

NEW YORK STATE

MEDICAID PROGRAM

ORDERED AMBULATORY

PROCEDURE CODES

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GENERAL INFORMATION

1. **INQUIRY:** Any questions regarding this section should be directed to the New York State Department of Health (See Inquiry Section under Information For All Providers).
2. **BY REPORT:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service as indicated by "BR" in the Fee Schedule. 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 must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (eg, procedure descriptions, itemized invoices, etc.) should accompany all claims submitted.

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

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

3. **UNLISTED PROCEDURES:** The value and appropriateness of services not specifically listed in the Fee Schedule will be manually reviewed by medical professional staff. The procedure codes to be utilized when submitting claims for such services may be found in this section.
4. **DVS AUTHORIZATION (#):** Codes followed by # require an authorization via the dispensing validation system (DVS) before services are rendered.
5. **FEES:** Fees in the Fee Schedule are the maximum reimbursable Medicaid fees and are available at: <http://www.emedny.org/ProviderManuals/OrderedAmbulatory/index.html>

LABORATORY SERVICES INFORMATION

To claim payment for laboratory services performed on an ordered ambulatory basis, the applicable procedure codes and fees must be identified from the Laboratory Provider Manual Fee Schedule.

RADIOLOGY INFORMATION

Fees listed in the Fee Schedule represent maximum allowances for reimbursement purposes in the Medicaid Program and include the administrative, technical and professional components of the service provided. To determine the fee applicable only to the technical and administrative component, multiply the listed dollar value by a maximum conversion factor of 60%. (See below for further reference to the administrative, technical and professional components of a radiology fee item.)

Fees listed in the Fee Schedule are to be considered as payment for the complete radiological procedure, unless otherwise indicated. In order to be paid for both the professional and the technical and administrative components of the radiology service, qualified facilities which provide radiology services on an ordered ambulatory basis must perform the professional component of radiology services and own or directly lease the equipment and must supervise and control the radiology technician who performs the radiology procedures.

Each State agency may determine, on an individual basis, fees for services or procedures not included in the Fee Schedule. Such fee determinations should be reported promptly to the Division of Health Care Financing of the State Department of Health for review by the Interdepartmental Committee on Health Economics for possible incorporation in the Radiology Fee Schedule.

RADIOLOGY PRIOR APPROVAL (underlined procedure codes)

Information for Radiology Providers-

If you are **performing** a CT, CTA, MRI, MRA, Cardiac Nuclear, or PET procedure, you must verify that an approval has been obtained before performing these diagnostic imaging services for New York Medicaid FFS. Approvals will be required for claims payment. Failure to obtain an approval number may delay or prevent payment of a claim.

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

Additional information is available at

<http://www.emedny.org/ProviderManuals/Radiology/index.html>

TECHNICAL, ADMINISTRATIVE AND PROFESSIONAL RADIOLOGY COMPONENTS

When radiological services are rendered in hospital departments by radiologists who receive no salary/compensation from the facility for patient care and who bill separately, the charge for the professional component may not exceed 40% of the maximum fee listed in the Fee Schedule. The remaining 60% of the fee is the maximum amount applicable for the technical and administrative services provided by the hospital. No payment will be made to a qualified facility solely for the professional component.

The professional component (see modifier -26) for radiological services is intended to cover professional services, when applicable, as listed below:

1. Determination of the problem, including interviewing the patient, obtaining the history and making appropriate physical examination to determine the method of performing the radiologic procedure.

2. Study and evaluation of results obtained in diagnostic or therapeutic procedures, interpretation of radiographs or radioisotope data estimation resultant from treatment.
3. Dictating report of examination or treatment.
4. Consultation with referring physician regarding results of diagnostic or therapeutic procedures.

The technical or administrative component (see modifier -TC) includes items such as: cost or charges for technologists, clerical staff, films, opaques, radioactive materials, chemicals, drugs or other materials, purchase, rental use or maintenance of space, equipment, telephone services or other facilities or supplies.

Certain radiological procedures require the performance of a medical or surgical procedure (eg, studies necessitating an injection of radiopaque media, fluoroscopy, consultation) which must be performed by the radiologist and is not separable into technical and professional components for billing purposes. In these instances, reimbursement for the medical or surgical procedure will be made to the physician via the appropriate procedure code listed in the Physician Fee Schedules.

GENERAL RULES

General rules which apply to all procedure codes in Radiology including sections of Diagnostic Radiology, Diagnostic Ultrasound, Radiation Oncology and Nuclear Medicine are as follows:

1. Dollar values include usual contrast media, equipment and materials. An additional charge may be warranted when special materials are provided.
2. Dollar values include consultation and a written report to the referring physician.
3. When multiple X-ray examinations are performed during the same visit, reimbursement shall be limited to the greater fee plus 60% of the lesser fee(s). When more than one part of the body is included in a single X-ray for which reimbursement is claimed, the charge shall be only for a single X-ray. When bilateral X-ray examinations are performed during the same visit, reimbursement shall be limited to 160% of the procedure value (see modifier -50). The above provisions regarding fee reductions for multiple X-rays are applicable to X-rays taken of all parts of the body.
4. When repeat X-ray examinations of the same part and for the same illness are required because of technical or professional error in the original X-rays, such repeat X-rays are not eligible for payment. (See Rule 5 below.)
5. When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it should be identified by use of modifier -76.
6. **RADIOLOGICAL SUPERVISION AND INTERPRETATION CODES:** The maximum fee is applicable when the facility incurs the costs of both the technical/administrative and professional components of the imaging procedure. (For the technical or administrative component of imaging procedures, see modifier -TC). When the procedure is performed on an ordered ambulatory basis by a non-salaried/non-compensated physician, reimbursement will be made for the technical /administrative component of the imaging procedure via the use of modifier -TC on the appropriate "radiological supervision and interpretation" code.
7. **BY REPORT:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service as indicated by "BR" in the Fee Schedule. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.

Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate), diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate), concurrent problems, and follow up care.

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

and equipment necessitated. Appropriate documentation (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.

8. SEPARATE PROCEDURES: Some of the listed procedures are commonly carried out as an integral part of a total service, and as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

MMIS MODIFIERS

- 26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier -26 to the usual procedure number. (Reimbursement will not exceed 40% of the maximum State Medical Fee Schedule amount.)
- TC Technical Component: Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier -TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. (Reimbursement will not exceed 60% of the maximum State Medical Fee Schedule amount.)
- 50 Bilateral Procedures (X-ray): When bilateral X-ray examinations are performed, the service will be identified by adding the modifier -50 to the usual procedure code number. (Reimbursement will not exceed 160% of the maximum State Medical Fee Schedule amount. One claim line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)
- 76 Repeat X-ray Procedure: When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it will be identified by adding modifier -76. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- FP Service Provided as Part of a 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.)
- UD 340B Purchased Drug: Drugs purchased through the 340B Program.

RADIOLOGY SERVICES

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

HEAD AND NECK

- 70010 Myelography, posterior fossa; radiological supervision and interpretation
- 70015 Cisternography, positive contrast; radiological supervision and interpretation
- 70030 Radiologic examination, eye, for detection of foreign body (includes detection and localization)
- 70100 Radiologic examination, mandible; partial, less than four views
- 70110 complete, minimum of four views
- 70120 Radiologic examination, mastoids; less than three views per side
- 70130 complete, minimum of three views per side
- 70134 Radiologic examination, internal auditory meati, complete
- 70140 Radiologic examination, facial bones; less than three views
- 70150 complete, minimum of three views
- 70160 Radiologic examination, nasal bones, complete, minimum of three views
- 70170 Dacryocystography, nasolacrimal duct; radiological supervision and interpretation
- 70190 Radiologic examination; optic foramina
- 70200 orbits, complete, minimum of four views
- 70210 Radiologic examination, sinuses, paranasal; less than three views
- 70220 complete, minimum of three views
- 70240 Radiologic examination, sella turcica
- 70250 Radiologic examination, skull; less than four views
- 70260 complete, minimum of four views
- 70300 Radiologic examination, teeth; single view
- 70310 partial examination, less than full mouth
- 70320 complete, full mouth
- 70328 Radiologic examination, temporomandibular joint, open and closed mouth; unilateral
- 70330 bilateral
- 70332 Temporomandibular joint arthrography; radiological supervision and interpretation (Do not report 70332 in conjunction with 77002)
- 70336 Magnetic resonance (eg, proton) imaging, temporomandibular joint
- 70350 Cephalogram, orthodontic
- 70355 Orthopantomogram (eg, panoramic x-ray)
- 70360 Radiologic examination; neck, soft tissue
- 70370 pharynx or larynx, including fluoroscopy and/or magnification technique
- 70371 Complex dynamic pharyngeal and speech evaluation by cine or video recording
- 70380 Radiologic examination, salivary gland for calculus
- 70390 Sialography; radiological supervision and interpretation
- 70450 Computed tomography, head or brain; without contrast material
- 70460 with contrast material(s)
- 70470 without contrast material, followed by contrast material(s) and further sections
- 70480 Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material

Ordered Ambulatory Procedure Codes

- 70481 with contrast material(s)
70482 without contrast material, followed by contrast material(s) and further sections
70486 Computed tomography, maxillofacial area; without contrast material
70487 with contrast material(s)
70488 without contrast material, followed by contrast material(s) and further sections
70490 Computed tomography, soft tissue neck; without contrast material
70491 with contrast material(s)
70492 without contrast material, followed by contrast material(s) and further sections
70496 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70498 Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70540 Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)
70542 with contrast material
70543 without contrast material(s), followed by contrast material(s) and further sequences (Report 70540-70543 once per imaging session)
70544 Magnetic resonance angiography, head; without contrast material(s)
70545 with contrast material(s)
70546 without contrast material(s), followed by contrast material(s) and further sequences
70547 Magnetic resonance angiography, neck; without contrast material(s)
70548 with contrast material
70549 without contrast material(s), followed by contrast material(s) and further sequences
70551 Magnetic resonance (eg, proton) imaging, brain, (including brain stem); without contrast material
70552 with contrast material(s)
70553 without contrast material, followed by contrast material(s) and further sequences
70555 Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, requiring physician or psychologist administration of entire neurofunctional testing (Do not report 70555 unless 96020 is performed) (Do not report 70555 in conjunction with 70551-70553 unless a separate diagnostic MRI is performed)
70557 Magnetic resonance (eg, proton) imaging, brain, (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material
70558 with contrast material(s)
70559 without contrast material(s), followed by contrast material(s) and further sequences

