement for supplies and material (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. **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 : Nurse Practitioner Provider Communications

9. **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.

10. **RADIOLOGY PRIOR APPROVAL: Information for Ordering Providers-**
    If you are **ordering** a CT, CTA, MRI, MRA, Cardiac Nuclear, or PET procedure, you or your office staff are required to obtain an approval number through the RadConsult program. Requests will be reviewed against guidelines, and a prior approval number will be issued.

    Using a secure login, you will have the ability to access RadConsult Online or call the RadConsult contact center to check the status of procedure requests.

    Beneficiaries who are eligible for both Medicaid and Medicare (dual eligible) or beneficiaries who are enrolled in a managed care plan are not included.

    Additional information is available at
    http://www.emedny.org/ProviderManuals/Radiology/index.html

11. **DVS AUTHORIZATION (#):** Codes followed by # require an authorization via the dispensing validation system (DVS) before services are rendered.

12. **PAYMENT IN FULL:** Fees paid in accordance with the allowances in the Medical Fee Schedule shall be considered full payment for services rendered. No additional charge shall be made by a practitioner.

13. **FEES:** The fees are listed in the Nurse Practitioner Fee Schedule, available at http://www.emedny.org/ProviderManuals/NursePractitioner/index.html
Listed fees are the maximum reimbursable Medicaid fees**.** Fees for the MOMS Program and PPAC Program can be found in the Enhanced Program Fee Schedule.

STATE DEPARTMENT OF HEALTH CONDITIONS FOR PAYMENT

CONDITION FOR PAYMENT: Qualified practitioners may be paid on a fee-for-service basis for direct care of patients when their salary/compensation is not paid for purposes of providing direct patient care, i.e., when the salary/compensation is paid exclusively for activities such as teaching, various administrative duties (department heads, etc.) or for research.

CONDITIONS BARRING PAYMENT: Payment on a fee-for-service basis to a salaried/compensated practitioner may not be made when (1) any portion of the salary/compensation paid to such salaried/compensated practitioner is: for direct care of patients, and (2) there is any prohibition for such payment in law, in the rules of the particular hospital or in the contractual arrangement with the salaried/compensated practitioner or group.

MAXIMUM REIMBURSABLE FEE SCHEDULE: In those instances where a patient is admitted to a hospital service which is covered by an approved training program and at the time of admission the patient is without a "private" practitioner, the attending practitioner assigned as "personal" practitioner to assume professional responsibility for the patient's care, is eligible for payment as per the Hospital Evaluation and Management codes.

If at the time of admission to a hospital service covered by an approved training program, the patient has a "private" practitioner who accepts continuing responsibility for the patient's care, that practitioner is eligible for payment as per the Hospital Evaluation and Management codes.

PRACTITIONER SERVICES PROVIDED IN HOSPITALS

When non-salaried/non-compensated practitioners, either individually or as a group, provide services to either outpatients or inpatients, payment will be made via the appropriate Evaluation and Management code.

Salaries/compensation of practitioners employed by a hospital to provide patient care are included as hospital costs in determining inpatient and outpatient reimbursement rates and therefore no separate payments may be made to such practitioners.

MMIS MODIFIERS

Note: NCCI associated modifiers are recognized for NCCI code pairs/related edits. For additional information please refer to the CMS website: http://www.cms.hhs.gov/NationalCorrectCodInitEd/

Under certain circumstances, the MMIS code identifying a specific procedure or service must be expanded by two additional characters to further define or explain the nature of the procedure.

The circumstances under which such further description is required are detailed below along with the appropriate modifiers to be added to the basic code when the particular circumstance applies.

-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.)

-77 Repeat Procedure by Another Practitioner: The practitioner may need to indicate that a basic procedure performed by another practitioner 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.)

-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.)

-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.)

-SL State Supplied Vaccine: (Used to identify administration of vaccine supplied by the Vaccines for Children 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.)

MEDICINE SECTION

GENERAL INFORMATION AND RULES

1. **PRIMARY CARE:** Primary care is first contact care, the type furnished to individuals when they enter the health care system. Primary care is, comprehensive in that it deals with a wide range of health problems, diagnosis and modes of treatment. Primary care is continuous in that an ongoing relationship is established with the primary care practitioner who monitors and provides the necessary follow-up care and is coordinated by linking patients with more varied specialized services when needed. Consultations and care provided on referral from another practitioner is not considered primary care.

2. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES:** The Federal Health Care Finance Administration has mandated that all state Medicaid programs utilize the new Evaluation and Management coding as published in the American Medical Association's CPT.

   For the first time, a major section has been devoted entirely to E/M services. The new codes are more than a clarification of the old definitions; they represent a new way of classifying the work of practitioners. In particular, they involve far more clinical detail than the old visit codes. For this reason, it is important to treat the new codes as a new system and not make a one-for-one substitution of a new code number for a code number previously used to report a level of service defined as "brief", "limited", "intermediate", etc.

   The E/M section is divided into broad categories such as office visits, hospital visits and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of practitioner work varies by type of service, place of service, and the patient's status.

   The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office service. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See levels of E/M services following for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified.

3. **DEFINITIONS OF COMMONLY USED E/M TERMS:** Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting. (For complete procedure descriptions, see page 7-18)

   NEW AND ESTABLISHED PATIENT: A new patient is one who has not received any professional services from the practitioner within the past three years.

An established patient is one who has received professional services from the practitioner within the past three years.

In the instance where a practitioner is on call for or covering for another practitioner, the patient's encounter will be classified as it would have been by the practitioner who is not available.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

CHIEF COMPLAINT: A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

CONCURRENT CARE: is the provision of similar services, eg, hospital visits, to the same patient by more than one practitioner on the same day. When concurrent care is provided, no special reporting is required. Modifier -75 has been deleted.

COUNSELING: Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction; and
- patient and family education.

FAMILY HISTORY: A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children;
- specific diseases related to problems identified in the Chief Complaint or History of the Present Illness and/or System Review;
- diseases of family members which may be hereditary or place patient at risk.

HISTORY OF PRESENT ILLNESS: A chronological description of the development of the patient's present illness from the first sign and/or symptom present. This includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

NATURE OF PRESENTING PROBLEM: A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal - A problem that may not require the presence of the practitioner, but service is provided under the practitioner's supervision.

- Self-limited or Minor - A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

PAST HISTORY: A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (eg, drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status

SOCIAL HISTORY: An age appropriate review of past and current activities that includes significant information about:

- marital status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

SYSTEM REVIEW (REVIEW OF SYSTEMS): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)

- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

TIME: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions. The inclusion of time as an explicit factor beginning in 1992 is done to assist practitioners in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for practitioners to provide accurate estimates of the time spent face-to-face with the patient.

Intra-service times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

A. **Face-to-face time (office and other outpatient visits):** For coding purposes, face-to-face time for these services is defined as only that time that the practitioner spends face-to-face with the patient and/or family. This includes the time in which the practitioner performs such tasks as obtaining a history, performing an examination, and counseling the patient.

   Practitioners also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

   This non face-to-face time for office and other outpatient services - also called pre- and post encounter time - is **not included** in the time component described in the E/M codes. However, the pre- and post face-to-face work associated with an encounter was included in calculating the total work of typical services.

   Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

B. **Unit/floor time (inpatient hospital care, nursing facility):** For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the practitioner is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the practitioner establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.
In the hospital, pre- and post time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

This pre- and post visit time is not included in the time component described in these codes. However, the pre- and post work performed during the time spent off the floor or unit was included in calculating the total work of typical services.

Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

4.A. **LEVELS OF E/M SERVICES:** Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (eg, office and other outpatient setting, emergency department, nursing facility, etc.). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history; examination; medical decision making; counseling; coordination of care; nature of presenting problem; and time.

The first three of these components (history, examination and medical decision making) are considered the key components in selecting a level of E/M services. The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter. The final component, time, has already been discussed in detail.

The actual performance of diagnostic tests/studies for which specific CPT codes are available is not included in the levels of E/M services. Practitioner performance of diagnostic tests/studies for which specific CPT codes are available should be reported separately, in addition to the appropriate E/M code.

4.B. INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE:

i. IDENTIFY THE CATEGORY AND SUBCATETORY OF SERVICE: Select from the categories and subcategories of codes available for reporting E/M services.

ii. REVIEW THE REPORTING INSTRUCTIONS FOR THE SELECTED CATEGORY OR SUBCATEGORY: Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Care", special instructions will be presented preceding the levels of E/M services.

iii. REVIEW THE LEVEL OF E/M SERVICE DESCRIPTORS AND EXAMPLES IN THE SELECTED CATEGORY OR SUBCATEGORY: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time.

