

NEW YORK STATE

MEDICAID PROGRAM

MIDWIFE

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. **REFERRAL:** A referral is the transfer of the total or specific care of a patient from one 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.
3. **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 (e.g., visits, procedures) on and subsequent to the date of transfer.

4. **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 lesion(s), if appropriate), diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate

documentation (e.g., 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.

5. **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 in the Midwife Communications, available at:
<https://www.emedny.org/ProviderManuals/Midwife/communications.aspx>

6. **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>

7. **PAYMENT IN FULL:** Fees paid in accordance with the allowances in the Midwife Fee Schedule shall be considered full payment for services rendered. No additional charge shall be made by a practitioner.
8. **FEES:** The fees are listed in the Midwife Fee Schedule, available at
<http://www.emedny.org/ProviderManuals/Midwife/index.html>

Listed fees are the maximum reimbursable Medicaid fees.

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 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: 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 Physician (or 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.)

- 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 Vaccine for Children’s Program (VFC) for children under 19 years of age). When administering vaccine supplied by the state (VFC program), you must append modifier –SL State Supplied Vaccine to the procedure code number representing the vaccine administered. Omission of this modifier on claims for recipients under 19 years of age will cause your claim to deny. (Reimbursement will not exceed \$17.85, the administration fee for the VFC program).

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 Physicians' Current Procedural Terminology.

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, e.g., office service. Third, the content of the service is defined, e.g., 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.

NEW AND ESTABLISHED PATIENT: Solely for the purpose of distinguishing between new and established patients, professional services are those face-to-face services rendered by a practitioner and reported by a specific code. 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.

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, e.g., 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.

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 the 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 to the 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 (e.g., drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

SOCIAL HISTORY: an age appropriate review of past and current activities that include 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.

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 (e.g., office and other outpatient visits)**: For coding purposes, face-to-face time for these services is defined as only that time 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 face-to-face time with the patient, performing such tasks 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 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):** 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.

- 4A.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 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 (e.g., 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.

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

- i. IDENTIFY THE CATEGORY AND SUBCATEGORY 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, e.g., “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 (i.e., 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 the patient's problems.
- Comprehensive – chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified 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 of 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.

v. 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 purpose of these definitions, the following body areas are recognized: head, including the face; neck; chest, including breasts and axilla; abdomen; genitalia, groin, buttocks; back and each extremity.

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.

vi. 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 of 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	straightforward
limited	limited	low	low complexity
multiple	moderate	moderate	moderate complexity
extensive	extensive	high	high complexity

Co-morbidities/underlying disease, 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.

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

- a. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (i.e., 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; and home, new patient.
- b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (i.e., 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%) 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), 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.

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. **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 lesion(s), if appropriate), diagnostic and therapeutic procedures (including major supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, is to be furnished. Appropriate documentation (e.g., operative report, procedure description, and/or itemized invoices) 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. **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.

8. **MATERIALS SUPPLIED BY PRACTITIONER:** Supplies and materials provided by the practitioner, e.g., sterile trays/drugs, **over and above** those usually included with the procedures, office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as 99070.

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.

9. **EVALUATION AND MANAGEMENT SERVICES:** Hospital 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.
10. **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.

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 99201-99205, 99211-99215 and 99385-99396 Office or Other Outpatient Services, report the place of service code that represents the location where the service was rendered in claim form field 24B 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". The Maximum Fee for codes 99201-99205, 99211-99215 and 99385-99396 in a Hospital Outpatient setting is noted in the **Facility Fee column in the Fee Schedule**.

OFFICE SERVICES

NEW PATIENT

99201 Office or other outpatient 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
- 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 three key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- 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 three key components:

- a detailed history,
- a detailed 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.

99204 Office or other outpatient 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 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 three key components:

- a comprehensive history,
- a comprehensive examination, and
- 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 practitioner.