CHEST

- 71010 Radiologic examination, chest; single view, frontal
71015 stereo, frontal
71020 Radiologic examination, chest, two views, frontal and lateral;
71021 with apical lordotic procedure
71022 with oblique projections
71023 with fluoroscopy

Ordered Ambulatory Procedure Codes

- 71030 Radiologic examination, chest, complete, minimum of four views;
71034 with fluoroscopy
- 71035 Radiologic examination, chest, special views, (eg, lateral decubitus, Bucky studies)
- 71100 Radiologic examination, ribs, unilateral; two views
71101 including posteroanterior chest, minimum of three views
- 71110 Radiologic examination, ribs, bilateral; three views
71111 including posteroanterior chest, minimum of four views
- 71120 Radiologic examination; sternum, minimum of two views
- 71130 sternoclavicular joint or joints, minimum of three views
- 71250 Computed tomography, thorax; without contrast material
71260 with contrast material(s)
71270 without contrast material, followed by contrast material(s) and further sections
- 71275 Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 71550 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)
71551 with contrast material(s)
71552 without contrast material(s), followed by contrast material(s) and further sequences
- 71555 Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)

SPINE AND PELVIS

- 72020 Radiologic examination, spine, single view, specify level
- 72040 Radiologic examination, spine, cervical; 2 or 3 views
72050 4 or 5 views
72052 6 or more views
- 72070 Radiologic examination, spine; thoracic, 2 views
72072 thoracic, 3 views
72074 thoracic, minimum of 4 views
72080 thoracolumbar junction, minimum of 2 views
- 72081 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view
72082 2 or 3 views
72083 4 or 5 views
72084 minimum of 6 views
- 72100 Radiologic examination, spine, lumbosacral; 2 or 3 views
72110 minimum of 4 views
72114 complete, including bending views, minimum of 6 views
72120 bending views only, 2 or 3 views
- 72125 Computed tomography, cervical spine; without contrast material
72126 with contrast material(s)
72127 without contrast material, followed by contrast material(s) and further sections
- 72128 Computed tomography, thoracic spine; without contrast material
72129 with contrast material(s)
72130 without contrast material, followed by contrast material(s) and further sections
- 72131 Computed tomography, lumbar spine; without contrast material
72132 with contrast material(s)

Ordered Ambulatory Procedure Codes

<u>72133</u>	without contrast material, followed by contrast material(s) and further sections
<u>72141</u>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
<u>72142</u>	with contrast material(s)
<u>72146</u>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
<u>72147</u>	with contrast material(s)
<u>72148</u>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
<u>72149</u>	with contrast material(s)
<u>72156</u>	Magnetic resonance (eg, proton) imaging, spinal canal and contents without contrast material, followed by contrast material(s) and further sequences; cervical
<u>72157</u>	thoracic
<u>72158</u>	lumbar
<u>72159</u>	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72170	Radiologic examination, pelvis; 1 or 2 views
72190	complete, minimum of 3 views
<u>72191</u>	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing (Do not report 72191 in conjunction with 73706 or 75635. For CTA aorto-iliofemoral runoff, use 75635) (Do not report 72191 in conjunction with 74175. For a combined computed tomographic angiography abdomen and pelvis study, use 74174)
<u>72192</u>	Computed tomography, pelvis; without contrast material
<u>72193</u>	with contrast material(s)
<u>72194</u>	without contrast material, followed by contrast material(s) and further sections
<u>72195</u>	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
<u>72196</u>	with contrast material(s)
<u>72197</u>	without contrast material(s), followed by contrast material(s) and further sequences
<u>72198</u>	Magnetic resonance angiography, pelvis, with or without contrast material(s)
72200	Radiologic examination, sacroiliac joints; less than 3 views
72202	3 or more views
72220	Radiologic examination, sacrum and coccyx, minimum of 2 views

UPPER EXTREMITIES

73000	Radiologic examination; clavicle, complete
73010	scapula, complete
73020	Radiologic examination, shoulder; 1 view
73030	complete, minimum of 2 views
73040	Radiologic examination, shoulder, arthrography, radiological supervision and interpretation (Do not report 73040 in conjunction with 77002)
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction
73060	humerus, minimum of 2 views
73070	Radiologic examination, elbow; 2 views
73080	complete, minimum of 3 views
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation

Ordered Ambulatory Procedure Codes

- (Do not report 73085 in conjunction with 77002)
- 73090 Radiologic examination; forearm, 2 views
- 73092 upper extremity, infant, minimum of 2 views
- 73100 Radiologic examination, wrist; 2 views
- 73110 complete, minimum of 3 views
- 73115 Radiologic examination, wrist, arthrography, radiological supervision and interpretation
(Do not report 73115 in conjunction with 77002)
- 73120 Radiologic examination, hand; 2 views
- 73130 minimum of 3 views
- 73140 Radiologic examination, finger(s), minimum of 2 views
- 73200 Computed tomography, upper extremity; without contrast material
- 73201 with contrast material(s)
- 73202 without contrast material, followed by contrast material(s) and further sections
- 73206 Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 73218 Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)
- 73219 with contrast material(s)
- 73220 without contrast material(s), followed by contrast material(s) and further sequences
extremity, other than joint
- 73221 Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
- 73222 with contrast material(s)
- 73223 without contrast material(s), followed by contrast material(s) and further sections
- 73225 Magnetic resonance angiography, upper extremity, with or without contrast material(s)

LOWER EXTREMITIES

- 73501 Radiologic examination, hip, unilateral, with pelvis when performed, 1 view
- 73502 2-3 views
- 73503 minimum of 4 views
- 73521 Radiologic examination, hips, bilateral, with pelvis when performed, 2 views
- 73522 3-4 views
- 73523 minimum 5 views
- 73525 Radiologic examination, hip, arthrography, radiological supervision and interpretation
(Do not report 73525 in conjunction with 77002)
- 73551 Radiologic examination, femur; 1 view
- 73552 minimum 2 views
- 73560 Radiologic examination, knee; 1 or 2 views
- 73562 3 views
- 73564 complete, 4 or more views
- 73565 both knees, standing, anteroposterior
- 73580 Radiologic examination, knee, arthrography; radiological supervision and interpretation
(Do not report 73580 in conjunction with 77002)
- 73590 Radiologic examination; tibia and fibula, 2 views
- 73592 lower extremity, infant, minimum of 2 views
- 73600 Radiologic examination, ankle; 2 views
- 73610 complete, minimum of 3 views

Ordered Ambulatory Procedure Codes

- 73615 Radiologic examination, ankle, arthrography, radiological supervision and interpretation
(Do not report 73615 in conjunction with 77002)
- 73620 Radiologic examination, foot; 2 views
- 73630 complete, minimum of 3 views
- 73650 Radiologic examination; calcaneus, minimum of 2 views
- 73660 toe(s), minimum of 2 views
- 73700 Computed tomography, lower extremity; without contrast material
- 73701 with contrast material(s)
- 73702 without contrast material, followed by contrast material(s) and further sections
- 73706 Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 73718 Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
- 73719 with contrast material(s)
- 73720 without contrast material(s) followed by contrast material(s) and further sequences
- 73721 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
- 73722 with contrast material(s)
- 73723 without contrast material(s), followed by contrast material(s) and further sequence
- 73725 Magnetic resonance angiography, lower extremity, with or without contrast material(s)

ABDOMEN

- 74000 Radiologic examination, abdomen; single anteroposterior view
- 74010 anteroposterior and additional oblique and cone views
- 74020 complete, including decubitus and/or erect views
- 74022 complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest
- 74150 Computed tomography, abdomen; without contrast material
- 74160 with contrast material(s)
- 74170 without contrast material, followed by contrast material(s) and further sections
- 74174 Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
(Do not report 74174 in conjunction with 72191, 73706, 74175, 75635, 76376, 76377)
- 74175 Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
(Do not report 74175 in conjunction with 73706 or 75635. For CTA aorto-iliofemoral runoff, use 75635)
(Do not report 74175 in conjunction with 72191. For a combined computed tomographic angiography abdomen and pelvis study, use 74174)
- 74176 Computed tomography, abdomen and pelvis; without contrast material
- 74177 with contrast material
- 74178 without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
(Do not report 74176-74178 in conjunction with 72192, 72194, 74150-74170)
- 74181 Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
- 74182 with contrast material(s)
- 74183 without contrast material(s), followed by contrast material(s) and further sequences
- 74185 Magnetic resonance angiography, abdomen, with or without contrast material(s)

74190 Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation

GASTROINTESTINAL TRACT

74210 Radiologic examination; pharynx and/or cervical esophagus
 74220 esophagus
 74230 Swallowing function, with cineradiography/videoradiography
 74235 Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation
 74240 Radiologic examination, gastrointestinal tract, upper; with or without delayed images, without KUB
 74241 with or without delayed images, with KUB
 74245 with small intestine, includes multiple serial images
 74246 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, without KUB
 74247 with or without delayed images, with KUB
 74249 with small intestine follow-through
 74250 Radiologic examination, small intestine, includes multiple serial images;
 74251 via enteroclysis tube
 74260 Duodenography, hypotonic
 74270 Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB
 74280 air contrast with specific high density barium, with or without glucagon
 74283 Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus)
 74290 Cholecystography, oral contrast;
 74328 Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation
 74329 Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation
 74330 Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation
 74340 Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and images, radiological supervision and interpretation
 74355 Percutaneous placement of enteroclysis tube, radiological supervision and interpretation
 74360 Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation
 74363 Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation

