

**NEW YORK STATE
MEDICAID PROGRAM**

NURSE PRACTITIONER

FEE SCHEDULE

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GENERAL INFORMATION

- 1. MULTIPLE CALLS:** If an individual patient is seen on more than one occasion during a single day, the fee for each visit may be allowed.
- 2. CHARGES FOR DIAGNOSTIC PROCEDURES:** Charges for special diagnostic procedures which are not considered to be a routine part of an examination (eg, ECG) are reimbursable in addition to the usual visit fee.
- 3. REFERRAL:** A referral is the transfer of the total or specific care of a patient from one physician or nurse practitioner to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in LEVELS OF E/M SERVICE.

Referral is to be distinguished from consultation. REFERRAL is the transfer of the patient from one practitioner to another for definitive treatment. CONSULTATION is advice and opinion from an accredited physician specialist called in by the attending practitioner in regard to the further management of the patient by the attending practitioner.

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

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

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

When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (eg, procedure description, itemized invoices, etc.) should accompany all claims submitted. Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

5. **PAYMENT IN FULL:** Fees paid in accordance with the allowances in the Medical Fee Schedule shall be considered full payment for services rendered. No additional charge shall be made by a practitioner.
6. **FEES:** Listed fees are the maximum reimbursable Medicaid fees.
7. **PRESCRIBER WORKSHEET:** Enteral formula requires voice interactive telephone prior authorization from the Medicaid program. The prescriber must initiate the authorization through this system. The worksheet specifies the questions asked on the voice interactive telephone system and must be maintained in the patient's clinical record. The worksheet can be found on the Provider Communication link. [eMedNY : Provider Manuals : Nurse Practitioner Provider Communications](#)

STATE DEPARTMENT OF HEALTH CONDITIONS FOR PAYMENT

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

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

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

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

UNDERLINED PROCEDURE CODES: Require Prior Approval before services are rendered.

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

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.

If more than one modifier is required, the "multiple modifier" code should be added to the basic procedure code number and other applicable modifiers shall be listed as part of the service description.

- 24 Unrelated Evaluation and Management Service by the Same Practitioner during a Postoperative Period: The practitioner may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier -24 to the appropriate level of E/M service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Practitioner on the Day of a Procedure: (Effective 10/1/92) The practitioner may need to indicate that on the day a procedure or service identified by an MMIS code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition, for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier -25 to the appropriate level of E/M service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- 77 Repeat Procedure By Another Practitioner: The practitioner may need to indicate that a basic procedure performed by another practitioner had to be repeated. This situation may be reported by adding modifier -77 to the repeated service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

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

- EP Child/Teen Health Program (EPSDT Program): Service provided as part of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program or Child/Teen Health Program will be identified by adding the modifier -EP to the usual procedure number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

- FP Service Provided as Part of Family Planning Program: All Family Planning Services will be identified by adding the modifier '-FP' to the usual procedure code: number. (Reimbursement will not exceed 100% of the maximum State' Medical Fee Schedule amount.)

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

- 99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier '-99' should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

MEDICINE SECTION

GENERAL INFORMATION AND RULES

1. **PRIMARY CARE:** Primary care is first-contact care, the type furnished to individuals when they enter the health care system. Primary care is, comprehensive in that it deals with a wide range of health problems, diagnosis and modes of treatment. Primary care is continuous in that an ongoing relationship is established with the primary care practitioner who monitors and provides the necessary follow-up care and is coordinated by linking patients with more varied specialized services when needed. Consultations and care provided on referral from another practitioner is not considered primary care.
2. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES:** The Federal Health Care Finance Administration has mandated that all state Medicaid programs utilize the new Evaluation and Management coding as published in the American Medical Association's CPT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- i. IDENTIFY THE CATEGORY AND 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, eg, "Hospital Care", special instructions will be presented preceding the levels of E/M services.
- iii. REVIEW THE LEVEL OF E/M SERVICE DESCRIPTORS AND EXAMPLES IN THE SELECTED CATEGORY OR SUBCATEGORY: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time.

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

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

- iv. DETERMINE THE EXTENT OF HISTORY OBTAINED: The levels of E/M services recognize four types of history that are defined as follows:
 - Problem Focused -- chief complaint; brief history of present illness or problem.
 - Expanded Problem Focused -- chief complaint; brief history of present illness; problem pertinent system review.
 - Detailed -- chief complaint; extended history of present illness; problem pertinent system review extended to include review of a limited number of additional systems; pertinent past, family and/or social history directly related to patients problems.
 - Comprehensive -- chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) indicated in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

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

social history as well as a comprehensive assessment/history of pertinent risk factors.

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

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

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

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

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

- a. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (ie, history, examination, and medical decision making), must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; hospital observation services; and home, new patient.
- b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.
- c. In the case where counseling and/or coordination of care dominates (more than 50%) of the practitioner/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the medical record.

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

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

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

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

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

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

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

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

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 and 99211-99215 Office or Other Outpatient Services, report the place of service code that represents the location where the service was rendered in claim form field for Place of Service. The maximum reimbursable amount for these codes is dependent on the Place of Service reported.

For Evaluation and Management services rendered in the practitioner's private office, report place of service "11". The Maximum Fee for Office Evaluation and Management services is \$30.00. For services rendered in a Hospital Outpatient setting report place of service "22". The Maximum Fee for codes 99201-99205 and 99211-99215 in a Hospital Outpatient setting are noted in parenthesis.

For services provided by practitioner in the Emergency Department, see 99281-99285. For services provided to hospital inpatients, see Hospital Services 99221-99239.

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

For observation care, see 99217-99220.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

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.	30.00 (6.50)
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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.	30.00 (6.50)
	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.	30.00 (6.50)
	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.	30.00 (6.50)
	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 components: a comprehensive history, a comprehensive examination and medical decision making of high complexity.	30.00 (6.50)
	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 visit for the evaluation and management of an established patient, who presents for follow-up and/or periodic re-evaluation of problems or for evaluation and management of new problems.	30.00 (6.50)
	Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	

99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history, a problem focused examination, and/or straightforward medical decision making.	30.00 (6.50)
	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.	30.00 (6.50)
	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.	30.00 (6.50)
	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.	30.00 (6.50)
	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)) 5.00

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 three key components: a detailed or comprehensive history, a detailed or comprehensive examination and medical decision making that is straightforward or of low complexity. 6.50
- Usually the problem(s) requiring admission to "observation status" are of low severity.
- 99219 Initial observation 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. 6.50
- Usually the problem(s) requiring admission to "observation status" are of moderate severity.
- 99220 Initial observation 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. 6.50
- Usually the problem(s) requiring admission to "observation status" are of high severity.

HOSPITAL INPATIENT SERVICES

The following codes are used to report evaluation and management services provided to inpatients. For services rendered in a hospital outpatient setting, see procedure codes 99201-99215 Office or Other Outpatient Services.