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 two of these three key components:

- a problem focused history,
- a problem focused examination, and/or
- 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 two of these three key components:

- an expanded problem focused 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. 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 two of these three key components:

- a detailed history,
- a detailed examination, and/or
- 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 two of these three key components:

- a comprehensive history,
- a comprehensive examination, and/or
- 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 area 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 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 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 three 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. 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 three 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. 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 three 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 three key components:

- a problem focused history,
- a problem focused examination, and
- 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 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 low to moderate severity.

99283 Emergency department visit for the evaluation and management of a patient, which requires these three 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 three 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 physician 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 three 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 - NEW OR ESTABLISHED PATIENT

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;
- straightforward 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 facility 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 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 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 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 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 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 complexity. Practitioners 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 three 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. Practitioners 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 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 physician attention. Practitioners 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 two of these three 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. Practitioners typically spend 15 minutes with the patient and/or family or caregiver.

99335 Domiciliary or rest 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, and/or
- medical decision making of low complexity.

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

99336 Domiciliary or rest 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, and/or
- medical decision making of moderate complexity.

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

99337 Domiciliary or rest 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, 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. Practitioners typically spend 60 minutes with the patient and/or family or caregiver.

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 provided to patients ages 12–64 years old.

NEW PATIENT

- 99384 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 appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
- 99385 18-39 years
- 99386 40-64 years

ESTABLISHED PATIENT

- 99394 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 appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
- 99395 18-39 years
- 99396 40-64 years

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 normal 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 (For newborn hospital discharge services provided on a date subsequent to the admission date see 99238, 99239)

AUDIOLOGIC FUNCTION TESTS

92586 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited

OTHER SERVICES

96040 Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family

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 material, provided by the practitioner 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

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 group session (2 or more), per 30 minutes

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, group, per session. (Up to a maximum of 8 participants in a group session. 60 minute minimum session length. One prenatal and one postpartum class per recipient per pregnancy.) 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

T1013 Sign language or oral interpretive services, per 15 minutes

LABORATORY SERVICES PERFORMED IN THE OFFICE

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

The midwife 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 (includes RBC morphology and platelet estimation)
- 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 (throat only)
- 87880 Infectious agent detection by immunoassay with direct optical observation; streptococcus, group A (throat only)

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

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 the supply of materials and administration.

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

For dates of service on or after 7/1/03 when immunization materials are supplied by the Vaccine 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 MMIS Modifiers for further information.

For administration of vaccines supplied by VFC, including influenza and pneumococcal administration, providers are required to bill vaccine administration code 90460. Providers must 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.

NCCI editing will allow payment for an office visit (E&M and preventative medicine codes) and a vaccine administration service billed on the same day of service if the office visit meets a higher complexity level of care than a service represented by CPT code 99211. For payment to be made for both services, the office visit must be billed with Modifier-25. Providers must maintain documentation in the medical record to support use of an appropriate modifier.

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the estimated acquisition cost of the antigen. For immunizations not supplied by the VFC Program, insert actual acquisition cost in amount charged field on the claim form. For codes listed BR, 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 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.

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 dosage 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

- 90384 Rho (D) immune globulin (Rhlg), human, full-dose, for intramuscular use
- 90385 Rho (D) immune globulin (Rhlg), human, mini-dose, for intramuscular use

IMMUNIZATION ADMINISTRATION FOR VACCINES/TOXOIDS AND ADMINISTRATION FOR THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTIONS

- 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); one 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 (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
- 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (Bill on one claim line for multiple injections)

VACCINES/TOXOIDS

When billing for vaccine supplied by the Vaccines for Children Program, append modifier –SL to the appropriate procedure code to receive the VFC administration fee.

- 90636 Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, 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, trivalent (IIV3), 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
- 90661** Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular 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
- 90672 Influenza virus vaccine, quadrivalent, live, for intranasal use
- 90673** Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular 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
- 90688** Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
- 90703 Tetanus toxoid adsorbed, for intramuscular 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
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
- 90744 Hepatitis B vaccine; pediatric/adolescent dosage (3 dose schedule), for intramuscular use
- 90746 adult dosage (3 dose schedule), for intramuscular use

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

The following list of drugs can be injected either subcutaneous, intramuscular or intravenously.