URINARY TRACT

74400 Urography (pyelography), intravenous, with or without KUB, with or without tomography
 74410 Urography, infusion, drip technique and/or bolus technique
 74420 Urography, retrograde, with or without KUB
 74425 Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation

Ordered Ambulatory Procedure Codes

- 74430 Cystography, minimum of three views, radiological supervision and interpretation
- 74440 Vasography, vesiculography, or epididymography, radiological supervision and interpretation
- 74445 Corpora cavernosography, radiological supervision and interpretation
- 74450 Urethrocytography, retrograde, radiological supervision and interpretation
- 74455 Urethrocytography, voiding, radiological supervision and interpretation

GYNECOLOGICAL AND OBSTETRICAL

- 74710 Pelvimetry, with or without placental localization
- 74712 Magnetic resonance imaging (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
- 74713 each additional gestation (List separately in addition to code for primary procedure)
- 74740 Hysterosalpingography, radiological supervision and interpretation
- 74742 Transcervical catheterization of fallopian tube, radiological supervision and interpretation
- 74775 Perineogram (eg, vaginogram, for sex determination or extent of anomalies)

HEART

- 75557 Cardiac magnetic resonance imaging for morphology and function without contrast material
- 75559 with stress imaging
- 75561 Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;
- 75563 with stress imaging
- 75565 Cardiac magnetic resonance imaging for velocity flow mapping
(List separately in addition to primary procedure)
(Do not report 75557, 75559, 75561, 75563, 75565 in conjunction with 76376, 76377)
- 75574 Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

VASCULAR PROCEDURES

AORTA AND ARTERIES

- 75600 Aortography, thoracic, without serialography, radiological supervision and interpretation
- 75605 Aortography, thoracic, by serialography, radiological supervision and interpretation
- 75625 Aortography, abdominal, by serialography, radiological supervision and interpretation
- 75630 Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation
- 75635 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing
(Do not report 75635 in conjunction with 72191, 73706, 74175 or 74174)
- 75658 Angiography, brachial, retrograde, radiological supervision and interpretation

- 75705 Angiography, spinal, selective, radiological supervision and interpretation
- 75710 Angiography, extremity, unilateral, radiological supervision and interpretation
- 75716 Angiography, extremity, bilateral, radiological supervision and interpretation
- 75726 Angiography, visceral; selective or supraseductive, (with or without flush aortogram), radiological supervision and interpretation
- 75731 Angiography, adrenal, unilateral, selective, radiological supervision and interpretation
- 75733 Angiography, adrenal, bilateral, selective, radiological supervision and interpretation
- 75736 Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation
- 75741 Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation
- 75743 Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation
- 75746 Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation
- 75756 Angiography, internal mammary, radiological supervision and interpretation
- 75774 Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation

VEINS AND LYMPHATICS

- 75801 Lymphangiography, extremity only, unilateral, radiological supervision and interpretation
- 75803 Lymphangiography, extremity only, bilateral, radiological supervision and interpretation
- 75805 Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation
- 75807 Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation
- 75820 Venography, extremity, unilateral, radiological supervision and interpretation
- 75822 Venography, extremity, bilateral, radiological supervision and interpretation
- 75825 Venography, caval, inferior, with serialography, radiological supervision and interpretation
- 75827 Venography, caval, superior, with serialography, radiological supervision and interpretation
- 75831 Venography, renal, unilateral, selective, radiological supervision and interpretation
- 75833 Venography, renal, bilateral, selective, radiological supervision and interpretation
- 75840 Venography, adrenal, unilateral, selective, radiological supervision and interpretation
- 75842 Venography, adrenal, bilateral, selective, radiological supervision and interpretation
- 75860 Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation
- 75870 Venography, superior sagittal sinus, radiological supervision and interpretation
- 75872 Venography, epidural, radiological supervision and interpretation
- 75880 Venography, orbital, radiological supervision and interpretation
- 75885 Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation
- 75887 Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation

TRANSCATHETER THERAPY AND BIOPSY

- 75894 Transcatheter therapy, embolization, any method, radiological supervision and interpretation
- 75984 Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation

75989 Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography) for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation

MISCELLANEOUS PROCEDURES

76000 Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

76001 Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)

76010 Radiologic examination from nose to rectum for foreign body, single view, child

76080 Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation

76100 Radiological examination, single plane body section (eg, tomography), other than with urography

76101 Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral

76102 bilateral
(Do not report 76101, 76102 more than once per day)

76120 Cineradiography/videoradiography, except where specifically included

76125 Cineradiography/videoradiography, to complement routine examination
(List separately in addition to primary procedure)

76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
(Use 76376 in conjunction with code[s] for base imaging procedure[s])

76377 requiring image postprocessing on an independent workstation
(Use 76377 in conjunction with code[s] for base imaging procedure[s])

76380 Computed tomography, limited or localized follow-up study

76496 Unlisted fluoroscopic procedure (eg, diagnostic, interventional)

76497 Unlisted computed tomography procedure (eg, diagnostic, interventional)

76498 Unlisted magnetic resonance procedure (eg, diagnostic, interventional)

76499 Unlisted diagnostic radiographic procedure

G0297 Low-dose computer tomography for lung cancer screening

DIAGNOSTIC ULTRASOUND

Definitions:

A-mode: Implies a one-dimensional ultrasonic measurement procedure.

M-mode: Implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo producing structures.

B-scan: Implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

Real-time scan: Implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

HEAD AND NECK

- 76506 Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated
- 76510 Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
- 76511 quantitative A-scan only
- 76512 B-scan (with or without superimposed non-quantitative A-scan)
- 76513 anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
- 76514 corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
- 76516 Ophthalmic biometry by ultrasound echography, A-scan;
- 76519 with intraocular lens power calculation
- 76529 Ophthalmic ultrasonic foreign body localization
- 76536 Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation

CHEST

- 76604 Ultrasound, chest (includes mediastinum) real time with image documentation
- 76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
- 76642 limited

ABDOMEN AND RETROPERITONEUM

- 76700 Ultrasound, abdominal, real time with image documentation; complete
- 76705 limited (eg, single organ, quadrant, follow-up)
- 76706 Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)
- 76770 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
- 76775 limited
- 76776 Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation

SPINAL CANAL

- 76800 Ultrasound, spinal canal and contents

PELVIS

OBSTETRICAL

Codes 76801 and 76802 include determination of the number of gestational sacs and fetuses, gestational sac/fetal measurements appropriate for gestation (<14 weeks 0 days), survey of visible fetal and placental anatomic structure, qualitative assessment of amniotic fluid volume/gestational sac shape and examination of the maternal uterus and adnexa.

Codes 76805 and 76810 include determination of number of fetuses and amniotic/chorionic sacs, measurements appropriate for gestational age (> or = 14 weeks 0 days), survey of intracranial/spinal/abdominal anatomy, 4 chambered heart, umbilical cord insertion site, placenta location and amniotic fluid assessment and, when visible, examination of maternal adnexa.

Codes 76811 and 76812 include all elements of codes 76805 and 76810 plus detailed anatomic evaluation of the fetal brain/ventricles, face, heart/outflow tracts and chest anatomy, abdominal organ specific anatomy, number/length/architecture of limbs and detailed evaluation of the umbilical cord and placenta and other fetal anatomy as clinically indicated.

Patient record should document the results of the evaluation of each element described above or the reason for non-visualization.

Code 76815 represents a focused "quick look" exam limited to the assessment of one or more of the elements listed in code 76815.

Code 76816 describes an examination designed to reassess fetal size and interval growth or re-evaluated one or more anatomic abnormalities of a fetus previously demonstrated on ultrasound, and should be coded once regardless of the number of fetuses.

Code 76817 describes a transvaginal obstetric ultrasound performed separately or in addition to one of the transabdominal examinations described above. For the transvaginal examinations performed for non-obstetrical purposes, use code 76830.

- 76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; (complete fetal and maternal evaluation), single or first gestation
- 76802 each additional gestation
 (List separately in addition to primary procedure)
- 76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach (complete fetal and maternal evaluation); single of first gestation
- 76810 each additional gestation
 (List separately in addition to primary procedure)
 (Use 76810 in conjunction with 76805)
- 76811 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
- 76812 each additional gestation
 (List separately in addition to primary procedure)
 (Use 76812 in conjunction with 76811)
- 76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
- 76814 each additional gestation

Ordered Ambulatory Procedure Codes

(List separately in addition to primary procedure)

- 76815 Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses
(Use 76815 only once per exam and not per element)
- 76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
- 76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal
(If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 76817 in addition to appropriate transabdominal exam code)
- 76818 Fetal biophysical profile; with non-stress testing
- 76819 without non-stress testing
- 76820 Doppler velocimetry, fetal; umbilical artery
(Billable with a diagnosis of polyhydramnios, oligohydramnios, placental transfusion syndromes or poor fetal growth)
- 76821 middle cerebral artery
(Billable with a diagnosis of rhesus isoimmunization, placental transfusion syndromes or viral diseases complicating pregnancy (e.g. parvovirus B-19 infection))
- 76825 Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
- 76826 follow-up or repeat study
- 76827 Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
- 76828 follow-up or repeat study

NON-OBSTETRICAL

- 76830 Ultrasound, transvaginal
(If transvaginal examination is done in addition to transabdominal non-obstetrical ultrasound exam, use 76830 in addition to appropriate transabdominal exam code)
- 76831 Saline infusion sonohysterography (sis), including color flow Doppler, when performed
- 76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
- 76857 limited or follow-up (eg, for follicles)

GENITALIA

- 76870 Ultrasound, scrotum and contents
- 76872 Ultrasound, transrectal;
- 76873 prostate volume study for brachytherapy treatment planning
(separate procedure)

EXTREMITIES

- 76881 Ultrasound, extremity, nonvascular, real-time with image documentation; complete

Ordered Ambulatory Procedure Codes

- 76882 limited, anatomic specific
- 76885 Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician or other qualified health care professional manipulation)
- 76886 limited, static (not requiring physician or other qualified health care professional manipulation)