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. 6.50
- 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. 6.50

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. 6.50

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. 5.00

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. 5.00

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. 5.00

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.

For patients admitted to observation or inpatient care and discharged on a different date, see codes 99218-99220 and 99217, or 99221-99223 and 99238-99239.

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. 6.50

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

99235 Observation or inpatient hospital care, for the 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. 6.50

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.	6.50
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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	5.00
99239	more than 30 minutes	5.00

(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.)

(For Observation Care Discharge, use 99217)

(For discharge services provided to newborns admitted and discharged on the same date, see 99435)

(For Nursing Facility Care Discharge, see 99315, 99316)

(For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see 99234-99236)

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.

For evaluation and management services provided to a patient in an observation area of a hospital, see 99217-99220.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

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.	6.50
	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.	6.50
	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.	6.50
	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.	6.50
	Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the practitioner but do not pose an immediate significant threat to life or physiologic function.	
99285	Emergency department visit for the evaluation and management of a patient, which requires these 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.	6.50
	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 three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. 8.00

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

99305 Initial nursing facility 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. 8.00

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

99306 Initial nursing facility 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. 8.00

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

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 include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.

99307 Subsequent nursing facility care, per day, for the evaluation and management of a new or 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. 7.00

Usually, the patient is stable, recovering or improving.

99308	Subsequent nursing facility care, per day, for the evaluation and management of a new or 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 patient is responding inadequately to therapy or has developed a minor complication.	7.00
99309	Subsequent nursing facility care, per day, for the evaluation and management of a new or 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 patient has developed a significant complication or a significant new problem.	7.00
99310	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a comprehensive interval history, a comprehensive examination, and/or medical decision making of high complexity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.	7.00

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	8.00
99316	more than 30 minutes	8.00

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

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| 99324 | <p>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.</p> <p>Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.</p> | 8.00 |
| 99325 | <p>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.</p> <p>Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.</p> | 8.00 |
| 99326 | <p>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.</p> <p>Usually, the presenting problem(s) are of moderate to high complexity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.</p> | 8.00 |
| 99327 | <p>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.</p> <p>Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.</p> | 8.00 |
| 99328 | <p>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.</p> <p>Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.</p> | 8.00 |

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. 7.00

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

99335 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 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. 7.00

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

99336 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of moderate complexity. 7.00

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

99337 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history, a comprehensive examination, and medical decision making of moderate to high complexity. 7.00

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

HOME SERVICES

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

NEW PATIENT

99341 Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and medical decision making that is straightforward. 7.00

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. 7.00

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. 8.00

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. 8.00

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. 8.00

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. 7.00

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.	7.00
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.	8.00
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.	8.00

PREVENTIVE MEDICINE SERVICES

The following codes are used to report well visit services provided to patients ages 0 – 20 years old in the practitioner's private office setting only.

NEW PATIENT

99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age under 1 year)	30.00
99382	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; early childhood (age 1 through 4 years)	30.00

99383	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; late childhood (age 5 through 11 years)	30.00
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)	30.00
99385	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; (18-20 years)	30.00

ESTABLISHED PATIENT

99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age under 1 year)	30.00
99392	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; early childhood (age 1 through 4 years)	30.00
99393	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; late childhood (age 5 through 11 years)	30.00

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)	30.00
99395	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; (18-20 years)	30.00

NEWBORN CARE

The following codes are used to report services provided to newborns in several different settings. For newborn hospital discharge services provided on a date subsequent to the admission date of the newborn, use 99238. For discharge services provided to newborns admitted and discharged on the same date, see 99435.

99431	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records (This code should also be used for birthing room deliveries).	6.50
99433	Subsequent hospital care, for the evaluation and management of a normal newborn, per day.	5.00
99435	History and examination of the normal newborn infant, including the preparation of medical records (This code should only be used for newborns assessed and discharged from the hospital or birthing room on the same date).	6.50

PREFERRED PHYSICIAN AND CHILDRENS PROGRAM (PPAC) (158)

The following reimbursement amounts are for the practitioners in the Preferred Physician and Children's Program (PPAC). For information on the PPAC Program see Policy Guidelines.

OFFICE SERVICES

The following reimbursement amounts are for services rendered in the practitioner's private office. For services rendered in a hospital outpatient setting see the list of reimbursement amounts for "Hospital Outpatient Services".

NEW PATIENT (Problem Visit)

ESTABLISHED PATIENT (Problem Visit)

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99201	39.64	33.63
99202	39.64	33.63
99203	39.64	33.63
99204	39.64	33.63
99205	39.64	33.63

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99211	39.64	33.63
99212	39.64	33.63
99213	39.64	33.63
99214	39.64	33.63
99215	39.64	33.63

NEW PATIENT (Well Visit, Ages 0-20)

ESTABLISHED PATIENT (Well Visit, Ages 0-20)

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99381	39.64	33.63
99382	39.64	33.63
99383	39.64	33.63
99384	39.64	33.63
99385	39.64	33.63

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99391	39.64	33.63
99392	39.64	33.63
99393	39.64	33.63
99394	39.64	33.63
99395	39.64	33.63

HOSPITAL OUTPATIENT SERVICES

Reimbursement amounts are for services rendered in a hospital outpatient setting. For services rendered in the practitioner's private office, see above.

NEW PATIENT

ESTABLISHED PATIENT

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99201	36.00	30.00
99202	36.00	30.00
99203	36.00	30.00
99204	36.00	30.00
99205	36.00	30.00

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99211	36.00	30.00
99212	36.00	30.00
99213	36.00	30.00
99214	36.00	30.00
99215	36.00	30.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE
DISCHARGE SERVICES

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99217	36.00	30.00

INITIAL OBSERVATION CARE
NEW OR ESTABLISHED PATIENT

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99218	36.00	30.00
99219	36.00	30.00
99220	36.00	30.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE
NEW OR ESTABLISHED PATIENT

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99221	36.00	30.00
99222	36.00	30.00
99223	36.00	30.00

SUBSEQUENT HOSPITAL CARE

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99231	36.00	30.00
99232	36.00	30.00
99233	36.00	30.00

OBSERVATION OR INPATIENT CARE SERVICES
(Including Admission and Discharge Services)

99234	36.00	30.00
99235	36.00	30.00
99236	36.00	30.00

HOSPITAL DISCHARGE SERVICES

99238	36.00	30.00
99239	36.00	30.00

NURSING FACILITY SERVICES

INITIAL NURSING FACILITY
CARE NEW OR ESTABLISHED
PATIENT

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99304	36.00	30.00
99305	36.00	30.00
99306	36.00	30.00

SUBSEQUENT NURSING FACILITY
CARE NEW OR ESTABLISHED PATIENT

<u>Procedure Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99307	36.00	30.00
99308	36.00	30.00
99309	36.00	30.00
99310	36.00	30.00

NURSING FACILITY DISCHARGE SERVICES

<u>Procedure</u> <u>Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>
99315	36.00	30.00
99316	36.00	30.00