The first three of these components (ie, history, examination and medical decision making) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care (See vii.c.).

The nature of the presenting problem and time are provided in some levels to assist the practitioner in determining the appropriate level of E/M service.

iv. DETERMINE THE EXTENT OF HISTORY OBTAINED: The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused -- chief complaint; brief history of present illness or problem.
- Expanded Problem Focused -- chief complaint; brief history of present illness; problem pertinent system review.
- Detailed -- chief complaint; extended history of present illness; problem pertinent system review extended to include review of a limited number of additional systems; pertinent past, family and/or social history directly related to patients problems.
- Comprehensive -- chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) indicated in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

  The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family and social history as well as a comprehensive assessment/history of pertinent risk factors.

DETERMINE THE EXTENT OF EXAMINATION PERFORMED: The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused -- a limited examination of the affected body area or organ system.
- Expanded Problem Focused -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- Detailed -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive -- a general multi-system examination or a complete examination of a single organ system. **NOTE:** The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.

  For the purposes of these definitions, the following organ systems are recognized: eyes, ears, nose, mouth and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin; neurologic; psychiatric; hematologic/lymphatic/immunologic.

v. DETERMINE THE COMPLEXITY OF MEDICAL DECISION MAKING: Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and, high complexity. To qualify for a given type of decision making, two of the three elements in the table following must be met or exceeded:

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
minimal	minimal or none	minimal	straight forward
limited	limited	low	low complexity
multiple	moderate	moderate	moderate complexity
extensive	extensive	high	high complexity

Co-morbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

vi. SELECT THE APPROPRIATE LEVEL OF E/M SERVICES BASED ON THE FOLLOWING:

a. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (ie, history, examination, and medical decision making), must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; hospital observation services; and home, new patient.

b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

c. In the case where counseling and/or coordination of care dominates (more than 50%) of the practitioner/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the medical record.

NOTE: CLINICAL EXAMPLES: Clinical examples of the codes for E/M services are provided to assist practitioners in understanding the meaning of the descriptors and selecting the correct code.

The same problem, when seen by different practitioners, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the example.

5. **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.

6. **EVALUATION AND MANAGEMENT SERVICES (OUTPATIENT OR INPATIENT):** Evaluation and management fees do not apply to preoperative consultations or follow-up visits as designated in accordance with the surgical fees listed in the SURGERY section of the State Medical Fee Schedule.

   For additional information on the appropriate circumstances governing the billing of the hospital visit procedure codes see **PRACTITIONER SERVICES PROVIDED IN HOSPITALS.**

EVALUATION AND MANAGEMENT CODES

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

OFFICE OR OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the practitioner's office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs. When claiming for Evaluation and Management procedure codes report the place of service code that represents the location where the service was rendered in the claim form field for Place of Service. The maximum reimbursable amount for these codes is dependent on the Place of Service reported.

For Evaluation and Management services rendered in the practitioner's private office, report place of service "11". For services rendered in a Hospital Outpatient setting report place of service "22".

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or comprehensive nursing facility assessments.

NEW PATIENT

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- a problem focused history,
- a problem focused examination,
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination,
- straightforward medical decision making.

Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 20 minutes face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- a detailed history,
- a detailed examination,
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Practitioners typically spend 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination,
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination,
- medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.

ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a problem focused history,
- a problem focused examination,
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination,
- medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a detailed history,
- a detailed examination,
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a comprehensive history,
- a comprehensive examination,
- medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.

HOSPITAL OBSERVATION SERVICES

The following codes are used to report evaluation and management services provided to patients designated/admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation are designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.

Typical times have not yet been established for this category of services.

OBSERVATION CARE DISCHARGE SERVICES

Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.

99217 Observation care discharge day management. (This code is to be utilized by the practitioner to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status". To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services (99234-99236))

INITIAL OBSERVATION CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the encounter(s) by the supervising practitioner with the patient when designated as "observation status". This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments.

To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate initial hospital care codes (99221-99223). For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. Do not report observation discharge (99217) in conjunction with the hospital admission.

When "observation status" is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, practitioner's office, nursing facility) all evaluation and management services provided by the supervising practitioner in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising practitioner should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting. Evaluation and Management services on the same date provided in sites that are related to initiating "observation status" should NOT be reported separately.

These codes may not be utilized for post-operative recovery if the procedure is considered a part of the surgical "package". These codes apply to all Evaluation and Management services that are provided on the same date of initiating "observation status".

99218 Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components:

- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Usually the problem(s) requiring admission to "observation status" are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit.

99219 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Usually the problem(s) requiring admission to "observation status" are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit.

99220 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Usually the problem(s) requiring admission to "observation status" are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

SUBSEQUENT OBSERVATION CARE

All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician.

99224 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- problem focused interval history;
- problem focused examination;
- medical decision making that is straightforward or of low complexity.

Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99225 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of moderate complexity.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99226 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

HOSPITAL INPATIENT SERVICES

The following codes are used to report evaluation and management services provided to inpatients.

INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the first hospital encounter with the patient by the admitting practitioner. For subsequent hospital care codes (99231-99233) as appropriate.

99221 Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components:

- a detailed or comprehensive history,
- a detailed or comprehensive examination,
- medical decision making that is straightforward or of low complexity.

Usually, the problem(s) requiring admission are of low severity. Practitioners typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination,
- medical decision making of moderate complexity.

Usually, the problem(s) requiring admission are of moderate severity. Practitioners typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination,
- medical decision making of high complexity.

Usually, the problem(s) requiring admission are of high severity. Practitioners typically spend 70 minutes at the bedside and on the patient’s hospital floor or unit.

SUBSEQUENT HOSPITAL CARE

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status, (i.e., changes in history, physical condition and response to management) since the last assessment by the practitioner.

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these 3 key components:

- a problem focused interval history,
- a problem focused examination, and/or
- medical decision making that is straightforward or of low complexity.

Usually, the patient is stable, recovering or improving. Practitioners typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit.

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- an expanded problem focused interval history,
- an expanded problem focused examination, and/or
- medical decision making of moderate complexity.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Practitioners typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a detailed interval history,
- a detailed examination, and/or
- medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Practitioners typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

OBSERVATION OR INPATIENT CARE SERVICES (INCLUDING ADMISSION AND DISCHARGE SERVICES)

The following codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. When a patient is admitted to the hospital from observation status on the same date, the practitioner should report only the initial hospital care code. The initial hospital care code reported by the admitting practitioner should include the services related to the observation status services he/she provided on the same date of inpatient admission.

When "observation status" is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, practitioner's office, nursing facility) all evaluation and management services provided by the supervising practitioner in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting when provided by the same practitioner.

99234 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Usually the presenting problem(s) requiring admission are of low severity.

99235 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Usually the presenting problem(s) requiring admission are of moderate severity.

99236 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Usually the presenting problem(s) requiring admission are of high severity.

HOSPITAL DISCHARGE SERVICES

The hospital discharge day management codes are to be used to report the total duration of time spent by a practitioner for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the practitioner on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. For patients admitted and discharged from observation or inpatient status on the same date, the service should be reported with codes 99234-99236 as appropriate.

99238 Hospital discharge day management; 30 minutes or less
99239 more than 30 minutes
(These codes are to be utilized by the practitioner to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status. To report services to a patient who is admitted as an inpatient, and discharge on the same date, see codes 99234-99236 for observation or inpatient hospital care including the admission and discharge of the patient on the same date. To report concurrent care services provided by a practitioner(s) other than the attending practitioner, use subsequent hospital care codes (99231-99233) on the day of discharge.)

EMERGENCY DEPARTMENT SERVICES - NEW OR ESTABLISHED PATIENT

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention.

The facility must be available 24 hours a day.

99281 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- a problem focused history,
- a problem focused examination,
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor.

99282 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination; and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity.

99283 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate severity.

99284 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

- a detailed history,
- a detailed examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the practitioner but do not pose an immediate significant threat to life or physiologic function.

99285 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

NURSING FACILITY SERVICES

The following codes are used to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs)).

INITIAL NURSING FACILITY CARE – NEW OR ESTABLISHED PATIENT

More than one comprehensive assessment may be necessary during an inpatient confinement.

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a detailed or comprehensive history,
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination; and
- medical decision making of moderate complexity.