VASCULAR STUDIES

(For vascular studies, see 93981)

ULTRASONIC GUIDANCE PROCEDURES

- 76930 Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation
- 76932 Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation supervision and interpretation
- 76937 Ultrasonic guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to primary procedure)
- 76940 Ultrasound guidance for, and monitoring of, parenchymal tissue ablation
- 76941 Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation
- 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
- 76945 Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation
- 76946 Ultrasonic guidance for amniocentesis, imaging supervision and interpretation
- 76965 Ultrasonic guidance for interstitial radioelement application
- 76975 Gastrointestinal endoscopic ultrasound, supervision and interpretation
- 76977 Ultrasound bone density measurement and interpretation, peripheral site(s), any method

MISCELLANEOUS ULTRASONIC PROCEDURE

- 76999 Unlisted ultrasound procedure (eg, diagnostic, interventional)

RADIOLOGIC GUIDANCE

FLUOROSCOPIC GUIDANCE

- 77001 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position)
(List separately in addition to primary procedure)
(Do not use 77001 in conjunction with 77002)
- 77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)
(List separately in addition to code for primary procedure)
- 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)
(List separately in addition to code for primary procedure)

COMPUTED TOMOGRAPHY GUIDANCE

- 77012 Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation
- 77013 Computerized tomography guidance for, and monitoring of, parenchymal tissue ablation

MAGNETIC RESONANCE GUIDANCE

- 77021 Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation
- 77022 Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation

BREAST, MAMMOGRAPHY

- 77053 Mammary ductogram or galactogram, single duct, radiological supervision and interpretation
- 77054 Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation
- 77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
- 77059 Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
- 77065 Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
- 77066 bilateral
- 77067 Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

MAMMOGRAPHY CODES TO BE BILLED FOR MEDICARE PRIMARY RECIPIENTS ONLY

- G0202 Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed
- G0204 Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral
- G0206 Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral

BONE/JOINT STUDIES

- 77072 Bone age studies
- 77073 Bone length studies (orthoroentgenogram, scanogram)
- 77074 Radiologic examination, osseous survey; limited (eg, for metastases)
- 77075 Radiologic examination, osseous survey; complete (axial and appendicular skeleton)
- 77076 Radiologic examination, osseous survey, infant
- 77077 Joint survey, single view, 2 or more joints (specify)
- 77078 Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
- 77080 Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
- 77081 Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)
- 77084 Magnetic resonance (eg, proton) imaging, bone marrow blood supply

RADIATION ONCOLOGY

Listings for Radiation Oncology provide for teletherapy and brachytherapy to include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during course of treatment and for three months following its completion.

For treatment by injectable or ingestible isotopes, see subsection **Nuclear Medicine**.

CLINICAL TREATMENT PLANNING (EXTERNAL AND INTERNAL SOURCES)

The clinical treatment planning process is a complex service including interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size, of treatment ports, selection of appropriate treatment devices, and other procedures.

Reimbursement for procedure codes 77261, 77262 & 77263 is for the global fee.

77261	Therapeutic radiology treatment planning; simple
77262	intermediate
77263	complex

Definitions:

Simple - simulation of a single treatment area with either a single port or parallel opposed ports. Simple or no blocking.

Intermediate – simulation of three or more converging ports, two separate treatment areas, multiple blocks.

Complex – simulation of tangential portals, three or more treatment areas, rotation or arc therapy, complex blocking, custom shielding blocks, brachytherapy source verification, hyperthermia probe verification, any use of contrast materials.

Three-dimensional (3D) - computer-generated 3D reconstruction of tumor volume and surrounding critical normal tissue structures from direct CT scans and/or MRI data in preparation for non-coplanar or coplanar therapy. The stimulation utilizes documented 3D beam's eye view volume-dose displays of multiple or moving beams. Documentation with 3D volume reconstruction and dose distribution is required.

(Simulation may be carried out on a dedicated simulator, a radiation therapy treatment unit, or diagnostic x-ray machine.)

77280	Therapeutic radiology simulation-aided field setting; simple
77285	intermediate
77290	complex
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)
77299	Unlisted procedure, therapeutic radiology clinical treatment planning

MEDICAL RADIATION PHYSICS, DOSIMETRY, TREATMENT DEVICES AND SPECIAL SERVICES

77295	3-dimensional radiotherapy plan, including dose-volume histograms
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Ordered Ambulatory Procedure Codes

- 77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose as required during course of treatment, only when prescribed by the treating physician
- 77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
- 77306 Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
- 77307 complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
- 77316 Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
- 77317 intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)
- 77318 complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)
- 77321 Special teletherapy port plan, particles, hemibody, total body
- 77331 Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
- 77332 Treatment devices, design and construction; simple (simple block, simple bolus)
- 77333 intermediate (multiple blocks, stents, bite blocks, special bolus)
- 77334 complex (irregular blocks, special shields, compensators, wedges, molds or casts)
- 77336 Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy (Reimbursement is for the global fee)

STEREOTACTIC RADIATION TREATMENT DELIVERY

- 77371 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based
- 77372 linear accelerator based
- 77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

MISCELLANEOUS PROCEDURES

- 77399 Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services

RADIATION TREATMENT DELIVERY

Radiation treatment delivery (77401-77416) recognizes the technical component and the various energy levels. Procedure codes 77401-77417 are for the **TC component only**, no modifier required.

- 77401 Radiation treatment delivery, superficial and/or ortho voltage, per day
- 77402 Radiation treatment delivery,>1 MeV: simple
- 77407 intermediate
- 77412 complex
- 77417 Therapeutic radiology port image(s)
- 77385 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 complex
- 77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed
of radiation therapy

RADIATION TREATMENT MANAGEMENT

Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately.

The professional services furnished during treatment management typically consists of:

- Review of port films;
- Review of dosimetry, dose delivery; and treatment parameters;
- Review of patient treatment set-up;

Examination of patient for medical evaluation and management (eg, assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab results).

- 77427 Radiation treatment management, 5 treatments
- 77431 Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only
(77431 is not to be used to fill in the last week of a long course of therapy)
- 77432 Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
- 77435 Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions
(Do not report 77435 in conjunction with 77427-77432)
- 77470 Special treatment procedure (eg, total body irradiation, hemibody irradiation, per oral or endocavitary irradiation)

(77470 assumes that the procedure is performed 1 or more times during the course of therapy, in addition to daily or weekly patient management)

77499 Unlisted procedure, therapeutic radiology clinical treatment management

PROTON BEAM TREATMENT DELIVERY

Definitions:

Simple proton treatment delivery to a single treatment area utilizing a single non-tangential/oblique port, custom block with compensation (77522) and without compensation (77520).

Intermediate proton treatment delivery to one or more treatment areas utilizing two or more ports or one or more tangential/oblique ports, with custom blocks and compensators.

Complex proton treatment delivery to one or more treatment areas utilizing two or more ports per treatment area with matching or patching fields and/or multiple isocenters, with custom blocks and compensators.

77520 Proton treatment delivery; simple, without compensation

77522 simple, with compensation

77523 intermediate

77525 complex

HYPERTHERMIA

Hyperthermia treatments as listed in this section include external (superficial and deep), interstitial, and intracavitary. Radiation therapy when given concurrently is listed separately. Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy. It may be induced by a variety of sources, (eg, microwave, ultrasound, low energy radio-frequency conduction, or by probes).

The listed treatments include management during the course of therapy and follow-up care for three months after completion. Physics planning and interstitial insertion of temperature sensors, and use of external or interstitial heat generating sources are included.

77600 Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)

77605 deep (ie, heating to depths greater than 4 cm)

77610 Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators

77615 more than 5 interstitial applicators

CLINICAL INTRACAVITARY HYPERTHERMIA

77620 Hyperthermia generated by intracavitary probe(s)

CLINICAL BRACHYTHERAPY

Clinical brachytherapy requires the use of either natural or man-made radioelements applied into or around a treatment field of interest. The supervision of radioelements and dose interpretation are performed solely by the therapeutic radiologist. When a procedure requires the service of a surgeon, see appropriate codes from the Surgery Section Services. Services 77750-77799 include admission to the hospital and daily visits.

Definitions:

(Sources refer to intracavitary placement or permanent interstitial placement; ribbons refer to temporary interstitial placement.)

Simple - application with one to four sources/ribbons

Intermediate - application with five to ten sources/ribbons

Complex - application with greater than ten sources/ribbons

- 77750 Infusion or instillation of radioelement solution (includes 3- month follow-up care)
- 77761 Intracavitary radiation source application; simple
- 77762 intermediate
- 77763 complex
- 77767 Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel
- 77768 lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions
- 77770 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel
- 77771 2-12 channels
- 77772 over 12 channels
- 77778 Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed
- 77789 Surface application of low dose radionuclide source
- 77799 Unlisted procedure, clinical brachytherapy

NUCLEAR MEDICINE

The services listed do not include the provision of radium or other radioelements. Those materials supplied by the provider should be billed separately and identified by the specific code describing the diagnostic radiopharmaceutical(s) and/or the therapeutic radiopharmaceutical(s) which are listed at the end of this section.