DOMICILIARY, REST HOME (eg, BOARDING HOME), OR CUSTODIAL CARE SERVICES

NEW PATIENT

ESTABLISHED PATIENT

<u>NEW PATIENT</u>			<u>ESTABLISHED PATIENT</u>		
<u>Procedure</u> <u>Code</u>	<u>Maximum Fee</u>		<u>Procedure</u> <u>Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>		<u>Co. Group A</u>	<u>Co. Group B</u>
99324	36.00	30.00	99334	36.00	30.00
99325	36.00	30.00	99335	36.00	30.00
99326	36.00	30.00	99336	36.00	30.00
99327	36.00	30.00	99337	36.00	30.00
99328	36.00	30.00			

HOME SERVICES

NEW PATIENT

ESTABLISHED PATIENT

<u>NEW PATIENT</u>			<u>ESTABLISHED PATIENT</u>		
<u>Procedure</u> <u>Code</u>	<u>Maximum Fee</u>		<u>Procedure</u> <u>Code</u>	<u>Maximum Fee</u>	
	<u>Co. Group A</u>	<u>Co. Group B</u>		<u>Co. Group A</u>	<u>Co. Group B</u>
99341	36.00	30.00	99347	36.00	30.00
99342	36.00	30.00	99348	36.00	30.00
99343	36.00	30.00	99349	36.00	30.00
99344	36.00	30.00	99350	36.00	30.00
99345	36.00	30.00			

LABORATORY SERVICES PERFORMED IN THE OFFICE

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

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

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

For detection of pregnancy, use code 81025.

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

81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specificgravity, urobilinogen, any number of these constituents; non-automated, with microscopy	4.00
81002	non-automated, without microscopy	2.00
81015	Urinalysis; microscopic only	2.00
81025	Urine pregnancy test, by visual color comparison methods	2.00
85007	Blood count; blood smear, microscopic examination with manual differential WBC count (includes RBC morphology and platelet estimation)	1.43
85013	spun microhematocrit	2.00
85018	hemoglobin (Hgb)	2.00
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	3.17
85041	red blood cell (RBC) automated	3.17
85048	leukocyte (WBC), automated	3.17
85651	Sedimentation rate, erythrocyte; non-automated	2.00
85652	automated	2.00
87081	Culture, presumptive, pathogenic organisms, screening only (throat only)	5.20
87880	Infectious agent detection by immunoassay with direct optical observation; streptococcus, group A (throat only)	3.75

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

DRUG ADMINISTRATION

IMMUNIZATIONS

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

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

For dates of service on or **after 7/1/03** when immunization materials are supplied by the Vaccine for Children's 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 Medicine Section Modifiers for further information.

When immunization materials are supplied by the Vaccine for Children Program (VFC), bill using the procedure code that represents the immunization(s) administered to receive the VFC administration fee.

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 per dose plus a two dollar (\$2.00) administration fee in amount charged field on 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 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.

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

IMMUNE GLOBULINS

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

90281	Immune Globulin (Ig), human, for intramuscular use (per 1 ml)	
90283	Immune Globulin (IgIV), human, for intravenous use (per 500 mg)	
90291	Cytomegalovirus Immune Globulin (CMV-IgIV), human, for intravenous use	BR
90371	Hepatitis B Immune Globulin (HBIG), human, for intramuscular use	
90375	Rabies Immune Globulin (RIG), human, for intramuscular and/or subcutaneous use (150 IU/ml)	
90376	Rabies Immune Globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use	BR
90379	Respiratory Syncytial Virus Immune Globulin (RVS-IgIV), human, for intravenous use (per 50 mg)	
90384	Rho(D) Immune Globulin (RhIg), human, full-dose, for intramuscular use	
90385	Rho(D) Immune Globulin (RhIg), human, mini-dose, for intramuscular use	
90386	Rho(D) Immune Globulin (RhIgIV), human, for intravenous use (per 1500 IU)	
90389	Tetanus Immune Globulin (TIG), human, for intramuscular use (up to 250 units)	
90393	Vaccinia Immune Globulin, human, for intramuscular use	BR
90396	Varicella-Zoster Immune Globulin, human, for intramuscular use (per 62.5 u/ml)	
90399	Unlisted Immune Globulin	BR

VACCINES/TOXOIDS

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

90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (Hep-A-Hep-B), adult dose for intramuscular use
90645	Hemophilus Influenza B vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646	Hemophilus Influenza B vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647	Hemophilus Influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use

- 90648 Hemophilus Influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
- 90655 Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
- 90657 Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
- 90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- 90660 Influenza virus vaccine, live, for intranasal use
- 90665 Lyme Disease vaccine, adult dosage, for intramuscular use
- 90669 Pneumococcal Conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
- 90675 Rabies vaccine, for intramuscular use
- 90676 Rabies vaccine, for intradermal use
- 90690 Typhoid vaccine, live, oral
- 90691 Typhoid vaccine, VI capsular polysaccharide (ViCPs), for intramuscular use
- 90692 Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use
- 90700 Diphtheria, Tetanus toxoids, and Acellular Pertussis vaccine (DTap), for use in individuals younger than 7 years, for intramuscular use
- 90701 Diphtheria, Tetanus toxoids, and whole cell Pertussis vaccine (DTP), for intramuscular use
- 90702 Diphtheria and Tetanus toxoids (DT) adsorbed for use in individuals younger than 7 years, for intramuscular use
- 90703 Tetanus toxoid adsorbed, for intramuscular use
- 90704 Mumps virus vaccine, live, for subcutaneous use
- 90705 Measles virus vaccine, live, for subcutaneous use
- 90706 Rubella virus vaccine, live, for subcutaneous use
- 90707 Measles, Mumps and Rubella virus vaccine (MMR), live, for subcutaneous use
- 90708 Measles and Rubella virus vaccine, live, for subcutaneous use
- 90710** Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
- 90712 Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
- 90713 Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
- 90714** Tetanus and Diphtheria toxoids (Td) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use
- 90715** Tetanus, Diphtheria toxoids and Acellular Pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
- 90716 Varicella virus vaccine, live, for subcutaneous use
- 90717 Yellow Fever vaccine, live, for subcutaneous use
- 90718 Tetanus and Diphtheria toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular use

- 90720 Diphtheria, Tetanus toxoids, and whole cell Pertussis vaccine and Hemophilus Influenza B vaccine (DTP-Hib), for intramuscular use
- 90721 Diphtheria, Tetanus toxoids, and Acellular Pertussis vaccine and Hemophilus Influenza B vaccine (DtaP-Hib), for intramuscular use
- 90723 Diphtheria, Tetanus toxoids, Acellular Pertussis vaccine, Hepatitis B, and Poliovirus vaccine, inactivated (Dtap-HepB-IPV), for intramuscular use
- 90725 Cholera vaccine for injectable use
- 90732 Pneumococcal Polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
- 90733 Meningococcal Polysaccharide vaccine (any group(s)), for subcutaneous use
- 90734 Meningococcal Conjugate vaccine, serogroups A, C, Y and W-135 (Tetavalent), for intramuscular use
- 90735 Japanese Encephalitis virus vaccine, for subcutaneous use
- 90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
- 90743 Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
- 90744 Hepatitis B vaccine; pediatric/adolescent dosage, (3 dose schedule) for intramuscular use
- 90746 adult dose, for intramuscular use
- 90747 dialysis or immunosuppressed patient, dosage (4 dose schedule), for intramuscular use
- 90748 Hepatitis B and Hemophilus Influenza B (Hep B -HIB), for intramuscular use
- 90749 Unlisted vaccine/toxoid