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination; and
- medical decision making of high complexity.

Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.

SUBSEQUENT NURSING FACILITY CARE

The following codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.

All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician.

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a problem focused interval history;
- a problem focused examination;
- straight-forward medical decision making.

Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of low complexity.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity.

Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a comprehensive interval history;
- a comprehensive examination;
- medical decision making of high complexity.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

NURSING FACILITY DISCHARGE SERVICES

The nursing facility discharge day management codes are to be used to report the total duration of time spent by a practitioner for the final nursing facility discharge of patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the practitioner on that date is not continuous.

Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

99315 Nursing facility discharge day management; 30 minutes or less
99316 more than 30 minutes

DOMICILIARY, REST HOME (e.g., BOARDING HOME), OR CUSTODIAL CARE SERVICES

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component.

NEW PATIENT

99324 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a problem focused history,
- a problem focused examination, and
- medical decision making that is straightforward.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.

99325 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.

99326 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a detailed history,
- a detailed examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high complexity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

99327 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

99328 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

ESTABLISHED PATIENT

99334 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a problem focused interval history,
- a problem focused examination, and/or
- medical decision making that is straightforward.

Usually, the presenting problem(s) are self-limited or minor.

99335 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history,
- an expanded problem focused examination, and/or
- medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity.

99336 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a detailed interval history,
- a detailed examination, and/or
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity.

99337 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a comprehensive interval history,
- a comprehensive examination, and
- medical decision making of moderate to high complexity.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

HOME SERVICES

The following codes are used to report evaluation and management services provided in a private residence.

NEW PATIENT

99341 Home visit for the evaluation and management of a new patient, which requires these three key components:

- a problem focused history,
- a problem focused examination, and
- medical decision making that is straightforward.

Usually the presenting problem(s) are of low severity. Practitioners typically spend 20 minute face-to-face with the patient and/or family.

99342 Home visit for the evaluation and management of a new patient, which requires these three key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Practitioners typically spend 30 minutes face-to-face with the patient and/or family.

99343 Home visit for the evaluation and management of a new patient, which requires these three key components:

- a detailed history,
- a detailed examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with patient and/or family.

99344 Home visit for the evaluation and management of a new patient, which requires these three key components:

- a comprehensive history,
- a comprehensive examination; and
- medical decision making of moderate complexity.

Usually the presenting problem(s) are of high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.

99345 Home visit for the evaluation and management of a new patient, which requires these three key components:

- a comprehensive history,
- a comprehensive examination; and
- medical decision making of high complexity.

Usually the patient is unstable or has developed a significant new problem requiring immediate Practitioner attention. Practitioners typically spend 75 minutes face-to-face with the patient and/or family.

ESTABLISHED PATIENT

99347 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination and
- straightforward medical decision making.

Usually the presenting problem(s) are self-limited or minor. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.

99348 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of low complexity.

Usually the presenting problem(s) are of low to moderate severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.

99349 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity.

Usually the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.

99350 Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a comprehensive interval history;
- a comprehensive examination;
- medical decision making of moderate to high complexity.

Usually the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate practitioner attention. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.

PREVENTIVE MEDICINE SERVICES

The following codes are used to report well visit services.

NEW PATIENT

99381 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382 early childhood (age 1 through 4 years)
99383 late childhood (age 5 through 11 years)
99384 adolescent (age 12 through 17 years)
99385 18-39 years
99386 40-64 years
99387 65 years and older

ESTABLISHED PATIENT

99391 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392 early childhood (age 1 through 4 years)
99393 late childhood (age 5 through 11 years)
99394 adolescent (age 12 through 17 years)
99395 18 - 39 years
99396 40 - 64 years
99397 65 years and older

COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

BEHAVIOR CHANGE INTERVENTIONS, INDIVIDUAL

99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407 intensive, greater than 10 minutes

NEWBORN CARE SERVICES

The following codes are used to report the services provided to newborns (birth through the first 28 days) in several different settings. Use of the newborn codes is limited to the initial care of the newborn in the first days after birth prior to home discharge.

99460 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant
99462 Subsequent hospital care, per day, for evaluation and management of normal newborn
99463 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date

LABORATORY SERVICES PERFORMED IN THE OFFICE

Certain laboratory procedures specified below are eligible for direct nurse practitioner reimbursement when performed in the office of the nurse practitioner in the course of treatment of her own patients.

The nurse practitioner must be registered with the federal Health Care Finance Administration (HCFA) to perform laboratory procedures as required by the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA '88).

Procedures other than those specified must be performed by a laboratory, holding a valid clinical laboratory permit in the commensurate laboratory, specialty issued by the New York State Department of Health or, where appropriate, the New York City Department of Health.

For detection of pregnancy, use code 81025.

Procedure code 85025, complete blood count (CBC), may not be billed with its component codes 85007, 85013, 85018, 85041 or 85048.

81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001 automated, with microscopy
81002 non-automated, without microscopy
81003 automated, without microscopy
81015 Urinalysis; microscopic only
81025 Urine pregnancy test, by visual color comparison methods
83655 Lead
85007 Blood count; blood smear, microscopic examination with manual differential WBC count
85013 spun microhematocrit
85018 hemoglobin (Hgb)
85025 complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85041 red blood cell (RBC) automated
85048 leukocyte (WBC), automated
85651 Sedimentation rate, erythrocyte; non-automated
85652 automated
86701 Antibody; HIV-1
87081 Culture, presumptive, pathogenic organisms, screening only;
87880 Streptococcus, group A

NOTE: Medicare reimburses for these services at 100 percent. No Medicare co-insurance payments may be billed for the above listed procedure codes.

DRUGS AND DRUG ADMINISTRATION

IMMUNIZATIONS

If a significantly separately identifiable Evaluation and Management services (eg, office service, preventative medicine services) is performed, the appropriate E/M code should be reported in addition to the vaccine and toxoid codes.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, a minimal service may be listed in addition to the injection. Immunization procedures include reimbursement for the supply of materials **and administration**.

Reimbursement for drugs (including vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, 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 drug dosage administered.

IMMUNE GLOBULINS

Immune globulin products listed here include broad-spectrum and anti-infective immune globulins, antitoxins, and various isoantibodies.

90291 Cytomegalovirus immune globulin (CMV-lgIV), human, for intravenous use **(BR)**
90371 Hepatitis B immune globulin (HBlg), human, for intramuscular use
90375 Rabies immune globulin (Rlg), human, for intramuscular and/or subcutaneous use (150 IU/ml)
90376 Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use
90378 Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
90384 Rho(D) immune globulin (Rhlg), human, full-dose, for intramuscular use
90385 Rho(D) immune globulin (Rhlg), human, mini-dose, for intramuscular use
90386 Rho(D) immune globulin (RhIgIV), human, for intravenous use
90389 Tetanus immune globulin (Tlg), human, for intramuscular use
90393 Vaccinia immune globulin, human, for intramuscular use **(BR)**
90396 Varicella-zoster immune globulin, human, for intramuscular use
90399 Unlisted immune globulin **(BR)**

IMMUNIZATION ADMINISTRATION FOR VACCINES/TOXOIDS

90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered)
90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure))
90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid) **(Administration for 90660)**
90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)

VACCINES/TOXOIDS

For dates of service on or after 7/1/03 when immunization materials are supplied by the Vaccines for Children Program (VFC), bill using the procedure code that represents the immunization(s) administered and **append modifier –SL State Supplied Vaccine** to receive the VFC administration fee. See Modifier Section for further information.
For administration of vaccines supplied by VFC, including i**nfluenza and pneumococcal administration,** providers will be required to bill **vaccine administration** code **90460.** Providers **must continue to bill the specific vaccine code with the "SL"** modifier on the claim (payment for "SL" will be $0.00). If an administration code is billed without a vaccine code with "SL", the claim will be denied. For reimbursement purposes, the administration of the components of a combination vaccine will continue to be considered as one vaccine administration. More than one vaccine administration is reimbursable under 90460 on a single date of service.

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the current acquisition cost of the antigen. For immunizations not supplied by the VFC Program insert acquisition cost in amount charged field on claim form. For codes listed **BR/Report required**, also attach itemized invoice to claim form.

To meet the reporting requirements of immunization registries, vaccine distribution programs, and reporting systems (eg, Vaccine Adverse Event Reporting System) the exact vaccine product administered needs to be reported with modifier -SL. Multiple codes for a particular vaccine are provided in CPT when the schedule (number of doses or timing) differs for two or more products of the same vaccine type (eg, hepatitis A, Hib) or the vaccine product is available in more than one chemical formulation, dosage, or route of administration.