DIAGNOSTIC

ENDOCRINE SYSTEM

- 78012 Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
- 78013 Thyroid imaging (including vascular flow, when performed);
- 78014 with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
- 78015 Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)
- 78016 with additional studies (eg, urinary recovery)
- 78018 whole body
- 78020 Thyroid carcinoma metastases uptake

(List separately in addition to primary procedure)

(Use 78020 in conjunction with 78018 only)

- 78070 Parathyroid planar imaging (including subtraction, when performed);
- 78071 with tomographic (SPECT)
- 78075 Adrenal imaging, cortex and/or medulla
- 78099 Unlisted endocrine procedure, diagnostic nuclear medicine

HEMATOPOIETIC, RETICULOENDOTHELIAL AND LYMPHATIC SYSTEM

- 78102 Bone marrow imaging; limited area
- 78103 multiple areas
- 78104 whole body
- 78110 Plasma volume, radio-pharmaceutical volume-dilution technique (separate procedure);
single sampling
- 78111 multiple samplings
- 78120 Red cell volume determination (separate procedure); single sampling
- 78121 multiple samplings
- 78122 Whole blood volume determination, including separate measurement of plasma volume
and red cell volume (radio-pharmaceutical volume-dilution technique)
- 78130 Red cell survival study
- 78135 Differential organ/tissue kinetics, (eg, splenic and/or hepatic sequestration)
- 78185 Spleen imaging only, with or without vascular flow
- 78190 Kinetics, study of platelet survival, with or without differential organ/tissue localization
- 78191 Platelet survival study
- 78195 Lymphatics and lymph nodes imaging
- 78199 Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear
medicine

GASTROINTESTINAL SYSTEM

- 78201 Liver imaging; static only
- 78202 with vascular flow
- 78205 Liver imaging (SPECT)
- 78206 with vascular flow
- 78215 Liver and spleen imaging; static only
- 78216 with vascular flow
- 78226 Hepatobiliary system imaging, including gallbladder when present;
- 78227 with pharmacologic intervention, including quantitative measurement(s) when
performed
- 78230 Salivary gland imaging;
- 78231 with serial images
- 78232 Salivary gland function study
- 78258 Esophageal motility
- 78261 Gastric mucosa imaging
- 78262 Gastroesophageal reflux study

Ordered Ambulatory Procedure Codes

- 78264 Gastric emptying imaging study (eg, solid, liquid or both)
78265 Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit
78266 with small bowel transit and colon transit, multiple days
(Report 78264, 78265, or 78266 only once per imaging study)
78270 Vitamin B-12 absorption study (eg, Schilling test); without intrinsic factor
78271 with intrinsic factor
78272 Vitamin B-12 absorption studies combined, with and without intrinsic factor
78278 Acute gastrointestinal blood loss imaging
78290 Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)
78291 Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt)
78299 Unlisted gastrointestinal procedure, diagnostic nuclear medicine

MUSCULOSKELETAL SYSTEM

- 78300 Bone and/or joint imaging; limited area
78305 multiple areas
78306 whole body
78315 three phase study
78320 tomographic (SPECT)
78350 Bone density (bone mineral content) study; 1 or more sites; single photon absorptiometry
78351 dual photon absorptiometry, 1 or more sites
78399 Unlisted musculoskeletal procedure, diagnostic nuclear medicine

CARDIOVASCULAR SYSTEM

- 78451 Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78452 Multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78453 Planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78454 Planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performer); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78456 Acute venous thrombosis imaging, peptide
78457 Venous thrombosis imaging, venogram; unilateral
78458 bilateral
78466 Myocardial imaging, infarct avid, planar; qualitative or quantitative
78468 with ejection fraction by first pass technique
78469 tomographic SPECT with or without quantification

Ordered Ambulatory Procedure Codes

- 78472 Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing
- 78473 multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification
- 78481 Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
- 78483 multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
- 78494 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing
- 78496 Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique
(Use 78496 in conjunction with 78472)
- 78499 Unlisted cardiovascular procedure, diagnostic nuclear medicine

RESPIRATORY SYSTEM

- 78579 Pulmonary ventilation imaging (eg, aerosol or gas)
- 78580 Pulmonary perfusion imaging (eg, particulate)
- 78582 Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging
- 78597 Quantitative differential pulmonary perfusion, including imaging when performed
- 78598 Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed
(Report 78579, 78580, 78582-78598, only once per imaging session)
(Do not report 78580, 78582-78598 in conjunction with 78451-78454)
- 78599 Unlisted respiratory procedure; diagnostic nuclear medicine

NERVOUS SYSTEM

- 78600 Brain imaging, less than 4 static views;
78601 with vascular flow
- 78605 Brain imaging, minimum 4 static views;
78606 with vascular flow
78607 tomographic (SPECT)
- 78610 Brain imaging, vascular flow only
- 78630 Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography
78635 ventriculography
78645 shunt evaluation
78647 tomographic (SPECT)
- 78650 Cerebrospinal fluid leakage detection and localization
- 78660 Radio-pharmaceutical dacryocystography
- 78699 Unlisted nervous system procedure, diagnostic nuclear medicine

GENITOURINARY SYSTEM

- 78700 Kidney imaging morphology
- 78701 with vascular flow
- 78707 with vascular flow and function, single study without pharmacological intervention
- 78708 single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)
- 78709 multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)
- 78710 tomographic (SPECT)
- 78725 Kidney function study, non-imaging radioisotopic study
- 78730 Urinary bladder residual study
(List separately in addition to primary procedure)
(Use 78730 in conjunction with 78740)
- 78740 Ureteral reflux study (radio-pharmaceutical voiding cystogram)
(Use 78740 in conjunction with 78730 for urinary bladder residual study)
- 78761 Testicular imaging with vascular flow
- 78799 Unlisted genitourinary procedure, diagnostic nuclear medicine

MISCELLANEOUS PROCEDURES

- 78800 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area
- 78801 multiple areas
- 78802 whole body, single day imaging
- 78803 tomographic (SPECT)
- 78804 whole body, requiring two or more days imaging
- 78805 Radiopharmaceutical localization of inflammatory process, limited area
- 78806 whole body
- 78807 tomographic (SPECT)
- 78999 Unlisted miscellaneous procedure, diagnostic nuclear medicine

THERAPEUTIC

- 79005 Radiopharmaceutical therapy, by oral administration
- 79101 by intravenous administration
- 79200 by intracavitary administration
- 79300 by interstitial radioactive colloid administration
- 79403 radiolabeled monoclonal antibody by intravenous infusion
(Do not report 79403 in conjunction with 79101)
- 79440 by intra-articular administration
- 79445 by intra-arterial particulate administration
- 79999 Unlisted radio-pharmaceutical therapeutic procedure

RADIOPHARMACEUTICAL IMAGING AGENTS (Report and Invoice Required)

- A4641 Radiopharmaceutical, diagnostic, not otherwise classified
- A4642 Indium IN-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries
- A9500 Technetium TC-99m sestamibi, diagnostic, per study dose
- A9501 Technetium TC-99m teboroxime, diagnostic, per study dose
- A9502 Technetium TC-99m tetrofosmin, diagnostic, per study dose
- A9503 Technetium TC-99m medronate, diagnostic, per study dose, up to 30 millicuries
- A9504 Technetium TC-99m apcitide, diagnostic, per study dose, up to 20 millicuries
- A9505 Thallium TI-201 thallos chloride, diagnostic, per millicurie
- A9507 Indium IN-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries
- A9508 Iodine I-131 iobenguane sulfate, diagnostic, per 0.5 millicurie
- A9509 Iodine I-123 sodium iodide, diagnostic, per millicurie
- A9510 Technetium Tc-99m disofenin, diagnostic, per study dose, up to 15 millicuries
- A9512 Technetium T-99m pertechnetate, diagnostic, per millicurie
- A9515 Choline C-11, diagnostic, per study dose up to 20 millicuries
- A9516 Iodine I-123 sodium iodide, diagnostic, per 100 microcuries, up to 999 microcuries
- A9517 Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie
- A9520 Technetium Tc-99m tilmanocept, diagnostic, up to 0.5 millicuries
- A9521 Technetium T-99m exametazime, diagnostic, per study dose, up to 25 millicuries
- A9524 Iodine I-131 iodinated serum albumin, diagnostic, per 5 microcuries
- A9526 Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries
- A9527 Iodine I-125, sodium iodide solution, therapeutic, per millicurie
- A9528 Iodine I-131 sodium iodide capsule(s), diagnostic, per millicurie
- A9529 Iodine I-131 sodium iodide solution, diagnostic, per millicurie
- A9530 Iodine I-131 sodium iodide solution, therapeutic, per millicurie
- A9531 Iodine I-131 sodium iodide, diagnostic, per microcurie (up to 100 microcuries)
- A9532 Iodine I-125 serum albumin, diagnostic, per 5 microcuries
- A9536 Technetium Tc-99m depreotide, diagnostic, per study dose, up to 35 millicuries
- A9537 Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 millicuries
- A9538 Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries
- A9539 Technetium Tc-99m pentetate, diagnostic, per study dose, up to 25 millicuries
- A9540 Technetium Tc-99m macroaggregated albumin, diagnostic, per study dose, up to 10 millicuries
- A9541 Technetium Tc-99m sulfur colloid, diagnostic, per study dose, up to 20 millicuries
- A9542 Indium IN-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries
- A9543 Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries
- A9546 Cobalt Co-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie
- A9547 Indium IN-111 oxyquinoline, diagnostic, per 0.5 millicurie
- A9548 Indium IN-111 pentetate, diagnostic, per 0.5 millicurie
- A9550 Technetium Tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie
- A9551 Technetium Tc-99m succimer, diagnostic, per study dose, up to 10 millicuries
- A9552 Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries
- A9553 Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries

Ordered Ambulatory Procedure Codes

A9554	Iodine I-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries
A9555	Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries
A9557	Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries
A9558	Xenon Xe-133 gas, diagnostic, per 10 millicuries
A9559	Cobalt Co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie
A9560	Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries
A9561	Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 millicuries
A9562	Technetium Tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries
A9563	Sodium phosphate P-32, therapeutic, per millicurie
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie
A9566	Technetium Tc-99m fanolesomab, diagnostic, per study dose, up to 25 millicuries
A9567	Technetium Tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 millicuries
A9568	Technetium Tc-99m arcitumomab, diagnosis, per study dose up to 45 millicuries
A9569	Technetium Tc-99m exametazime labeled autologous white blood cells, diagnostic, per study dose
A9570	Indium IN-111 labeled autologous white blood cells, diagnostic, per study dose
A9571	Indium IN-111 labeled autologous platelets, diagnostic, per study dose
A9572	Indium IN-111 pentetretotide, diagnostic, per study dose, up to 6 millicuries
A9580	Sodium fluoride F-18, diagnostic, per study dose, up to 30 millicuries
A9582	Iodine I-123 lobenguane, diagnostic, per study dose, up to 15 millicuries
A9584	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
A9587	Gallium Ga-68, dotatate, diagnostic, 0.1 millicurie
A9588	Fluciclovine F-18, diagnostic, 1 millicurie
A9597	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified
A9598	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries
A9606	Radium Ra-223 dichloride, therapeutic, per microcurie
A9699	Radiopharmaceutical, therapeutic, not otherwise classified

POSITRON EMISSION TOMOGRAPHY (PET)

Maximum reimbursement amounts are for the complete procedure (professional and technical/administrative components) excluding the tracer. **Medicaid will reimburse for the professional/technical administrative component of a PET scan and separate reimbursement will be made for the PET scan tracer.** To receive reimbursement for only the technical/administrative component, see modifier –TC Technical Component.