BR

HYDRATION, THERAPEUTIC, PROPHYLACTIC AND DIAGNOSTIC INJECTIONS AND INFUSIONS (EXCLUDES CHEMOTHERAPY)

HYDRATION

90760	Intravenous infusion, hydration; initial, up to 1 hour	35.00
90761	each additional hour, up to 8 hours (List separately in addition to primary procedure)	5.00

THERAPEUTIC, PROPHYLACTIC AND DIAGNOSTIC INJECTIONS AND INFUSIONS (EXCLUDES CHEMOTHERAPY)

These procedures encompass prolonged intravenous injections. These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous or intramuscular or routine IV drug injections. These codes may not be used in addition to prolonged services codes

90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	35.00
90766	each additional hour, up to 8 hours (List separately in addition to primary procedure)	5.00
90767	additional sequential infusion, up to 1 hour (List separately in addition to primary procedure)	35.00
90768	concurrent infusion (List separately in addition to primary procedure)	5.00
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	BR

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

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

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

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.

THERAPEUTIC INJECTIONS (Maximum fee includes cost of materials)

- J0135 Adalimumab, 20 mg
- J0150 Adenosine, for therapeutic use, 6 mg
(not to be used to report any adenosine phosphate compounds, instead use unlisted code)
- J0170 Adrenalin, Epinephrine, up to 1 ml ampule
- J0180 Agalsidase Beta, 1 mg
- J0205 Alglucerase, per 10 units
- J0207 Amifostine, 500 mg
- J0210 Methyldopate HCL (Aldomet), up to 250 mg
- J0215 Alefacept (Amevive), 0.5 mg
- J0256 Alpha 1-Proteinase Inhibitor-Human, 10 mg
- J0270 Alprostadil, per 1.25 mcg
(administered under direct physician supervision, not for self-administration)
- J0275 Alprostadil Urethral Suppository
(administered under direct physician supervision, not for self-administration)
- J0280 Aminophyllin, up to 250 mg
- J0290 Ampicillin Sodium, up to 500 mg
- J0295 Ampicillin Sodium/Sulbactam Sodium, per 1.5 gm
- J0300 Amobarbital, up to 125 mg
- J0360 Hydralazine HCL, up to 20 mg
- J0380 Metaraminol Bitartrate, per 10 mg
- J0390 Chloroquine Hydrochloride, up to 250 mg
- J0456 Azithromycin, 500 mg
- J0460 Atropine Sulfate, up to 0.3 mg
- J0470 Dimercaprol, per 100 mg
- J0475 Baclofen, 10 mg
- J0500 Dicyclomine HCl, up to 20 mg
- J0515 Benztropine Mesylate, per 1 mg
- J0520 Bethanechol Chloride, Mytonachol or Urecholine, up to 5 mg
- J0530 Penicillin G Benzathine and Penicillin G Procaine, up to 600,000 units
- J0540 Penicillin G Benzathine and Penicillin G Procaine, up to 1,200,000 units
- J0550 Penicillin G Benzathine and Penicillin G Procaine, up to 2,400,000 units
- J0560 Penicillin G Benzathine, up to 600,000 units
- J0570 Penicillin G Benzathine, up to 1,200,000 units
- J0580 Penicillin G Benzathine, up to 2,400,000 units
- J0585 Botulinum Toxin Type A, per unit
- J0587 Botulinum Toxin Type B, per 100 units
- J0600 Edetate Calcium Disodium (Calcium Disodium Versenate), up to 1000 mg
- J0610 Calcium Gluconate, per 10 ml
- J0620 Calcium Glycerophosphate and Calcium Lactate, per 10 ml
- J0630 Calcitonin-Salmon (Calcimar), up to 400 units
- J0636 Calcitriol, 0.1 mcg

J0640	Leucovorin Calcium, per 50 mg
J0690	Cefazolin Sodium, up to 500 mg
J0694	Cefoxitin Sodium, 1 gm
J0696	Ceftriaxone Sodium, per 250 mg
J0697	Sterile Cefuroxime Sodium, per 750 mg
J0698	Cefotaxime Sodium, per gm
J0702	Betamethasone Acetate and Betamethasone Sodium Phosphate, per 3 mg (1 unit= 3 mg of Betamethasone Acetate <u>and</u> 3 mg of Betamethasone Sodium Phosphate)
J0704	Betamethasone Sodium Phosphate, per 4 mg
J0710	Cephapirin Sodium (Cefadyl), up to 1 gm
J0713	Ceftazidime, per 500 mg
J0715	Ceftizoxime Sodium, per 500 mg
J0720	Chloramphenicol Sodium Succinate (Chloromycetin Sodium Succinate), up to 1 gm
J0725	Chorionic Gonadotropin, per 1,000 USP units
J0740	Cidofovir, 375 mg
J0744	Ciprofloxacin for intravenous infusion, 200 mg
J0745	Codeine Phosphate, per 30 mg
J0760	Colchicine, per 1 mg
J0770	Colistimethate Sodium (Coly-Mycin M), up to 150 mg
J0780	Prochlorperazine (Compazine), up to 10 mg
J0795	Corticotropin Ovine Triflutate, 1 mg
J0835	Cosyntropin, per 0.25 mg
J0881	Injection, darbepoetin alfa, 1 mcg (Non-ESRD use)
J0885	Injection, epoetin alfa, (Non-ESRD use), 1000 units
J0895	Deferoxamine Mesylate, 500 mg
J0900	Testosterone Enanthate and Estradiol Valerate, up to 1 cc
J0945	Brompheniramine Maleate, per 10 mg
J0970	Estradiol Valerate (Delestrogen), up to 40 mg
J1000	Depo-Estradiol Cypionate, up to 5 mg
J1020	Methylprednisolone Acetate (Depo-Medrol), 20 mg
J1030	Methylprednisolone Acetate (Depo-Medrol), 40 mg
J1040	Methylprednisolone Acetate (Depo-Medrol), 80 mg
J1051	Medroxyprogesterone Acetate (Depo-Provera Aq.), 50 mg
J1055	Medroxyprogesterone Acetate (Depo-Provera Ag.) for contraceptive use, 150 mg
J1056	Medroxyprogesterone Acetate/Estradiol Cypionate, (Lunelle) 5 mg/25 mg
J1060	Testosterone Cypionate and Estradiol Cypionate (Depo-Testadiol), up to 1 ml
J1070	Testosterone Cypionate (Depo-Testosterone Cypionate), up to 100 mg
J1080	Testosterone Cypionate (Depo-Testosterone Cypionate), 1 cc, 200 mg
J1094	Dexamethasone Acetate, 1 mg
J1100	Dexamethasone Sodium Phosphate, 1 mg
J1110	Dihydroergotamine Mesylate, per 1 mg
J1120	Acetazolamide Sodium, up to 500 mg
J1160	Digoxin, up to 0.5 mg
J1165	Phenytoin Sodium, per 50 mg
J1170	Hydromorphone, up to 4 mg