Separate codes are available for combination vaccines (eg, DTP-Hib, DtaP-Hib, HepB-Hib). It is inappropriate to code each component of a combination vaccine separately. If a specific vaccine code is not available, the Unlisted procedure code should be reported, until a new code becomes available.

90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586 Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632 Hepatitis A vaccine, adult dosage, for intramuscular use
90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use

90636 Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645 Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646 Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647 Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648 Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90649 Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90650 Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
90654 Influenza virus vaccine, split virus, preservative-free, for intradermal use
90655 Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656 Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657 Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
90658 Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660 Influenza virus vaccine, trivalent, live, for intranasal use
90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90669 Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90675 Rabies vaccine, for intramuscular use
90676 Rabies vaccine, for intradermal use
90680 Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90681 Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use
90685 Influenza virus vaccine, quadrivalent,split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686 Influenza virus vaccine, quadrivalent,split virus,preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90672 Influenza virus vaccine, quadrivalent, live, for intranasal use
90690 Typhoid vaccine, live, oral
90691 Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use
90692 Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use
90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for intramuscular use

90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
90702 Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use
90703 Tetanus toxoid adsorbed, for intramuscular use
90704 Mumps virus vaccine, live, for subcutaneous use
90705 Measles virus vaccine, live, for subcutaneous use
90706 Rubella virus vaccine, live, for subcutaneous use
90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90708 Measles and rubella virus vaccine, live, for subcutaneous use
90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90712 Poliovirus vaccine, (any type[s]) (OPV), live, for oral use
90713 Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714 Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use
90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716 Varicella virus vaccine, live, for subcutaneous use
90717 Yellow fever vaccine, live, for subcutaneous use

90720 Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90725 Cholera vaccine for injectable use
90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90733 Meningococcal polysaccharide vaccine (any group[s]), for subcutaneous use
90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735 Japanese encephalitis virus vaccine, for subcutaneous use
90736 Zoster (shingles) vaccine, live, for subcutaneous injection
90738 Japanese encephalitis virus vaccine, inactivated, for intramuscular use
90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90743 Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744 Hepatitis B vaccine; pediatric/adolescent dosage, (3 dose schedule) for intramuscular use
90746 Hepatitis B vaccine, adult dosage, (3 dose schedule), for intramuscular use
90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748 Hepatitis B and Hemophilus influenza b (HepB-Hib), for intramuscular use
90749 Unlisted vaccine/toxoid **(BR)**

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

The following list of drugs can be injected either subcutaneous, intramuscular or intravenously. A listing of chemotherapy drugs can be found in the Chemotherapy Section.

New York State Medicaid's policy for coverage of drugs administered by subcutaneous, intramuscular or intravenous methods in the physician's office is as follows: These drugs are covered for FDA approved indications and those recognized off-label indications listed in the drug compendia (the American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DrugDex information system or Facts and Comparisons). In the absence of such a recognized indication, an approved Institutional Review Board (IRB) protocol would be required with documentation maintained in the patient's clinical file. Drugs are not covered for investigational or experimental use.

Reimbursement for drugs (including vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice.

New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, 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 drug dosage administered.

NOTE: The maximum fees for these drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert acquisition cost per dose in amount charged field on claim form. For codes listed as BR in the Fee Schedule, also attach an itemized invoice to claim form.

THERAPEUTIC INJECTIONS (Maximum fee includes cost of materials)

J0129 Abatacept, 10 mg
(Administered under direct physician supervision, not for self-administration)

J0135 Adalimumab, 20 mg

J0150 Adenosine, for therapeutic use, 6 mg
(Not to be used to report any adenosine phosphate compounds, instead use unlisted code)

J0171 Adrenalin, epinephrine, 0.1 mg

J0180 Agalsidase beta, 1 mg

J0205 Alglucerase, per 10 units

J0207 Amifostine, 500 mg

J0210 Methyldopate HCl, up to 250 mg

J0215 Alefacept, 0.5 mg

J0256 Alpha 1proteinase inhibitor (human), not otherwise specified, 10 mg

J0270 Alprostadil, per 1.25 mcg
(Administered under direct physician supervision, not for self-administration)

J0275 Alprostadil urethral suppository
(Administered under direct physician supervision, not for self-administration)

J0280 Aminophylline, up to 250 mg
J0290 Ampicillin sodium, up to 500 mg
J0295 Ampicillin sodium/sulbactam sodium, per 1.5 gm
J0300 Amobarbital, up to 125 mg
J0360 Hydralazine HCl, up to 20 mg
J0380 Metaraminol bitartrate, per 10 mg
J0390 Chloroquine HCl, up to 250 mg
J0456 Azithromycin, 500 mg
J0461 Atropine sulfate, 0.01 mg
J0470 Dimercaprol, per 100 mg
J0475 Baclofen, 10 mg
J0500 Dicyclomine HCl, up to 20 mg
J0515 Benztropine mesylate, per 1 mg
J0520 Bethanechol chloride, myotonachol or urecholine, up to 5 mg
J0558 Penicillin G benzathine and penicillin G procaine, 100,000 units
J0561 Penicillin G benzathine, 100,000 units
J0585 OnabotulinumtoxinaA, 1 unit
J0586 AbobotulinumtoxinaA, 5 units
J0587 RimabotulinumtoxinB, 100 units
J0600 Edetate calcium disodium, up to 1000 mg
J0610 Calcium gluconate, per 10 ml
J0620 Calcium glycerophosphate and calcium lactate, per 10 ml
J0630 Calcitonin salmon, up to 400 units
J0636 Calcitriol, 0.1 mcg
J0640 Leucovorin calcium, per 50 mg
J0641 Levoleucovorin calcium, 0.5 mg
J0690 Cefezolin sodium, up to 500 mg
J0694 Cefoxitin sodium, 1 gm
J0696 Ceftriaxone sodium, per 250 mg
J0697 Sterile cefuroxime sodium, per 750 mg
J0698 Cefotaxime sodium, per gm
J0702 Betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg
J0710 Cephapirin sodium, up to 1 gm
J0713 Ceftazidime, per 500 mg
J0715 Ceftizoxime sodium, per 500 mg
J0720 Chloramphenicol sodium succinate, up to 1 gm
J0725 Chorionic gonadotropin, per 1,000 USP units
J0740 Cidofovir, 375 mg
J0744 Ciprofloxacin for intravenous infusion, 200 mg
J0745 Codeine phosphate, per 30 mg
J0760 Colchicine, per 1 mg
J0770 Colistimethate sodium, up to 150 mg
J0780 Prochlorperazine, up to 10 mg
J0834 Cosyntropin (Cortrosyn), 0.25 mg
J0881 Darbepoetin alfa, 1 mcg (**Non-ESRD** use)
J0885 Epoetin alfa, (**Non-ESRD** use), 1000 units

J0895 Deferoxamine mesylate, 500 mg
J0900 Testosterone enanthate and estradiol valerate, up to 1 cc
J0945 Brompheniramine maleate, per 10 mg
J1000 Depo-estradiol cypionate, up to 5 mg
J1020 Methylprednisolone acetate, 20 mg
J1030 Methylprednisolone acetate, 40 mg
J1040 Methylprednisolone acetate, 80 mg

J1050 Injection, medroxyprogesterone acetate, 1 mg
J1060 Testosterone cypionate and estradiol cypionate (Depo-Testadiol), up to 1 ml
J1070 Testosterone cypionate, up to 100 mg
J1080 Testosterone cypionate, 1 cc, 200 mg
J1094 Dexamethasone acetate, 1 mg
J1100 Dexamethasone sodium phosphate, 1 mg
J1110 Dihydroergotamine mesylate, per 1 mg
J1120 Acetazolamide sodium, up to 500 mg
J1160 Digoxin, up to 0.5 mg
J1165 Phenytoin sodium, per 50 mg
J1170 Hydromorphone, up to 4 mg
J1180 Dyphylline, up to 500 mg
J1190 Dexrazoxane HCl, per 250 mg
J1200 Diphenhydramine HCl, up to 50 mg
J1205 Chlorothiazide sodium, per 500 mg
J1212 DMSO, dimethyl sulfoxide, 50%, 50 ml
J1230 Methadone HCl, up to 10 mg
J1240 Dimenhydrinate, up to 50 mg
J1260 Dolasetron mesylate, 10 mg
J1300 Eculizumab, 10 mg
J1320 Amitriptyline HCl, up to 20 mg
J1330 Ergonovine maleate, up to 0.2 mg
J1364 Erythromycin lactobionate, per 500 mg
J1380 Estradiol valerate, up to 10 mg
J1410 Estrogen conjugated, per 25 mg
J1435 Estrone, per 1 mg
J1436 Etidronate disodium, per 300 mg
J1438 Etanercept, 25 mg
(Administered under direct physician supervision, not self administered)