- 78459 Myocardial imaging, positron emission tomography (PET), metabolic evaluation
- 78491 Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
- 78492 multiple studies at rest and/or stress
- 78608 Brain imaging, positron emission tomography (PET); metabolic evaluation
- 78609 perfusion evaluation
- 78811 Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)
- 78812 skull base to mid-thigh
- 78813 whole body
- 78814 Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)
- 78815 skull base to mid-thigh
- 78816 whole body

MEDICINE SERVICES

IMMUNIZATIONS

Immunization procedures include the supply of material and administration.

For dates of service on or after 7/1/03 when immunization materials are supplied by the Vaccine for Children Program (VFC), bill using the procedure code that represents the immunization(s) administered and append modifier –SL State Supplied Vaccine to receive the VFC administration fee. See Modifier –SL for further information.

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the estimated acquisition cost of the antigen. Insert actual acquisition cost per dose in amount charged field on claim form. For codes listed **BR** in the Fee Schedule, also attach an itemized invoice to claim form including the dose administered.

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. Multiple codes for a particular vaccine are provided in CPT when the schedule (number of doses or timing) differs for two or more products of the same vaccine type (eg, hepatitis A, Hib) or the vaccine product is available in more than one chemical formulation, dosage, or route of administration.

Reimbursement for drugs (including vaccines and immune globulins) furnished by provider to their patients is based on the acquisition cost to the provider of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the provider 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 provider. Regardless of whether an invoice must be submitted to Medicaid for payment, the provider 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.

-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 Vaccine for Children Program.)

IMMUNE GLOBULINS

Codes 90291-90399 identify the immune globulin product only and are reported in addition to the administration codes 96365-96368 as appropriate.

- 90291 Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
- 90371 Hepatitis B immune globulin (HBIG), human, for intramuscular use
- 90375 Rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous use
- 90376 Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use
- 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
- 90389 Tetanus immune globulin (TIG), human, for intramuscular use
- 90393 Vaccinia immune globulin, human, for intramuscular use
- 90396 Varicella-zoster immune globulin, human, for intramuscular use
- 90399 Unlisted immune globulin

IMMUNIZATION ADMINISTRATION FOR VACCINES/TOXOIDS

- 90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered)
- 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
- 90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure))
- 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
- 90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure))

VACCINES/TOXOIDS

For administration of vaccines supplied by VFC, including influenza and pneumococcal administration, providers will be required to bill vaccine administration code 90460. Providers **must continue to bill the specific vaccine code with the “SL”** modifier on the claim (payment for “SL” will be \$0.00). If an administration code is billed without a vaccine code with “SL”, the claim will be denied. For reimbursement purposes, the administration of the components of a combination vaccine will continue to be considered as one vaccine administration. More than one vaccine administration is reimbursable under 90460 on a single date of service.

- 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

Ordered Ambulatory Procedure Codes

- 90620 Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular use
- 90621 Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use
- 90632 Hepatitis A vaccine, adult dosage, for intramuscular use
- 90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
- 90636 Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
- 90647 Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
- 90648 Hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
- 90649 Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent) 3 dose schedule, for intramuscular use
- 90650 Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
- 90651 Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule for intramuscular use
- 90654 Influenza virus vaccine, trivalent (IIV3) split virus, preservative-free, for intradermal use
- 90655 Influenza virus vaccine, trivalent, split virus, preservative-free, 0.25 mL dosage, for intramuscular use
- 90656 Influenza virus vaccine, trivalent, split virus, preservative-free, 0.5 mL dosage, for intramuscular use
- 90657 Influenza virus vaccine, trivalent, split virus, 0.25 mL dosage, for intramuscular use
- 90658 Influenza virus vaccine, trivalent, split virus, 0.5 mL dosage, for intramuscular use
- 90660 Influenza virus vaccine, trivalent, live, for intranasal use
- 90661 Influenza virus vaccine, trivalent (cclIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
- 90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- 90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
- 90673 Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
- 90674 Influenza virus vaccine; quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
- 90675 Rabies vaccine, for intramuscular use
- 90676 Rabies vaccine, for intradermal use
- 90680 Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
- 90681 Rotavirus vaccine human, attenuated, 2 dose schedule, live, for oral use
- 90685 Influenza virus vaccine, quadrivalent, split virus, preservative free, 0.25 mL dosage, for intramuscular use
- 90686 Influenza virus vaccine, quadrivalent, split virus, preservative free, 0.5 mL dosage, for intramuscular use
- 90688 Influenza virus vaccine, quadrivalent, split virus, 0.5 mL dosage, for intramuscular use
- 90690 Typhoid vaccine, live, oral
- 90691 Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use

Ordered Ambulatory Procedure Codes

- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DtaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
- 90698 Diphtheria, tetanus toxoids, acellular vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DtaP – Hib – IPV), for intramuscular use
- 90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
- 90702 Diphtheria and tetanus toxoids (DT) absorbed when administered to individuals younger than 7 years, for intramuscular use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
- 90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
- 90713 Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
- 90714 Tetanus and diphtheria toxoids (Td) absorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
- 90716 Varicella virus vaccine, live, for subcutaneous use
- 90717 Yellow fever vaccine, live, for subcutaneous use
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
- 90733 Meningococcal polysaccharide vaccine (any group[s]), for subcutaneous use
- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (quadrivalent) (MCV4 or MenACWY) for intramuscular use
- 90736 Zoster (shingles) vaccine, live, for subcutaneous injection
- 90738 Japanese encephalitis virus vaccine, inactivated, for intramuscular use
- 90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
- 90743 Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
- 90744 Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
- 90746 adult dosage (3 dose schedule), for intramuscular use
- 90747 dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
- 90748 Hepatitis B and Hemophilus influenza B vaccine (HepB –Hib), for intramuscular use
- 90749 Unlisted vaccine/toxoid

MISCELLANEOUS DRUGS AND SOLUTIONS

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 (including vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the provider of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the provider 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 provider. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

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

J0129	Abatacept, 10 mg, (not for self-administered)
J0180	Agalsidase beta, 1 mg
J0202	Alemtuzumab, 1 mg
J0207	Amifostine, 500 mg
J0215	Alefacept (Amevive), 0.5 mg
J0221	Alglucosidase alfa, (lumizyme), 10 mg
J0256	Alpha 1proteinase inhibitor (human), not otherwise specified, 10 mg
J0401	Aripiprazole, extended release, 1 mg
J0456	Azithromycin, 500 mg
J0585	Onabotulinumtoxina, 1 unit
J0586	Abobotulinumtoxina, 5 units
J0587	Rimabotulinumtoxinb, 100 units
J0598	C1 esterase inhibitor (human), cinryze, 10 units
J0640	Leucovorin calcium, 50 mg
J0641	Levoleucovorin calcium, 0.5 mg
J0696	Ceftriaxone sodium, per 250 mg
J0697	Sterile cefuroxime sodium, per 750 mg
J0712	Ceftaroline fosamil, 10 mg
J0717	Certolizumab pegol, 1 mg (must be administered under direct physician supervision, not for self-administration)
J0740	Cidofovir, 375 mg
J0795	Corticotropin ovine triflutate, 1 mcg
J0875	Dalbavancin, 5 mg
J0878	Daptomycin, 1 mg
J0881	Darbepoetin alfa, 1 mcg (non-ESRD use)
J0882	Darbepoetin alfa, 1 mcg (for ESRD on dialysis)
J0885	Epoetin alfa, (non-ESRD use), 1000 units
J0897	Denosumab, 1 mg
J1050	Medroxyprogesterone acetate, 1 mg (J1050 Should not be billed in addition to the all-inclusive clinic rate)
J1100	Dexamethasone sodium phosphate, 1 mg
J1190	Dexrazoxane HCl, per 250 mg
J1260	Dolasetron mesylate, 10 mg
J1300	Eculizumab, 10 mg
J1436	Etidronate disodium, per 300 mg

Ordered Ambulatory Procedure Codes

J1438	Etanercept, 25 mg, (not for self-administration)
J1442	Filgrastim (g-csf), excludes biosimilars, 1 microgram
J1447	Tbo-filgrastim, 1 microgram
J1450	Fluconazole, 200 mg
J1452	Fomivirsen sodium, intraocular, 1.65 mg
J1453	Fosaprepitant, 1 mg
J1458	Galsulfase, 1 mg
J1459	Immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1460	Gamma globulin, intramuscular, 1 cc
J1556	Immune globulin Bivigam, 500 mg
J1557	Immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1560	Gamma globulin, intramuscular, over 10 cc
J1561	Immune globulin, (gamunex-C/gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562	Immune globulin (Vivaglobin), 100 mg
J1566	Immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg
J1568	Immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1569	Immune globulin, (gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg
J1570	Ganciclovir sodium, 500 mg
J1572	Immune globulin, (flebogamma/flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1575	Immune Globulin/Hyaluronidase (HYQVIA), 100 mg
J1595	Glatiramer acetate, 20 mg
J1599	Immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg
J1626	Granisetron HCl, 100 mcg
J1631	Haloperidol decanoate, per 50 mg
J1640	Hemin, 1 mg
J1652	Fondaparinux sodium, 0.5 mg
J1655	Tinzaparin sodium, 1000 IU
J1725	Hydroxyprogesterone caproate, 1 mg
J1740	Ibandronate sodium, 1 mg
J1741	Ibuprofen, 100 mg
J1743	Idursulfase, 1 mg
J1745	Infliximab (Remicade), 10 mg
J1750	Iron dextran, 50 mg
J1786	Imiglucerase, 10 units
J1826	Interferon beta-1a, 30 mcg
J1830	Interferon beta-1b, 0.25 mg (not for self-administration)
J1930	Lanreotide, 1 mg
J1942	Aripiprazole lauroxil, 1 mg
J1950	Leuprolide acetate (for depot suspension), per 3.75 mg
J2182	Mepolizumab, 1 mg
J2323	Natalizumab, 1 mg
J2353	Octreotide, depot form for intramuscular injection, 1 mg
J2355	Oprelvekin, 5 mg
J2358	Olanzapine, long-acting, 1 mg