J1180	Dyphylline, up to 500 mg
J1190	Dexrazoxane Hydrochloride, per 250 mg
J1200	Diphenhydramine HCL, up to 50 mg
J1205	Chlorothiazide Sodium, per 500 mg
J1212	DMSO, Dimethyl Sulfoxide, 50%, 50 ml
J1230	Methadone HCL, up to 10 mg
J1240	Dimenhydrinate, up to 50 mg
J1260	Dolasetron Mesylate, 10 mg
J1320	Amitriptyline HCL (Elavil HCL), up to 20 mg
J1330	Ergonovine Maleate (Ergotrate Maleate), up to 0.2 mg
J1364	Erythromycin Lactobionate, per 500 mg
J1380	Estradiol Valerate, up to 10 mg
J1390	Estradiol Valerate, up to 20 mg
J1410	Estrogen Conjugated, per 25 mg
J1435	Estrone, per 1 mg
J1436	Etidronate Disodium, per 300 mg
J1438	Etanercept, 25 mg (administered under direct physician supervision, not self administered)
J1440	Filgrastim (G-CSF) (Neupogen), 300 mcg
J1441	Filgrastim (G-CSF) (Neupogen), 480 mcg
J1450	Fluconazole, 200 mg
J1452	Fomivirsen Sodium, intraocular, 1.65 mg
J1455	Foscarnet Sodium, per 1000 mg
J1570	Ganciclovir Sodium, 500 mg
J1580	Garamycin, Gentamicin, up to 80 mg
J1590	Gatifloxacin, 10 mg
J1595	Glatiramer Acetate, 20 mg
J1600	Gold Sodium Thiomaleate, up to 50 mg
J1610	Glucagon Hydrochloride, per 1 mg
J1620	Gonadorelin Hydrochloride, per 100 mcg
J1626	Granisetron Hydrochloride, 100 mcg
J1630	Haloperidol (Haldol), up to 5 mg
J1631	Haloperidol Decanoate (Haldol), per 50 mg
J1642	Heparin Sodium, (heparin lock flush), per 10 units
J1644	Heparin Sodium, per 1000 units
J1645	Dalteparin Sodium, per 2500 IU
J1652	Fondaparinux Sodium, 0.5 mg
J1655	Tinzaparin Sodium, 1000 IU
J1710	Hydrocortisone Sodium Phosphate (Hydrocortone Phosphate), up to 50 mg
J1720	Hydrocortisone Sodium Succinate, (Solu-Cortef) up to 100 mg
J1730	Diazoxide (Hyperstat), up to 300 mg
J1745	Infliximab (Remicade), 10 mg
J1751	Iron Dextran 165, 50 mg
J1752	Iron Dextran 267, 50 mg
J1756	Iron Sucrose, 1 mg

J1785	Imiglucerase, per unit (per vial)	BR
J1790	Droperidol, up to 5 mg	
J1800	Propranolol HCL (Inderal), up to 1 mg	
J1815	Insulin, per 5 units	
J1817	Insulin (i.e., insulin pump) per 50 units	
J1825	Interferon Beta-1a, 33 mcg (administered under direct physician supervision, not for self administration)	
J1830	Interferon Beta-1b, 0.25 mg (administered under direct physician supervision, not for self-administration)	
J1840	Kanamycin Sulfate (Kantrex), up to 500 mg	
J1850	Kanamycin Sulfate (Kantrex Pediatric), up to 75 mg	
J1885	Ketorolac Tromethamine, per 15 mg	
J1890	Cephalothin Sodium (Keflin), up to 1 gm	
J1931	Laronidase, 0.1 mg	
J1940	Furosemide (Lasix), up to 20 mg	
J1950	Leuprolide Acetate (for depot suspension), per 3.75 mg	
J1955	Levocarnitine, per 1 gm	
J1960	Levorphanol Tartrate (Levo-Dromoran), up to 2 mg	
J1980	Hyoscyamine Sulfate (Levsin), up to 0.25 mg	
J1990	Chlordiazepoxide HCL (Librium), up to 100 mg	
J2001	Lidocaine HCL for intravenous infusion, 10 mg	
J2010	Lincomycin HCL (Lincocin), up to 300 mg	
J2060	Lorazepam, 2 mg	
J2150	Mannitol, 25% in 50 ml	
J2175	Meperidine Hydrochloride, per 100 mg	
J2210	Methylergonovine Maleate (Methergine Maleate), up to 0.2 mg	
J2260	Milrinone Lactate, per 5 mg	
J2270	Morphine Sulfate, up to 10 mg	
J2275	Morphine Sulfate (preservative-free sterile solution), per 10 mg	
J2278	Ziconotide, 1 mcg	
J2320	Nandrolone Decanoate, up to 50 mg	
J2321	Nandrolone Decanoate, up to 100 mg	
J2322	Nandrolone Decanoate, up to 200 mg	
J2353	Octreotide, depot form for intramuscular injection, 1 mg	
J2355	Oprelvekin, 5 mg	
J2357	Omalizumab (Xolair), 5 mg	
J2360	Orphenadrine Citrate (Norflex), up to 60 mg	
J2370	Phenylephrine HCL (Neo-Synephrine), up to 1 ml	
J2405	Odansetron Hydrochloride (Zofran), per 1 mg	
J2410	Oxymorphone HCL (Numorphan), up to 1 mg	
J2425	Palifermin, 50 mg	
J2430	Pamidronate Disodium, per 30 mg	
<u>J2440</u>	Papaverine HCL, up to 60 mg	
J2460	Oxytetracycline HCL, up to 50 mg	