J1442 Filgrastim (G-CSF), 1 microgram
J1446 Tbo-Filgrastim, 5 micrograms
J1450 Fluconazole, 200 mg
J1452 Fomivirsen sodium, intraocular, 1.65 mg
J1453 Fosaprepitant, 1 mg
J1455 Foscarnet sodium, per 1000 mg
J1458 Galsulfase, 1 mg **(Report required)**
J1459 Immune globulin (Privigen), intravenous, non lyophilized (e.g. liquid), 500 mg
J1460 Gamma globulin, intramuscular, 1 cc

J1556 Immune Globulin (Bivigam) , 500 mg
J1560 Gamma globulin, intramuscular, over 10 cc
J1561 Immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562 Immune globulin (Vivaglobin), 100 mg
J1566 Immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg **(Report required)**
J1568 Immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg

J1569 Immune globulin, (Gammagard Liquid), non-lyophilized, (e.g. liquid), 500 mg
J1570 Ganciclovir sodium, 500 mg
J1572 Immune globulin, (flebogamma/flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1573 Hepatitis B immune globulin (HepaGam B), intravenous, 0.5 ml
J1580 Garamycin, gentamicin, up to 80 mg
J1590 Gatifloxacin, 10 mg
J1595 Glatiramer acetate, 20 mg
J1599 Immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg **(Report required)**
J1600 Gold sodium thiomalate, up to 50 mg
J1602 Golimumab, per 1 mg for Intravenous use
J1610 Glucagon HCl, per 1 mg
J1620 Gonadorelin HCl, per 100 mcg
J1626 Granisetron HCl, 100 mcg
J1630 Haloperidol, up to 5 mg
J1631 Haloperidol decanoate, per 50 mg
J1642 Heparin sodium, (heparin lock flush), per 10 units
J1644 Heparin sodium, per 1000 units
J1645 Dalteparin sodium, per 2500 IU
J1652 Fondaparinux sodium, 0.5 mg
J1655 Tinzaparin sodium, 1000 IU
J1710 Hydrocortisone sodium phosphate, up to 50 mg
J1720 Hydrocortisone sodium succinate, up to 100 mg
J1725 Hydroxyprogesterone caproate, 1 mg
J1730 Diazoxide, up to 300 mg
J1740 Ibandronate sodium, 1 mg
J1741 Injection, ibuprofen, 100 mg
J1745 Infliximab, 10 mg
J1750 Iron dextran, 50 mg
J1756 Iron sucrose, 1 mg
J1786 Imiglucerase, 10 units
J1790 Droperidol, up to 5 mg
J1800 Propranolol HCl, up to 1 mg
J1815 Insulin, per 5 units
J1817 Insulin (i.e., insulin pump) per 50 units
(Administered under direct physician supervision, not for self administration)

J1826 Interferon beta-1a, 30 mcg

J1830 Interferon beta-1b, 0.25 mg
(Administered under direct physician supervision, not for self-administration)
J1840 Kanamycin sulfate, up to 500 mg
J1850 Kanamycin sulfate, up to 75 mg
J1885 Ketorolac tromethamine, per 15 mg
J1890 Cephalothin sodium, up to 1 gm
J1930 Lanreotide, 1 mg
J1931 Laronidase, 0.1 mg
J1940 Furosemide, up to 20 mg
J1950 Leuprolide acetate (for depot suspension), per 3.75 mg
J1955 Levocarnitine, per 1 gm
J1960 Levorphanol tartrate, up to 2 mg
J1980 Hyoscyamine sulfate, up to 0.25 mg
J1990 Chlordiazepoxide HCl, up to 100 mg
J2001 Lidocaine HCl for intravenous infusion, 10 mg
J2010 Lincomycin HCl, up to 300 mg
J2060 Lorazepam, 2 mg
J2150 Mannitol, 25% in 50 ml
J2175 Meperidine HCl, per 100 mg
J2210 Methylergonovine maleate, up to 0.2 mg
J2248 Micafungin sodium, 1 mg
J2260 Milrinone lactate, per 5 mg
J2270 Morphine sulfate, up to 10 mg
J2275 Morphine sulfate (preservative-free sterile solution), per 10 mg
J2278 Ziconotide, 1 mcg
J2320 Nandrolone decanoate, up to 50 mg
J2323 Natalizumab, 1 mg
J2353 Octreotide, depot form for intramuscular injection, 1 mg
J2355 Oprelvekin, 5 mg
J2357 Omalizumab, 5 mg
J2358 Olanzapine, long-acting, 1 mg
J2360 Orphenadrine citrate, up to 60 mg
J2370 Phenylephrine HCl, up to 1 ml
J2405 Ondansetron HCl, per 1 mg
J2410 Oxymorphone HCl, up to 1 mg
J2425 Palifermin, 50 mg
J2426 Paliperidone palmitate extended release, 1 mg
J2430 Pamidronate disodium, per 30 mg
J2440 Papaverine HCl, up to 60 mg
J2460 Oxytetracycline HCl, up to 50 mg
J2469 Palonosetron HCl, 25 mcg
J2504 Pegademase bovine, 25 IU
J2505 Pegfilgrastim, 6 mg
J2510 Penicillin G procaine, aqueous, up to 600,000 units
J2513 Pentastarch, 10% solution, 100 ml
J2515 Pentobarbital sodium, per 50 mg

J2540 Penicillin G potassium, up to 600,000 units
J2545 Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg
J2550 Promethazine HCl, up to 50 mg
J2560 Phenobarbital sodium, up to 120 mg
J2590 Oxytocin, up to 10 units

J2597 Desmopressin acetate, per 1 mcg
J2650 Prednisolone acetate, up to 1 ml
J2670 Tolazoline HCl, up to 25 mg
J2675 Progesterone, per 50 mg
J2680 Fluphenazine decanoate, up to 25 mg
J2690 Procainamide HCl, up to 1 gm
J2700 Oxacillin sodium, up to 250 mg
J2710 Neostigmine methylsulfate, up to 0.5 mg
J2720 Protamine sulfate, per 10 mg
J2730 Pralidoxime chloride, up to 1 gm
J2760 Phentolamine mesylate, up to 5 mg
J2765 Metoclopramide HCl, up to 10 mg
J2780 Ranitidine HCl, 25 mg
J2783 Rasburicase, 0.5 mg
J2794 Risperidone, long acting, 0.5 mg
J2796 Romiplostim, 10 micrograms
J2800 Methocarbamol, up to 10 ml
J2820 Sargramostim (GM-CSF), 50 mcg
J2910 Aurothioglucose, up to 50 mg
J2916 Sodium ferric gluconate complex in sucrose injection, 12.5 mg
J2920 Methylprednisolone sodium succinate, up to 40 mg
J2930 Methylprednisolone sodium succinate, up to 125 mg
J2940 Somatrem, 1 mg
J2941 Somatropin, 1 mg
J2995 Streptokinase, per 250,000 IU
J3000 Streptomycin, up to 1 gm
J3030 Sumatriptan succinate, 6 mg
J3060 Taliglucerace alfa, 10 units
J3070 Pentazocine, 30 mg
J3105 Terbutaline sulfate, up to 1 mg
J3120 Testosterone enanthate, up to 100 mg
J3130 Testosterone enanthate, up to 200 mg
J3140 Testosterone suspension, up to 50 mg
J3150 Testosterone propionate, up to 100 mg
J3230 Chlorpromazine HCl, up to 50 mg
J3240 Thyrotropin alpha, 0.9 mg. provided in 1.1 mg
J3250 Trimethobenzamide HCl, up to 200 mg
J3260 Tobramycin sulfate, up to 80 mg
J3262 Tocilizumab, 1 mg