Ordered Ambulatory Procedure Codes

J2405	Ondansetron HCl, per 1 mg
J2407	Oritavancin, 10 mg
J2425	Palifermin, 50 mcg
J2426	Paliperidone palmitate extended release, 1 mg
J2430	Pamidronate disodium, per 30
J2469	Palonosetron HCl (Aloxi), 25 mcg
J2502	Pasireotide long acting, 1mg
J2504	Pegademase bovine, 25 IU
J2505	Pegfilgrastim (Neulasta), 6 mg
J2513	Pentastarch, 10% solution, 100 ml
J2545	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg
J2562	Plerixafor, 1 mg
J2597	Desmopressin acetate, per 1 mcg
J2680	Fluphenazine decanoate, up to 25 mg
J2770	Quinupristin/dalfopristin, 500 mg (150/350)
J2783	Rasburicase, 0.5 mg
J2786	Reslizumab, 1 mg
J2793	Rilonacept, 1 mg
J2794	Risperidone, long acting, 0.5 mg
J2796	Romiplostim, 10 micrograms
J2840	Sebelipase alfa, 1 mg
J2860	Siltuximab, 10 mg
J2997	Alteplase recombinant, 1 mg
J3090	Tedizolid phosphate, 1 mg
J3110	Teriparatide, 10 mcg
J3240	Thyrotropin alpha (Thyrogen), 0.9 mg., provided in 1.1 mg vial
J3285	Treprostinil, 1 mg
J3305	Trimetrexate glucuronate, per 25 mg
J3380	Vedolizumab, 1 mg
J3385	Velaglucerase alfa, 100 units
J3472	Hyaluronidase, ovine, preservative free, per 1000 USP units
J3490	Unclassified drugs
J3590	Unclassified biologics
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
J7121	5% Dextrose in lactated ringers infusion, up to 1000 cc
J7131	Hypertonic saline solution, 1 ml

Ordered Ambulatory Procedure Codes

J7175	Factor X, (human), 1 IU
J7179	von Willebrand factor (recombinant), (vonvendi), 1IU
J7180	Factor XIII (antihemophilic factor, human), 1 i.u.
J7181	Factor XIII a-subunit,(recombinant),per iu
J7182	Factor VIII,(antihemophilic factor; recombinant),(novoeight),per iu
J7186	Antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII IU
J7187	Von Willebrand Factor Complex (Humate-P) per IU VWF: RCO
J7188	Factor VIII (antihemophilic factor, recombinant), (obizur) per i.u
J7189	Factor VIIA (antihemophilic factor, recombinant), per 1 microgram
J7190	Factor VIII antihemophilic factor; human, per IU
J7191	Factor VIII, antihemophilic factor (porcine), per IU
J7192	Factor VIII (antihemophilic factor; recombinant), per IU,not otherwise specified
J7193	Factor IX (antihemophilic factor; purified, non-recombinant), per IU
J7194	Factor IX, complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant), per IU, not otherwise specified
J7197	Antithrombin III (human), per IU
J7198	Anti-inhibitor, per IU
J7199	Hemophilia clotting factor; not otherwise classified
J7200	Factor IX,(antihemophilic factor; recombinant), rixubis, per iu
J7201	Factor IX, fc fusion protein (recombinant),per iu
J7202	Factor IX, albumin fusion protein, (recombinant), idelvion, 1 IU
J7205	Factor VIII Fc fusion protein (recombinant), per iu
J7207	Factor VIII, (antihemophilic factor, recombinant), pegylated, 1 IU
J7209	Factor VIII, (antihemophilic factor, recombinant), (nuwiq), 1 IU
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
J7310	Ganciclovir, 4.5 mg, long-acting implant
J7311	Fluocinolone acetonide, intravitreal implant
J7313	Fluocinolone acetonide, intravitreal implant, 0.01 mg
J7501	Azathioprine, parenteral, 100 mg
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg
J7505	Muromonab-CD3, parenteral, 5 mg
J7999	Compounded drug, not otherwise classified
J8498	Antiemetic drug, rectal/suppository, not otherwise specified
J8501	Aprepitant, oral, 5 mg
J8540	Dexamethasone, oral, 0.25 mg
J8597	Antiemetic drug, oral, not otherwise specified
J8650	Nabilone, oral, 1 mg
J9226	Histrelin implant (Supprelin LA), 50 mg
S0190	Mifepristone, oral, 200 mg

- S0191 (when administered for medically necessary non-surgical abortion)
Misoprostol, oral, 200 mg
- S9435^ (when administered for medically necessary non-surgical abortion)
Medical foods for inborn errors of metabolism
(Reimbursement limited to Inborn Metabolic Disease Centers or Medical Directors of Inborn Metabolic Disease Centers)

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

HYDRATION

- 96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour
(Do not report 96360 if performed as a concurrent infusion service)
(Do not report intravenous infusion for hydration of 30 minutes or less)
- 96361 each additional hour
(List separately in addition to primary procedure)
(Use 96361 in conjunction with 96360)
(Report 96361 for hydration infusion intervals of greater than 30 minutes beyond 1 hour increments)
(Report 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service [96360, 96409, 96413] is administered through the same IV access)

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

- 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
- 96366 each additional hour
(List separately in addition to primary procedure)
(Report 96366 in conjunction with 96365, 96367)
(Report 96366 for additional hour(s) of sequential infusion)
(Report 96366 for infusion intervals of greater than 30 minutes beyond 1 hour increments)
- 96367 additional sequential infusion of a new drug/substance, up to 1 hour
(List separately in addition to primary procedure)
- 96368 concurrent infusion
(List separately in addition to primary procedure)
(Report 96368 only once per encounter)
(Report 96368 in conjunction with 96365, 96366, 96413, 96415, 96416)

- 96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
- 96370 each additional hour
(List separately in addition to primary procedure)
(Use 96370 in conjunction with 96369)
(Use 96370 for infusion intervals of greater than 30 minutes beyond one hour increments)
- 96371 additional pump set-up with establishment of new subcutaneous infusion site(s)
(List separately in addition to primary procedure)
(Use 96371 in conjunction with 96369)
(Use 96369, 96371 only once per encounter)
- 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

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

Intravenous chemotherapy injections are administered by a physician, a nurse practitioner or by a qualified assistant under supervision of the physician or nurse practitioner.

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

- 96405 Chemotherapy administration; intralesional, up to and including 7 lesions
- 96406 intralesional, more than 7 lesions
- 96409 intravenous; push technique, single or initial substance/drug
- 96413 infusion technique, up to one hour, single or initial substance/drug
- 96415 each additional hour
(List separately in addition to primary procedure)
(Use 96415 in conjunction with 96413)
Report 96415 for infusion intervals of greater than 30 minutes beyond 1-hour increments)
- 96416 initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump

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

- 96420 Chemotherapy administration, intra-arterial; push technique
- 96422 infusion technique, up to 1 hour
- 96423 infusion technique, each additional hour
(List separately in addition to primary procedure)
(Report 96423 for infusion intervals of greater than 30 minutes beyond 1-hour increments)
- 96425 infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

OTHER INJECTION AND INFUSION SERVICES

Ordered Ambulatory Procedure Codes

96521	Refilling and maintenance of portable pump
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
96549	Unlisted chemotherapy procedure
J9999	Not otherwise classified, antineoplastic drugs

CHEMOTHERAPY DRUGS

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

NOTE: The maximum fees for these drugs are adjusted periodically by the State to reflect the current 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 furnished by providers to their patients is based on the acquisition cost to the provider of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the provider 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 provider. Regardless of whether an invoice must be submitted to Medicaid for payment, the provider is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

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

J9000	Doxorubicin HCl (Adriamycin), 10 mg
J9015	Aldesleukin, per single use vial
J9017	Arsenic trioxide (Trisenox), 1 mg
J9020	Asparaginase (Elspar) 10,000 Units
J9025	Azacitidine, 1 mg
J9027	Clofarabine, 1 mg
J9031	BCG live (Intravesical), per installation
J9032	Belinostat, 10 mg (BR)
J9033	Bendamustine HCL (Treanda), 1 mg
J9034	Bendamustine HCL (Bendeka), 1 mg
J9035	Bevacizumab, 10 mg
J9039	Blinatumomab, 1 microgram
J9040	Bleomycin sulfate (Lenoxane), 15 units
J9041	Bortezomib, 0.1 mg
J9042	Injection, brentuximab vedotin, 1 mg
J9043	Cabazitaxel, 1 mg
J9045	Carboplatin, 50 mg