J2469	Palonosetron HCL, 25 mcg
J2503	Pegaptanib sodium, 0.3 mg
J2504	Pegademase Bovine, 25 IU
J2505	Pegfilgrastim (Neulasta), 6 mg
J2510	Penicillin G Procaine, Aqueous, up to 600,000 units
J2515	Pentobarbital Sodium, per 50 mg
J2540	Penicillin G Potassium (Pfizerpen), up to 600,000 units
J2545	Pentamidine Isethionate, inhalation solution, per 300 mg
J2550	Promethazine HCL (Phenergan), up to 50 mg
J2560	Phenobarbital Sodium, up to 120 mg
J2590	Oxytocin (Pitocin), up to 10 units
J2597	Desmopressin Acetate, per 1 mcg
J2650	Prednisolone Acetate, up to 1 ml
J2670	Tolazoline HCL (Priscoline HCL), up to 25 mg
J2675	Progesterone (Injection), per 50 mg
J2680	Fluphenazine Decanoate (Prolixin Decanoate), up to 25 mg
J2690	Procainamide HCL (Pronestyl), up to 1 gm
J2700	Oxacillin Sodium (Prostaphlin), up to 250 mg
J2710	Neostigmine Methylsulfate (Prostigmin), up to 0.5 mg
J2720	Protamine Sulfate, per 10 mg
J2730	Pralidoxime Chloride (Protopam Chloride), up to 1 gm
<u>J2760</u>	Phentolamine Mesylate (Regitine), up to 5 mg
J2765	Metoclopramide HCL (Reglan), up to 10 mg
J2780	Ranitidine HCL, 25 mg
J2783	Rasburicase, 0.5 mg
J2794	Risperidone, long acting, 0.5 mg
J2800	Methocarbamol (Robaxin), up to 10 ml
J2820	Sargramostim (GM-CSF), 50 mcg
J2910	Aurothioglucose (Solganal), up to 50 mg
J2912	Sodium Chloride, 0.9%, per 2 ml
J2920	Methylprednisolone Sodium Succinate (Solu-Medrol), up to 40 mg
J2930	Methylprednisolone Sodium Succinate (Solu-Medrol), up to 125 mg
J2940	Somatrem, 1 mg
J2941	Somatropin, 1 mg
J2995	Streptokinase, per 250,000 IU
J3000	Streptomycin, up to 1 gm
J3030	Sumatriptan Succinate, 6 mg
J3070	Pentazocine, 30 mg
J3105	Terbutaline Sulfate, up to 1 mg
J3120	Testosterone Enanthate, up to 100 mg
J3130	Testosterone Enanthate, up to 200 mg
J3140	Testosterone Suspension, up to 50 mg
J3150	Testosterone Propionate, up to 100 mg
J3230	Chlorpromazine HCL (Thorazine), up to 50 mg
J3240	Thyrotropin Alpha (Thyrogen), 0.9 mg. provided in 1.1 mg

J3250	Trimethobenzamide HCL (Tigan), up to 200 mg
J3260	Tobramycin Sulfate (Nebcin), up to 80 mg
J3265	Torsemide, 10 mg/ml
J3280	Thiethylperazine Maleate (Torecan), up to 10 mg
J3285	Treprostinil, 1 mg
J3301	Triamcinolone Acetonide, per 10 mg
J3302	Triamcinolone Diacetate, per 5 mg
J3303	Triamcinolone Hexacetonide, per 5 mg
J3305	Trimetrexate Glucuronate, per 25 mg
J3310	Perphenazine (Trilafon), up to 5 mg
J3315	Triptorelin Pamoate, 3.75 mg
J3320	Spectinomycin Dihydrochloride (Trobicin), up to 2 gm
J3360	Diazepam (Valium), up to 5 mg
J3364	Urokinase, 5000 IU vial
J3370	Vancomycin HCL, 500 mg
J3400	Triflupromazine HCL (Vesprin), up to 20 mg
J3410	Hydroxyzine HCL (Vistaril), up to 25 mg
J3411	Thiamine HCL, 100 mg
J3415	Pyridoxine HCL, 100 mg
J3420	Vitamin B-12 Cyanocobalamin, up to 1000 mcg
J3430	Phytonadione, (Vitamin K), per 1 mg
J3470	Hyaluronidase (Wydase), up to 150 units
J3475	Magnesium Sulfate, per 500 mg
J3480	Potassium Chloride, per 2 mEq
J3487	Zoledronic Acid (Zometa), 1 mg
J3520	Edetate Disodium, per 150 mg
J3590	Unclassified Biologics

BR

MISCELLANEOUS DRUGS AND SOLUTIONS

A4216	Sterile water, saline and/or dextrose (diluent), 10 ml
A4218	Sterile saline or water, metered dose dispenser, 10 ml
J7030	Infusion, normal saline solution (or water), 1000 cc
J7040	Infusion, normal saline solution (or water), sterile (500 ml = 1 unit)
J7042	5% dextrose/normal saline (500 ml = 1 unit)
J7050	Infusion, normal saline solution (or water), 250 cc
J7060	5% dextrose/water (500 ml = 1 unit)
J7070	Infusion, D5W, 1000 cc
J7100	Infusion, Dextran 40, 500 ml
J7110	Infusion, Dextran 75, 500 ml
J7120	Ringers Lactate Infusion, up to 1000 cc
J7130	Hypertonic saline solution, 50 or 100 mEq, 20 cc vial
J7300	Intrauterine Copper Contraceptive
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	
J7308	Aminolevulinic Acid HCL for topical administration, 20%, single unit dosage form (354 mg)	
J7317	Sodium Hyaluronate (Hyalgan), per 20 to 25 mg dose for intra-articular injection	
J7320	Hylan (Synvisc), 16 mg, for intra-articular injection	
J7501	Azathioprine, parenteral (eg Imuran), 100 mg	
J7504	Lymphocyte Immune Globulin, anti-thymocyte globulin equine, parenteral, 250 mg	
J7611	Albuterol, inhalation solution, administered through DME, concentrated form, 1 mg	
J7612	Levalbuterol, inhalation solution, administered through DME, concentrated form 0.5 mg	
J7613	Albuterol, inhalation solution, administered through DME, unit dose 1 mg	
J7614	Levalbuterol, inhalation solution, administered through DME, unit dose 0.5 mg	
J7620	Albuterol, up to 2.5 mg and Ipratropium Bromide, up to 0.5 mg, non-compounded inhalation solution, administered through DME	
J7627	Budesonide, powder, compounded for inhalation solution, administered through DME, unit dose form, up to 0.5 mg	
J7628	Bitolterol Mesylate, inhalation solution, concentrated form, per mg	
J7631	Cromolyn Sodium, inhalation solution, unit dose form, per 10 mg	
J7640	Formoterol, inhalation solution administered through DME, unit dose form, 12 mg	
J7644	Ipratropium Bromide, inhalation solution, unit dose form, per mg	
J7648	Isoetharine HCL, inhalation solution, concentrated form, per mg	
J7649	Isoetharine HCL, inhalation solution, unit dose form, per mg	
J7658	Isoproterenol HCL, inhalation solution, concentrated form, per mg	
J7668	Metaproterenol Sulfate, inhalation solution, concentrated form, per 10 mg	
J7669	Metaproterenol Sulfate, inhalation solution, unit dose form, per 10 mg	
J7674	Methacholine Chloride administered as inhalation solution through a nebulizer, per 1 mg	
J7682	Tobramycin, unit dose form, 300 mg, inhalation solution	
J8501	Aprepitant, oral, 5 mg	
L8603	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies	BR
Q3031	Collagen Skin Test	BR
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	BR