J3265 Torsemide,10 mg/ml
J3280 Thiethylperazine maleate, up to 10 mg
J3285 Treprostinil, 1 mg
J3300 Triamcinolone acetonide, preservative free, 1 mg
J3301 Triamcinolone acetonide, not otherwise specified, 10 mg
J3302 Triamcinolone diacetate, per 5 mg
J3303 Triamcinolone hexacetonide, per 5 mg
J3305 Trimetrexate glucuronate, per 25 mg
J3310 Perphenazine, up to 5 mg
J3315 Triptorelin pamoate, 3.75 mg
J3320 Spectinomycin dihydrochloride, up to 2 gm
J3357 Ustekinumab, 1 mg **(Report required)**
J3360 Diazepam, up to 5 mg
J3364 Urokinase, 5000 IU vial
J3370 Vancomycin HCl, 500 mg
J3400 Triflupromazine HCl, up to 20 mg
J3410 Hydroxyzine HCl, up to 25 mg
J3411 Thiamine HCl, 100 mg
J3415 Pyridoxine HCl, 100 mg
J3420 Vitamin B-12 cyanocobalamin, up to 1000 mcg
J3430 Phytonadione, (vitamin K), per 1 mg
J3470 Hyaluronidase, up to 150 units
J3475 Magnesium sulfate, per 500 mg
J3480 Potassium chloride, per 2 meq
J3489 Zoledronic acid, 1 mg
J3490 Unclassified drugs **(BR)**
J3520 Edetate disodium, per 150 mg
J3590 Unclassified Biologics **(BR)**

MISCELLANEOUS DRUGS AND SOLUTIONS

Codes followed by an ^ do not require an NDC to be provided when billed.

A4216^ Sterile water, saline and/or dextrose diluent/flush, 10 ml
A4218^ Sterile saline or water, metered dose dispenser, 10 ml
J7030 Infusion, normal saline solution (or water), 1000 cc
J7040 Infusion, normal saline solution (or water), sterile (500 ml = 1 unit)
J7042 5% dextrose/normal saline (500 ml = 1 unit)
J7050 Infusion, normal saline solution (or water), 250 cc
J7060 5% dextrose/water (500 ml = 1 unit)
J7070 Infusion, D5W, 1000 cc
J7100 Infusion, Dextran 40, 500 ml
J7110 Infusion, dextran 75, 500 ml
J7120 Ringers lactate infusion, up to 1000 cc
J7131 Hypertonic saline solution, 1 ml
J7300 Intrauterine copper contraceptive
J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla)
J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg

J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive supply, hormone containing patch, each
J7306^	Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
J7308	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7321^	Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose
J7323^	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7324^	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7325^	Hyaluronan or derivative, Synvisc or Synvisc-One, intra-articular
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7335	Capsaicin 8% patch, per 10 square centimeters
J7501	Azathioprine, parenteral (eg Imuran), 100 mg
J7504	Lymphocyte immune globulin, antithymocyte globulin equine, parenteral, 250 mg
J7606	Formoterol fumarate, inhalation solution, non-compounded, administered through DME, unit dose form, 20 mcg
J7611	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1mg
J7612	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME. Unit dose. 0.5 mg
J7620	Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded, administered through DME
J7627	Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg
J7628	Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per mg
J7631	Cromolyn sodium, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7640	Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 mcg
J7644	Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7648	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7649	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7658	Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7668	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 10 mg
J7669	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-

compounded, administered through DME, unit dose form, per 10 mg
J7674 Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg
J7682 Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, 300 mg
J8501 Aprepitant, oral, 5 mg

J8540 Dexamethasone, oral, 0.25 mg
J8650 Nabilone, oral, 1 mg
J9226 Histrelin implant (Supprelin LA), 50 mg **(Report required)**

HYDRATION, THERAPEUTIC, PROPHYLACTIC, DIAGNOSTIC INJECTIONS and INFUSIONS, and CHEMOTHERAPY and OTHER HIGHLY COMPLEX DRUG or HIGHLY COMPLEX BIOLOGIC AGENT ADMINISTRATION

Physician work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff.

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported using modifier '25' in addition to 96360-96549. For same day E/M service a different diagnosis is not required.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

a. Use of local anesthesia
b. IV start
c. Access to indwelling IV, subcutaneous catheter or port
d. Flush at conclusion of infusion
e. Standard tubing, syringes, and supplies

When multiple drugs are administered, report the service(s) and the specific materials or drugs for each.

When administering multiple infusions, injections or combinations, only one "initial'' service code should be reported, unless protocol requires that two separate IV sites must be used. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (eg, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code). When these codes are reported by the physician, the "initial'' code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur. When reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered. Intravenous or intra-arterial push is defined as: (a) an injection in which the health care professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or (b) an infusion of 15 minutes or less.

HYDRATION

Codes 96360-96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal saline+30mEq KCl/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusions

typically require direct physician supervision for purposes of consent, safety oversight, or intraservice supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff that administer these do not typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring. These codes are not intended to be reported by the physician in the facility setting.

96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour
(Do not report 96360 if performed as a concurrent infusion service)
(Do not report intravenous infusion for hydration of 30 minutes or less)

96361 each additional hour
(List separately in addition to primary procedure)
(Use 96361 in conjunction with 96360)
(Report 96361 for hydration infusion intervals of greater than 30 minutes beyond 1 hour increments)
(Report 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service [96360, 96365, 96409, 96413] is administered through the same IV access)

THERAPEUTIC, PROPHYLACTIC AND DIAGNOSTIC INJECTIONS AND INFUSIONS (EXCLUDES CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG OR HIGHLY COMPLEX BIOLOGIC AGENT ADMINISTRATION)

A therapeutic, prophylactic or diagnosis IV infusion or injection (other than hydration) is for the administration of substances/drugs. When fluids are used to administer the drug(s), the administration of the fluid is considered incidental hydration and is not separately reportable. These services typically require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intra-service supervision of staff. Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and require periodic patient assessment with vital sign monitoring during the infusion. These codes are not intended to be reported by the physician in the facility setting.

(Do not report 96365-96371 with codes for which IV push or infusion is an inherent part of the procedure [eg, administration of contrast material for a diagnostic imaging study])

96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drugs); up to 1 hour

96366 each additional hour
(List separately in addition to primary procedure)
(Report 96366 in conjunction with 96365, 96367)
(Report 96366 for additional hour[s] of sequential infusion)
(Report 96366 for infusion intervals of greater than 30 minutes beyond 1 hour increments)

96367 additional sequential infusion of a new drug/substance, up to 1 hour
(List separately in addition to primary procedure)

(Report 96367 in conjunction with 96365, 96409, 96413 to identify the infusion of a new drug/substance provided as a secondary or subsequent service after a different initial service is administered through the same IV access.
(Report 96367 only once per sequential infusion of same infusate mix)

96368 concurrent infusion
(List separately in addition to primary procedure)
(Report 96368 only once per encounter)
(Report 96368 in conjunction with 96365, 96366, 96413, 96415, 96416)

96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)

96370 each additional hour
(List separately in addition to primary procedure)
(Use 96370 in conjunction with 96369)
(Use 96370 for infusion intervals of greater than 30 minutes beyond 1 hour increments)

96371 additional pump set-up with establishment of new subcutaneous infusion site(s)
(List separately in addition to primary procedure)
(Use 96371 in conjunction with 96369)
(Use 96369, 96371 only once per encounter)

96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (Bill on one claim line for multiple injections)

CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG OR HIGHLY COMPLEX BIOLOGIC AGENT ADMINISTRATION

Procedures 96405-96549 are independent of the patient's office visit. Either may occur independently from the other on any given day, or they may occur sequentially on the same day. Intravenous chemotherapy injections are administered by a physician, a nurse practitioner or by a qualified assistant under supervision of the physician or nurse practitioner. Preparation of chemotherapy agent(s) is included in the service for administration of the agent.

INJECTION AND INTRAVENOUS INFUSION CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG OR HIGHLY COMPLEX BIOLOGIC AGENT ADMINISTRATION

96405 Chemotherapy administration; intralesional; up to and including 7 lesions

96406 intralesional, more than 7 lesions

96409 intravenous, push technique, single or initial substance/drug

96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
(Report 96361 to identify hydration if administered as a secondary or subsequent service in association with 96413 through the same IV assess)
(Report 96366, 96367, to identify therapeutic, prophylactic, or diagnostic drug infusion or injection, if administered as a secondary or subsequent service in association with 96413 through the same IV access)

96415 each additional hour
(List separately in addition to primary procedure)
(Use 96415 in conjunction with 96413)
(Report 96415 for infusion intervals of greater than 30 minutes beyond 1-hour increments)

96416 initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump

INTRA-ARTERIAL CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG OR HIGHLY COMPLEX BIOLOGIC AGENT ADMINISTRATION

96420 Chemotherapy administration, intra-arterial; push technique
96422 infusion technique, up to 1 hour
96423 infusion technique, each additional hour
(List separately in addition to primary procedure)
(Use 96423 in conjunction with code 96422)
(Report 96423 for infusion intervals of greater than 30 minutes beyond 1-hour increments)

96425 infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

OTHER INJECTION AND INFUSION SERVICES

96440 Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96446 Chemotherapy administration into the peritoneal cavity via indwelling port or catheter
96450 Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
96521 Refilling and maintenance of portable pump
96522 Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic, (eg, intravenous, intra-arterial)
96542 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
96549 Unlisted chemotherapy procedure
J9999 Not otherwise classified, antineoplastic drugs

CHEMOTHERAPY DRUGS

(Maximum fee is for chemotherapy drug only and does not include the administration procedures as listed above)

NOTE: The maximum fees for these drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert actual acquisition cost per dose in amount charged field on claim form. For codes listed BR/Report required, also attach itemized invoice to claim form.