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 claims amount to the actual invoice cost of the drug dosage administered.

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

THERAPEUTIC INJECTIONS

(Maximum fee includes cost of materials)

- J1050 Injection, medroxyprogesterone acetate, 1 mg
- J1725 Hydroxyprogesterone caproate, 1 mg
- J1741 Injection, ibuprofen, 100 mg

MISCELLANEOUS DRUGS

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

- J7300 Intrauterine copper contraceptive
- J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 MG

Midwife Procedure Codes

- 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

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. **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)
4. **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.
5. **MATERIALS SUPPLIED BY A PRACTITIONER:** Supplies and materials provided by the practitioner, eg, sterile trays/drugs, **over and above** those usually included with the procedures, office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as 99070.

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.

6. **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.

7. **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, **or requests a licensed midwife to participate in the management of a Cesarean section**, 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.

8. **MMIS MODIFIER: SURGERY SECTION:**

-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. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

SURGERY SERVICES

INTEGUMENTARY SYSTEM

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

MALE GENITAL SYSTEM

EXCISION

- 54150 Circumcision, using clamp or other device with regional dorsal penile or ring block

FEMALE GENITAL SYSTEM

VULVA, PERINEUM AND INTROITUS

INCISION

- 56420 Incision and drainage of Bartholin's gland abscess

DESTRUCTION

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

EXCISION

- 56605 Biopsy of vulva or perineum (separate procedure); one lesion
- 56606 each separate additional lesion
(List separately in addition to primary procedure)

ENDOSCOPY

- 56820 Colposcopy of the vulva;
- 56821 with biopsy(s)

VAGINA

DESTRUCTION

- 57061 Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

EXCISION

- 57100 Biopsy of vaginal mucosa; simple (separate procedure)

INTRODUCTION

- 57150 Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease
- 57160 Fitting and insertion of pessary or other intravaginal support device
- 57180 Introduction of any hemostatic agent or pack for spontaneous or traumatic non-obstetrical vaginal hemorrhage (separate procedure)

ENDOSCOPY

- 57420 Colposcopy of the entire vagina, with cervix if present;
- 57421 with biopsy(s) of vagina/cervix

CERVIX UTERI

ENDOSCOPY

- 57452 Colposcopy of the cervix including upper/adjacent vagina;
- 57454 with biopsy(s) of the cervix and endocervical curettage
- 57455 with biopsy(s) of the cervix
- 57456 with endocervical curettage

EXCISION

- 57511 Cautery of cervix; cryocautery, initial or repeat

CORPUS UTERI

EXCISION

- 58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
- 58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to primary procedure)

INTRODUCTION

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

MATERNITY CARE AND DELIVERY

The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care.

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

If a practitioner provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy by abortion or referral to another practitioner for delivery, see 59425-59426.

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS) are noted in the **Fee Schedule**. For information on the MOMS Program, see Information For All Providers, Policy Section.

FETAL INVASIVE SERVICES

59020 Fetal contraction stress test

59025 Fetal non-stress test

59030 Fetal scalp blood sampling

INTRODUCTION

59200 Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)

REPAIR

59300 Episiotomy or vaginal repair, by other than attending

VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400 Routine obstetric care including antepartum care (59426), vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59409 Vaginal delivery only (with or without episiotomy and/or forceps); (when only **inpatient** postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M Code(s) for postpartum care visits)

59410 including (**inpatient and outpatient**) postpartum care

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 (**outpatient**) (separate procedure)

DELIVERY AFTER PREVIOUS CESAREAN DELIVERY

Patients who have had a previous cesarean delivery and now present with the expectation of a vaginal delivery are coded using codes 59610-59614. If the patient has a successful vaginal delivery after a previous cesarean delivery (VBAC), use codes 59610-59614.

59610 Routine obstetric care including antepartum care (59426), vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); (when only **inpatient** postpartum care is provided in addition to delivery, **see appropriate HOSPITAL E/M code(s) for postpartum care visits**)

59614 including (**inpatient and outpatient**) postpartum care