CHEMOTHERAPY ADMINISTRATION

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

96405	Chemotherapy administration, intralesional; up to and including 7 lesions	10.00
96406	more than 7 lesions	15.00
96409	intravenous, push technique, single or initial substance/drug	15.00
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	35.00
96415	each additional hour, 1 to 8 hours (List separately in addition to primary procedure)	5.00
96416	initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	35.00
96420	Chemotherapy administration, intra-arterial; push technique	15.00
96422	infusion technique, up to one hour	35.00
96423	infusion technique, each additional hour up to 8 hours (List separately in addition to primary procedure)	5.00
96425	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	35.00
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	47.00
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	47.00
96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture	42.00
96521	Refilling and maintenance of portable pump	15.00
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic, (eg, intravenous, intra-arterial) (Access of pump port is included in filling of implantable pump)	15.00
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	15.00
96549	UNLISTED chemotherapy procedure	BR
J9999	Not otherwise classified, antineoplastic drugs	BR

CHEMOTHERAPY DRUGS

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

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

Reimbursement for drugs furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, as established by invoice, to the practitioner. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

J0128	Abarelix, 10 mg
J9000	Doxorubicin HCL (Adriamycin), 10 mg
J9001	Doxorubicin Hydrochloride, all lipid formulations, 10 mg
J9010	Alentuzumalb, 10 mg
J9015	Aldesleukin, per single use vial
J9017	Arsenic Trioxide, 1 mg (Trisenox)
J9020	Asparaginase (Elspar) 10,000 units
J9025	Azacitidine, 1 mg
J9027	Clofarabine, 1 mg
J9035	Bevacizumab, 10 mg
J9040	Bleomycin Sulfate (Lenoxane), 15 units
J9041	Bortezomib, 0.1 mg
J9045	Carboplatin, 50 mg
J9050	Carmustine, 100 mg
J9055	Cetuximab, 10 mg
J9060	Cisplatin (Platinol), powder or solution, per 10 mg
J9062	Cisplatin (Platinol), 50 mg
J9065	Cladribine, per 1 mg
J9070	Cyclophosphamide (Cytoxan, Neosar), 100 mg
J9080	Cyclophosphamide (Cytoxan, Neosar), 200 mg
J9090	Cyclophosphamide (Cytoxan, Neosar), 500 mg
J9091	Cyclophosphamide (Cytoxan, Neosar), 1.0 gm
J9092	Cyclophosphamide (Cytoxan, Neosar), 2.0 gm
J9093	Cyclophosphamide, Lyophilized (Cytoxan), 100 mg
J9094	Cyclophosphamide, Lyophilized (Cytoxan), 200 mg
J9095	Cyclophosphamide, Lyophilized (Cytoxan), 500 mg
J9096	Cyclophosphamide, Lyophilized (Cytoxan), 1.0 gm
J9097	Cyclophosphamide, Lyophilized (Cytoxan), 2.0 gm

J9098	Cytarabine Liposome, 10 mg
J9100	Cytarabine (Cytosar-U), 100 mg
J9110	Cytarabine (Cytosar-U), 500 mg
J9120	Dactinomycin (Cosmegen), 0.5 mg
J9130	Dacarbazine, 100 mg
J9140	Dacarbazine, 200 mg
J9150	Daunorubicin HCL, 10 mg
J9151	Daunorubicin Citrate, liposomal formulation, 10 mg
J9160	Denileukin Diftitox, 300 mcg
J9165	Diethylstilbestrol Diphosphate, 250 mg
J9170	Docetaxel, 20 mg
J9178	Epirubicin HCL, 2 mg
J9181	Etoposide, 10 mg
J9182	Etoposide, 100 mg
J9185	Fludarabine Phosphate, 50 mg
J9190	Fluorouracil, 500 mg
J9200	Floxuridine (FUDR), 500 mg
J9201	Gemcitabine HCL, 200 mg
J9202	Goserelin Acetate Implant per 3.6 mg
J9206	Irinotecan, 20 mg
J9208	Ifosfomide, 1 gm
J9209	Mesna, 200 mg
J9211	Idarubicin Hydrochloride, 5 mg
J9212	Interferon Alfacon-1, Recombinant, 1 mcg
J9213	Interferon, Alfa-2A, Recombinant, 3 million units
J9214	Interferon, Alfa-2B, Recombinant, 1 million units
J9215	Interferon, Alfa-N3, (Human Leukocyte Derived), 250,000 IU
J9216	Interferon, Gamma 1-B, 3 million units
J9217	Leuprolide Acetate (for Depot Suspension), 7.5 mg
J9218	Leuprolide Acetate, per 1 mg
J9219	Leuprolide Acetate Implant, 65 mg
J9225	Histrelin Implant, 50 mg
J9230	Mechlorethamine Hydrochloride (Nitrogen Mustard), 10 mg
J9245	Melphalan Hydrochloride, 50 mg
J9250	Methotrexate Sodium, 5 mg
J9260	Methotrexate Sodium, 50 mg
J9263	Oxaliplatin (Eloxatin), 0.5 mg
J9264	Paclitaxel protein-bound particles, 1 mg
J9265	Paclitaxel, 30 mg
J9266	Pegaspargase, per single dose vial
J9268	Pentostatin, per 10 mg
J9270	Plicamycin, 2.5 mg
J9280	Mitomycin, 5 mg
J9290	Mitomycin, 20 mg
J9291	Mitomycin, 40 mg

J9293	Mitoxantrone Hydrochloride, per 5 mg	
J9300	Gemtuzumab Ozogamicin, 5 mg	
J9305	Pemetrexed, 10 mg	
J9310	Rituximab, 100 mg	
J9320	Streptozocin, 1 gm	
J9340	Thiotepa, 15 mg	
J9350	Topotecan, 4 mg	
J9355	Trastuzumab, 10 mg	
J9357	Valrubicin, intravesical, 200 mg	
J9360	Vinblastine Sulfate, 1 mg	
J9370	Vincristine Sulfate, 1 mg	
J9375	Vincristine Sulfate, 2 mg	
J9380	Vincristine Sulfate, 5 mg	
J9390	Vinorelbine Tartrate, per 10 mg	
J9395	Fulvestrant (Faslodex), 25 mg	
J9600	Porfimer Sodium, 75 mg	
J9999	Not Otherwise Classified, Antineoplastic Drugs	BR
Q0165	Prochlorperazine Maleate, 10 mg, oral	
Q0174	Thiethylperazine Maleate, 10 mg, oral	
Q0177	Hydroxyzine Pamoate, 25 mg, oral	
Q2017	Teniposide, 50 mg	

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures, eg, otoscopy, rhinoscopy, tuning fork test, does not apply.

Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using descriptors from the Audiologic Function Tests listed below.

All services include medical diagnostic evaluation. Technical procedures (which may or may not be performed by the practitioner personally) are often part of the service, but should not be mistaken to constitute the service itself.

AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION

The audiometric tests listed below imply the use of calibrated electronic equipment. Other hearing tests (such as whispered voice, tuning fork) are considered part of the general otorhinolaryngologic services and are not reported separately. All descriptors refer to testing of both ears.

92551	Screening test, pure tone, air only	5.00
92567	Tympanometry (impedance testing)	10.00
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	25.00

CARDIOVASCULAR

CARDIOGRAPHY

93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	15.00
93010	interpretation and report only	7.50

PULMONARY

Codes 94010-94200 include laboratory procedure(s), interpretation and practitioner's services.

94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation	15.00
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation	15.00
94016	physician review and interpretation only	7.50
94060	Bronchodilation responsiveness, spirometry as in 94010, pre and post-bronchodilator administration	25.00

94150	Vital capacity, total (separate procedure)	3.00
94200	Maximum breathing capacity, maximal voluntary ventilation	10.00
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (94664 can be reported one time only per day of service)	3.00

ALLERGY AND CLINICAL IMMUNOLOGY

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

SENSITIVITY TESTING (Maximum fees include reading of test)

86580	Skin test; tuberculosis, intradermal	5.00
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MISCELLANEOUS SERVICES

99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	BR
99082	Unusual travel (mileage, per mile, one way, beyond 10 mile radius of point of origin (office or home))	.50
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma	27.00

SURGERY SECTION

GENERAL INFORMATION AND RULES

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

Failure to submit an Operative Report when billing for a "By Report" procedure will cause your claim to be denied by MMIS.

4. **ADDITIONAL SERVICES:** Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges on a fee-for-service basis. (See modifiers -24, -25, -79)
5. When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.
6. **MULTIPLE SURGICAL PROCEDURES:**
 - a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total dollar value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified.
 - b. When an incidental procedure (eg, incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the fee will be that of the major procedure only.

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

Reimbursement for 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. **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.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>F/U DAYS</u>	<u>FEE</u>
SURGERY SERVICES			
INTEGUMENTARY SYSTEM			
SKIN, SUBCUTANEOUS AND AREOLAR TISSUES			
<u>INCISION</u>			
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single		8.00
10061	complicated or multiple		24.00
10120	Incision and removal of foreign body, subcutaneous tissues; simple		8.00
10140	Incision and drainage of hematoma, seroma or fluid collection		8.00
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst		4.00
<u>EXCISION - BENIGN LESIONS</u>			
Excision (including simple closure) of benign lesions of skin or subcutaneous tissues (eg, cicatricial, fibrous, inflammatory, congenital, cystic lesions), including local anesthesia. See appropriate size and area below.			
(For electrosurgical and other methods, see 17110 et seq)			
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	30	18.00
11400	Excision, benign lesion, including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	30	16.00
<u>INTRODUCTION</u>			
11975	Insertion, implantable contraceptive capsules		81.00
11976	Removal, implantable contraceptive capsules		57.00
11977	Removal with reinsertion, implantable contraceptive capsules		109.50
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies		BR

<u>CODE</u>	<u>DESCRIPTION</u>	<u>F/U DAYS</u>	<u>FEE</u>
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REPAIR

SIMPLE REPAIR is used when the wound is superficial; ie, involving skin and/or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. **FOR CLOSURE WITH ADHESIVE STRIPS, LIST APPROPRIATE EVALUATION AND MANAGEMENT SERVICE ONLY.**

Instructions for listing services at time of wound repair.

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

Simple ligation of vessels in an open wound is considered as part of any wound closure.

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

REPAIR – SIMPLE

12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	8.00
12002	2.6 cm to 7.5 cm	10.00
12004	7.6 cm to 12.5 cm	12.00
12005	12.6 cm to 20.0 cm	14.00
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	5.50
12013	2.6 cm to 5.0 cm	8.00
12014	5.1 cm to 7.5 cm	12.00
12015	7.6 cm to 12.5 cm	20.00
12016	12.6 cm to 20.0 cm	32.00

BURNS, LOCAL TREATMENT

Procedures 16000 and 16020 refer to local treatment of burned surface only.

List percentage of body surface involved and depth of burn.

For necessary related medical services (eg, hospital visits) in management of burned patients, see appropriate services in Medicine Section.

16000	Initial treatment, first degree burn, when no more than local treatment is required	6.00
16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)	8.00

Nurse Practitioner Fee Schedule

<u>CODE</u>	<u>DESCRIPTION</u>	<u>F/U DAYS</u>	<u>FEE</u>
<u>DESTRUCTION</u>			
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum or milia; up to 14 lesions (Retreatment same as office visit)	10	8.00
17111	15 or more lesions (For excision of fibrocutaneous tags, see 11200)	10	11.00
17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)		8.00
DIGESTIVE SYSTEM			
STOMACH			
43760	Change of gastrostomy tube		20.00
FEMALE GENITAL SYSTEM			
VULVA AND INTROITUS			
<u>DESTRUCTION</u>			
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)		8.00
<u>REPAIR</u>			
56820	Colposcopy of the vulva;	30	35.00
VAGINA			
<u>INTRODUCTION</u>			
57150	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease		4.00
<u>ENDOSCOPY</u>			
57420	Colposcopy of the entire vagina, with cervix If present		36.00
57452	Colposcopy of the cervix including upper/adjacent vagina;		44.00

Nurse Practitioner Fee Schedule

<u>CODE</u>	<u>DESCRIPTION</u>	<u>F/U DAYS</u>	<u>FEE</u>
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CORPUS UTERI

INTRODUCTION

(For materials supplied by practitioner, see Surgery Section, General Rules and Information #8)

58300	Insertion of intrauterine device (IUD)		49.00
58301	Removal of intrauterine device (IUD)		36.00
J7300	Intrauterine copper contraceptive		
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg.		

<u>CODE</u>	<u>DESCRIPTION</u>	<u>F/U DAYS</u>	<u>FEE</u>
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MATERNITY CARE

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

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

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

ANTEPARTUM AND POSTPARTUM CARE

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS) are noted in parenthesis after the description of each code. For information on the MOMS Program see Policy Guidelines.

59425	Antepartum care only; 4-6 visits (MOMS \$364.00) (Procedure code 59425 includes reimbursement for one initial antepartum encounter (\$54.00) and five subsequent encounters (\$31.00).		209.00
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If less than 6 antepartum encounters were provided, adjust the amount charged accordingly)

59426	7 or more visits (MOMS \$541.00) (Procedure code 59426 includes reimbursement for one initial antepartum encounter (\$54.00) and eight subsequent encounters (\$31.00).		302.00
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If less than 9 antepartum encounters were provided, adjust the amount charged accordingly).

For 6 or less antepartum encounters, see code 59425.

59430	Postpartum care only (outpatient) (separate procedure) (MOMS \$59.00)		31.00
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(When inpatient postpartum care is provided, see appropriate Hospital Evaluation and Management code(s).)