Reimbursement for drugs furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, 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 drug dosage administered.

Codes followed by an ^ do not require an NDC to be provided when billed.

J9000 Doxorubicin HCL (Adriamycin), 10 mg
J9010 Alemtuzumalb, 10 mg
J9015 Aldesleukin, per single use vial
J9017 Arsenic trioxide, 1 mg (Trisenox)
J9020 Asparaginase (Elspar) 10,000 units
J9025 Azacitidine, 1 mg
J9027 Clofarabine, 1 mg
J9031 BCG (intravesical) per instillation
J9033 Bendamustine HCL, 1 mg
J9035 Bevacizumab, 10 mg
J9040 Bleomycin sulfate (Blenoxane), 15 units
J9041 Bortezomib, 0.1 mg
J9043 Carboplatin, 50 mg **(Report required)**
J9045 Carboplatin, 50 mg
J9047 Carfilzomib, 1 mg
J9050 Carmustine, 100 mg
J9055 Cetuximab, 10 mg
J9060 Cisplatin, powder or solution, 10 mg
J9065 Cladribine, per 1 mg
J9070 Cyclophosphamide, 100 mg
J9098 Cytarabine liposome, 10 mg
J9100 Cytarabine (Cytosar-U), 100 mg
J9120 Dactinomycin (Cosmegen), 0.5 mg
J9130 Dacarbazine, 100 mg
J9150 Daunorubicin HCL, 10 mg
J9151 Daunorubicin citrate, liposomal formulation, 10 mg
J9155 Degarelix, 1 mg
J9160 Denileukin diftitox, 300 mcg
J9165 Diethylstilbestrol diphosphate, 250 mg
J9171 Docetaxel, 1 mg
J9178 Epirubicin HCL, 2 mg
J9179 Eribulin mesylate, 0.1mg **(Report required)**
J9181 Etoposide, 10 mg
J9185 Fludarabine phosphate, 50 mg

J9190 Fluorouracil, 500 mg
J9200 Floxuridine (FUDR), 500 mg
J9201 Gemcitabine HCl, 200 mg
J9202 Goserelin acetate implant per 3.6 mg
J9206 Irinotecan, 20 mg
J9207 Ixabepilone, 1 mg
J9208 Ifosfamide, 1 gm
J9209 Mesna, 200 mg
J9211 Idarubicin HCl, 5 mg
J9212 Interferon Alfacon-1, Recombinant, 1 mcg
J9213 Interferon, Alfa-2A, Recombinant, 3 million units
J9214 Interferon, Alfa-2B, Recombinant, 1 million units
J9215 Interferon, Alfa-N3, (Human Leukocyte Derived), 250,000 IU
J9216 Interferon, Gamma 1-B, 3 million units
J9217 Leuprolide acetate (for Depot Suspension), 7.5 mg
J9218 Leuprolide acetate, per 1 mg
J9219^ Leuprolide acetate implant, 65 mg
J9225 Histrelin implant (Vantas), 50 mg **(Report required)**
J9228 Ipilimumab, 1mg **(Report required)**
J9230 Mechlorethamine HCl (nitrogen mustard), 10 mg
J9245 Melphalan HCl, 50 mg
J9250 Methotrexate sodium, 5 mg
J9260 Methotrexate sodium, 50 mg
J9261 Nelarabine, 50 mg
J9262 Omacetaxine mepesuccinate, 0.01 mg
J9263 Oxaliplatin (Eloxatin), 0.5 mg
J9264 Paclitaxel protein-bound particles, 1 mg
J9265 Paclitaxel, 30 mg
J9266 Pegaspargase, per single dose vial
J9268 Pentostatin, per 10 mg
J9270 Plicamycin, 2.5 mg
J9280 Mitomycin, 5 mg
J9293 Mitoxantrone HCl, per 5 mg
J9300 Gemtuzumab ozogamicin, 5 mg
J9302 Ofatumumab, 10 mg
J9303 Panitumumab, 10 mg
J9305 Pemetrexed, 10 mg
J9306 Pertuzumab, 1 mg
J9307 Pralatrexate, 1 mg
J9310 Rituximab, 100 mg
J9315 Romidepsin, 1 mg
J9320 Streptozocin, 1 gm
J9330 Temsirolimus, 1 mg
J9340 Thiotepa, 15 mg
J9351 Topotecan, 0.1 mg

J9354 Ado-trastuzumab emtansine, 1 mg
J9355 Trastuzumab, 10 mg
J9357 Valrubicin, intravesical, 200 mg

J9360 Vinblastine sulfate, 1 mg
J9370 Vincristine sulfate, 1 mg
J9371 Vincristine sulfate liposome, 1 mg
J9390 Vinorelbine Tartrate, 10 mg
J9395 Fulvestrant (Faslodex), 25 mg
J9400 Ziv-aflibercept, 1 mg
J9600 Porfimer sodium, 75 mg
J9999 Not Otherwise Classified, Antineoplastic Drugs

Q0174 Thiethylperazine Maleate, 10 mg, oral
Q0177 Hydroxyzine Pamoate, 25 mg, oral
Q2017 Teniposide, 50 mg
Q2050 Doxorubicin HCL liposomal, NOS, 10 mg
T1013 Sign language or oral interpretive services, per 15 minutes

PSYCHIATRY

Note: To bill for the following codes, you must be certified by the NYS Education Department as a Nurse Practitioner in Psychiatry (Profession Code 040)

90785 Interactive complexity (List separately in addition to primary procedure)
90791 Psychiatric diagnostic evaluation
90792 Psychiatric diagnostic evaluation with medical services

PSYCHOTHERAPY

90832 Psychotherapy, 30 minutes with patient and/or family member
90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service
(List separately in addition to primary procedure)
90834 Psychotherapy, 45 minutes with patient and/or family member
90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service
(List separately in addition to primary procedure)

OTHER PSYCHOTHERAPY

Psychotherapy for Crisis
90839 Psychotherapy for crisis; first 60 minutes
90840 each additional 30 minutes (List separately in addition to primary service)
90847 Family psychotherapy (conjoint psychotherapy) (with patient present)
90849 Multiple-family group psychotherapy

OTHER PSYCHIATRIC SERVICES OR PROCEDURES

90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services
(List separately in addition to primary procedure)

SPECIAL OPHTHALMOLOGICAL SERVICES

92071 Fitting of contact lens for treatment of ocular surface disease
(Do not report 92071 in conjunction with 92072)

92072 Fitting of contact lens for management of keratoconus, initial fitting
(Do not report 92072 in conjunction with 92071)

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

Diagnostic or treatment procedures that are reported as evaluation and management services (eg, otoscopy, anterior rhinoscopy, tuning fork test, removal of non-impacted cerumen) are not reported separately.

Special otorhinolaryngologic services are those diagnostic and treatment services not included in an Evaluation and Management service. These services are reported separately, using codes 92502-92700.

VESTIBULAR FUNCTION TESTS, WITH RECORDING (eg, ENG)

92540 Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording

92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording

92542 Positional nystagmus test, minimum of 4 positions, with recording

92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording

92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording

92545 Oscillating tracking test, with recording

92546 Sinusoidal vertical axis rotational testing

AUDIOLOGIC FUNCTION TESTS

The audiometric tests listed below require the use of calibrated electronic equipment, recording of results and a report with interpretation. Hearing tests (such as whispered voice, tuning fork) that are otorhinolaryngologic Evaluation and Management services are not reported separately. All services include testing of both ears.

92550 Tympanometry and reflex threshold measurements

92551 Screening test, pure tone, air only

92552 Pure tone audiometry (threshold); air only

92553 air and bone
92555 Speech audiometry threshold
92556 with speech recognition
92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92563 Tone decay test
92565 Stenger test, pure tone
92567 Tympanometry (impedance testing)
92568 Acoustic reflex testing; threshold
92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
92571 Filtered speech test
92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586 limited
92587 Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

CARDIOVASCULAR

CARDIOGRAPHY

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93010 interpretation and report only

PULMONARY

Codes 94010-94799 include laboratory procedure(s) and interpretation of test results.

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
94012 Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age
94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV] in an infant or child through 2 years of age
94014 Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation
94016 physician review and interpretation only
94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
94200 Maximum breathing capacity, maximal voluntary ventilation
94644 Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour
94645 each additional hour (List separately in addition to primary procedure)

94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (94664 can be reported one time only per day of service)

ALLERGY AND CLINICAL IMMUNOLOGY

Immunotherapy (desensitization, hyposensitization) is the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. Indications for immunotherapy are determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases.

SENSITIVITY TESTING (Maximum fees include reading of test)

86580 Skin test; tuberculosis, intradermal

MISCELLANEOUS SERVICES

93797 Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798 with continuous ECG monitoring (per session)
95990 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed
96040 Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family

97542# Wheelchair management (eg, assessment, fitting, training), each 15 minutes (up to a maximum of 2 hours)
98960 Education and training for patient self-management by a qualified, non physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961 2-4 patients
98962 5-8 patients
99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99070 Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (List drugs, trays, supplies, or materials provided)
99170 Anogenital examination, magnified,in childhood for suspected trauma, including image recording when performed
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
G0109 group session (2 or more), per 30 minutes
G0372 Physician service required to establish and document the need for a power

mobility device

H0049 Alcohol and/or drug screening

H0050 Alcohol and/or drug services, brief intervention, per 15 minutes

S9445 Patient education ,not otherwise classified, non-physician provider, individual, per session. (The initial lactation counseling session should be a minimum of 45 minutes. Follow up session(s) should be a minimum of 30 minutes.)

S9446 Patient education ,not otherwise classified, non-physician provider, individual, per session. (The initial lactation counseling session should be a minimum of 45 minutes. Follow up session(s) should be a minimum of 30 minutes.)
NYS Medicaid will provide reimbursement for separate and distinct breastfeeding services provided by International Board Certified Lactation Consultants (IBCLCs) credentialed by the IBCLCE. For additional information see: http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-03.htm#fee

SURGERY SECTION

GENERAL INFORMATION AND RULES

1. **FEES:** Fees for office, home and hospital visits and other medical services are listed in the section entitled MEDICINE.
2. **FOLLOW-UP (F/U) DAYS:** Listed dollar values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "F/U Days". Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. (See modifier -24)
3. **BY REPORT:** When the value of a procedure is indicated as "By Report" (BR), an Operative Report must be submitted with the MMIS claim form for a payment determination to be made. The Operative Report must include the following information:
    a. Diagnosis (post-operative)
    b. Size, location and number of lesion(s) or procedure(s) where appropriate
    c. Major surgical procedure and supplementary procedure(s)
    d. Whenever possible, list the nearest similar procedure by number according to these studies
    e. Estimated follow-up period
    f. Operative time

    Failure to submit an Operative Report when billing for a "By Report" procedure will cause your claim to be denied by MMIS.
4. **ADDITIONAL SERVICES:** Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges on a fee-for-service basis. (See modifiers -24, -25, -79). When an additional surgical procedure(s) is carried out within the listed period of follow-

up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

5. **MULTIPLE SURGICAL PROCEDURES:**
   a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total dollar value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified.
   b. When an incidental procedure (eg, incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the fee will be that of the major procedure only.
6. **ASSIST AT SURGERY:** When a physician requests a nurse practitioner or a physician's assistant to participate in the management of a specific surgical procedure in lieu of another physician, by prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 20 percent under these circumstances. The claim for these services will be submitted by the physician using the appropriate modifier.

INTEGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND AREOLAR TISSUES

INCISION AND DRAINAGE

10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061 complicated or multiple
10120 Incision and removal of foreign body, subcutaneous tissues; simple
10140 Incision and drainage of hematoma, seroma or fluid collection
10160 Puncture aspiration of abscess, hematoma, bulla, or cyst

BIOPSY

11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
11101 each separate/additional lesion
(List separately in addition to primary procedure)
(Use 11101 in conjunction with 11100)

REMOVAL OF SKIN TAGS

Excision (including simple closure) of benign lesions of skin or subcutaneous tissues (eg, neoplasm, cicatricial, fibrous, inflammatory, congenital, cystic lesions), includes local anesthesia. See appropriate size and area below.

11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less

INTRODUCTION

11976 Removal, implantable contraceptive capsules
11981 Insertion, non-biodegradable drug delivery implant
11982 Removal, non-biodegradable drug delivery implant
11983 Removal with reinsertion, non-biodegradable drug delivery implant

REPAIR

Simple repair is used when the wound is superficial; eg, involving primarily skin and/or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. FOR CLOSURE WITH ADHESIVE STRIPS, LIST APPROPRIATE EVALUATION AND MANAGEMENT SERVICE ONLY.

Instructions for listing services at time of wound repair.

1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular or stellate.
2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and report as a single item.

Simple ligation of vessels in an open wound is considered as part of any wound closure. Simple exploration of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required.

REPAIR-SIMPLE

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002 2.6 cm to 7.5 cm
12004 7.6 cm to 12.5 cm
12005 12.6 cm to 20.0 cm
12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013 2.6 cm to 5.0 cm
12014 5.1 cm to 7.5 cm
12015 7.6 cm to 12.5 cm
12016 12.6 cm to 20.0 cm

BURNS, LOCAL TREATMENT

Procedures 16000 and 16020 refer to local treatment of burned surface only.
List percentage of body surface involved and depth of burn.
For necessary related medical services (eg, hospital visits) in management of burned patients, see appropriate services in **Medicine** section.

16000 Initial treatment, first degree burn, when no more than local treatment is required
16020 Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)

DESTRUCTION

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion **(Report required)**
17003 second through 14 lesions, each **(Report required)**
(List separately in addition to code for first lesion)
(Use 17003 in conjunction with 17000)

17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions **(Report required)**
(Do not report 17004 in conjunction with17000 -17003)

17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107 10.0 to 50.0 sq cm
17108 over 50.0 sq cm
17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111 15 or more lesions
17250 Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)

DIGESTIVE SYSTEM

STOMACH

43760 Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance

FEMALE GENITAL SYSTEM

VULVA AND INTROITUS

DESTRUCTION

56501 Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

REPAIR

56820 Colposcopy of the vulva;

VAGINA

INTRODUCTION

MATERNITY CARE

57150 Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease

ENDOSCOPY

57420 Colposcopy of the entire vagina, with cervix If present
57452 Colposcopy of the cervix including upper/adjacent vagina;

CORPUS UTERI

INTRODUCTION

(For materials supplied by a practitioner, see General Information #7)

58300 Insertion of intrauterine device (IUD)
58301 Removal of intrauterine device (IUD)

CODE	DESCRIPTION	FEE

Antepartum care includes usual prenatal services (initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, maternity counseling).

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.

For medical complications of pregnancy (toxemia, cardiac problems, neurological problems or other problems requiring additional or unusual services or requiring hospitalization), see services in **MEDICINE** section.

ANTEPARTUM AND POSTPARTUM CARE

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS) are noted in the **Enhanced Program Fee Schedule**. For information on the MOMS Program see Policy Guidelines.

59412 External cephalic version, with or without tocolysis
59425 Antepartum care only; 4-6 visits
59426 7 or more visits
(For 6 or less antepartum encounters, see code 59425)

Note: Antepartum services will no longer require prorated charges. This applies to all prenatal care providers, including those enrolled in the MOMS program. Providers should bill one unit of the appropriate antepartum code after **all** antepartum care has been rendered using the last antepartum visit as the date of service. Only one antepartum care code will be reimbursed per pregnancy.

59430 Postpartum care only (separate procedure)

(When inpatient postpartum care is provided, see appropriate Hospital Evaluation and Management code(s).)

NERVOUS SYSTEM

RESERVOIR/PUMP IMPLANTATION

62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refilling
62368 with reprogramming
62369 with reprogramming and refill

AUDITORY SYSTEM

69200 Removal foreign body from external auditory canal; without general anesthesia