Ordered Ambulatory Procedure Codes

J9047	Carfilzomib, 1 mg
J9050	Carmustine, 100 mg
J9055	Cetuximab, 10 mg
J9060	Cisplatin, powder or solution, per 10 mg
J9065	Cladribine, per 1 mg
J9070	Cyclophosphamide, 100 mg
J9098	Cytarabine liposome, 10 mg
J9120	Dactinomycin (Cosmegen), 0.5 mg
J9130	Dacarbazine, 100 mg
J9145	Daratumumab, 10 mg
J9150	Daunorubicin HCl, 10 mg
J9151	Daunorubicin citrate, liposomal formulation, 10 mg
J9155	Degarelix, 1 mg
J9160	Denileukin diftitox, 300 mcg
J9165	Diethylstilbestrol diphosphate, 250 mg
J9171	Docetaxel, 1 mg
J9175	Elliotts' B solution, 1 ml
J9176	Elotuzumab, 1 mg
J9178	Epirubicin HCl, 2 mg
J9179	Eribulin mesylate, 0.1 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
J9205	Irinotecan liposome, 1 mg
J9206	Irinotecan, 20 mg
J9207	Ixabepilone, 1 mg
J9208	Ifosfomide, 1 g
J9209	Mesna, 200 mg
J9211	Idarubicin HCl, 5 mg
J9212	Interferon alfacon-1, recombinant, 1 mcg
J9213	Interferon, alfa-2A, recombinant, 3 million units
J9214	Interferon, alfa-2B, recombinant, 1 million units
J9215	Interferon, alfa-N3, (human leukocyte derived), 250,000 IU
J9216	Interferon, gamma-1B, 3 million units
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219^	Leuprolide acetate implant, 65 mg
J9225	Histrelin implant (Vantas), 50 mg
J9228	Ipilimumab, 1 mg
J9230	Mechlorethamine HCl, (Nitrogen Mustard), 10 mg
J9245	Melphalan HCl, 50 mg

Ordered Ambulatory Procedure Codes

J9250	Methotrexate sodium, 5 mg
J9260	Methotrexate sodium, 50 mg
J9261	Nelarabine, 50 mg
J9262	Omacetaxine mepesuccinate, 0.01 mg
J9263	Oxaliplatin (Eloxatin), 0.5 mg
J9264	Paclitaxel protein-bound particles, 1 mg
J9265	Paclitaxel, 30 mg
J9266	Pegaspargase, per single dose vial
J9267	Paclitaxel, 1mg
J9268	Pentostatin, per 10 mg
J9270	Plicamycin, 2.5 mg
J9271	Pembrolizumab, 1 mg
J9280	Mitomycin, 5 mg
J9293	Mitoxantrone HCl, per 5 mg
J9295	Necitumumab, 1 mg
J9299	Nivolumab, 1 mg
J9300	Gemtuzumab ozogamicin, 5 mg
J9301	Obinutuzumab, 10 mg
J9302	Ofatumumab, 10 mg
J9303	Panitumumab, 10 mg
J9305	Pemetrexed, 10 mg
J9306	Pertuzumab (Perjeta) 1 mg
J9307	Pralatrexate, 1 mg
J9308	Ramucirumab, 5 mg
J9310	Rituximab, 100 mg
J9315	Topotecan, 0.1 mg
J9320	Streptozocin, 1 g
J9325	Talimogene laherparpvec, per 1 million plaque forming units
J9328	Temozolomide, 1 mg
J9330	Temsirolimus, 1 mg
J9340	Thiotepa, 15 mg
J9351	Topotecan, 0.1 mg
J9352	Trabectedin, 0.1 mg
J9354	Ado-trastuzuman emtansine (Kadcyla) 1 mg
J9355	Trastuzumab, 10 mg
J9357	Valrubicin, intravesical, 200 mg
J9360	Vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg
J9371	Vincristine sulfate liposome (Marqibo), 1 mg
J9390	Vinorelbine tartrate, 10 mg
J9395	Fulvestrant, 25 mg
J9400	Ziv-aflibercept (Zaltrap), 1 mg
J9600	Porfimer sodium, 75 mg
J9999	Not Otherwise Classified, Antineoplastic Drugs
Q2017	Teniposide, 50 mg

- Q2043 Sipuleucel-t (Provenge) minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion
- Q2050 Doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg

GASTROENTEROLOGY

- 91010 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;
- 91013 with stimulation or perfusion (eg, stimulant, acid or alkali perfusion)
(List separately in addition to primary procedure)
- 91020 Gastric motility (manometric) studies
- 91022 Duodenal motility (manometric) study
- 91030 Esophagus, acid perfusion (Bernstein) test for esophagitis
- 91034 Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
- 91035 Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation
(91034, 91035 are for patients with esophageal reflux who have already undergone endoscopy and manometry/motility studies, or for those patients who are unable to undergo conventional tests or in whom conventional tests have proven inconclusive. These test are not covered for screening for Barrett's Esophagus)
- 91037 Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;
- 91038 prolonged (greater than 1 hour, up to 24 hours)
- 91040 Esophageal balloon distension provocation study
- 91065 Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)
- 91110 Gastrointestinal track imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report
- 91120 Rectal sensation, tone, and compliance test (ie., response to graded balloon distention)
- 91122 Anorectal manometry
- 91200 Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report
- 91299 Unlisted diagnostic gastroenterology procedure

OPHTHALMOLOGY

GENERAL OPHTHALMOLOGICAL SERVICES

- 92002 Ophthalmological services, medical examination, and evaluation with initiation of diagnostic and treatment program; intermediate, new patient (with/without refraction)
- 92004 comprehensive, new patient, 1 or more visits (with/without refraction)
- 92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient (with/without refraction)
- 92014 comprehensive, established patient, 1 or more visits (with/without refraction)

SPECIAL OPHTHALMOLOGICAL SERVICES

- 92020 Gonioscopy (separate procedure)
- 92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report (Do not report 92025 in conjunction with 65710-65771)
- 92060 Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
- 92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
- 92082 intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
- 92083 extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
(Gross visual field testing (eg, confrontation testing) is a part of general ophthalmological services and is not reported separately.)
- 92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
- 92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
- 92134 retina
- 92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation (one or both eyes)

OPHTHALMOSCOPY

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated. It is a non-itemized service and is not reported separately.

- 92225 Ophthalmoscopy, extended, with retinal drawing, (eg, for retinal detachment, melanoma), with interpretation and report; initial
- 92226 subsequent
- 92230 Fluorescein angiography with interpretation and report
- 92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
- 92240 Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
- 92242 Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral
- 92250 Fundus photography with interpretation and report (one or both eyes)
- 92260 Ophthalmodynamometry (one or both eyes)

MISCELLANEOUS SPECIALIZED SERVICES

- 92265 Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report
- 92270 Electro-oculography with interpretation and report
- 92275 Electroretinography with interpretation and report
- 92286 Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis
- 92287 with fluorescein angiography

OTORHINOLARYNGOLOGIC & VESTIBULAR SERVICES

- 92533 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
- 92537 Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)
- 92538 monothermal (ie, one irrigation in each ear for a total of two irrigations)
- 92540 Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording
- 92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
- 92542 Positional nystagmus test, minimum of 4 positions, with recording
- 92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
- 92545 Oscillating tracking test, with recording
- 92546 Sinusoidal vertical axis rotational testing

AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION

- 92550 Tympanometry and reflex threshold measurements
- 92551 Screening test, pure tone, air only
- 92552 Pure tone audiometry (threshold); air only
- 92553 air and bone
- 92555 Speech audiometry threshold;
- 92556 with speech recognition
- 92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
- 92561 diagnostic
- 92563 Tone decay test
- 92564 Short increment sensitivity index (SISI)
- 92565 Stenger test, pure tone
- 92567 Tympanometry (impedance testing)
- 92568 Acoustic reflex testing; threshold
- 92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
- 92571 Filtered speech test
- 92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
- 92586 limited

Ordered Ambulatory Procedure Codes

- 92587 Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
- 92588 comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
- 92601 Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
- 92602 subsequent reprogramming
- 92603 Diagnostic analysis of cochlear implant, age 7 years or older; with programming
- 92604 subsequent reprogramming

CARDIOVASCULAR

CARDIOGRAPHY

- 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
- 93005 tracing only, without interpretation and report
- 93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report
- 93017 supervision only without interpretation and report
- 93024 Ergonovine provocation test
- 93025 Microvolt T-wave alternans for assessment of ventricular arrhythmias
- 93040 Rhythm ECG, one to three leads; with interpretation and report
- 93224 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional
- 93225 recording (includes connection, recording, and disconnection)
- 93268 External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional
- 93270 recording (includes connection, recording, and disconnection)
- 93271 transmission download and analysis
- 93278 Signal-averaged electrocardiography (SAECG), with or without ECG

CARDIOVASCULAR DEVICE MONITORING-IMPLANTABLE AND WEARABLE DEVICES

- 93279 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system
- 93280 dual lead pacemaker system
- 93281 multiple lead pacemaker system
- 93282 single lead transvenous implantable defibrillator system

Ordered Ambulatory Procedure Codes

- 93283 dual lead transvenous implantable defibrillator system
- 93284 multiple lead transvenous implantable defibrillator system
- 93260 implantable subcutaneous lead defibrillator system
- 93285 implantable loop recorder system
- 93288 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system
- 93289 single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements
(For monitoring physiologic cardiovascular data elements derived from an ICD, use 93290)
- 93261 implantable subcutaneous lead defibrillator system
- 93290 implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors
(For heart rhythm derived data elements, use 93289)
- 93291 implantable loop recorder system, including heart rhythm derived data analysis
- 93292 wearable defibrillator system
- 93293 Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days
(Report 93293 only once per 90 days)
- 93294 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
(Report 93294 only once per 90 days)
- 93295 single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
(Report 93295 only once per 90 days)
- 93297 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified
(Report 93297 only once per 30 days)
- 93298 implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional

(Report 93298 only once per 90 days)

ECHOCARDIOGRAPHY

For procedure codes 93303-93350, See Radiology Section General Instructions and General Information and Rules. When more than one of these procedures are performed during the same visit, reimbursement shall be limited to the greater fee plus 60% of the lesser fee(s).

(Echocardiography includes obtaining ultrasonic signals from the heart and great arteries, with two-dimensional image and/or Doppler ultrasonic signal documentation, and interpretation and report. When technical component is performed separately, use Modifier –TC.)

- 93303 Transthoracic echocardiography for congenital cardiac anomalies; complete
- 93304 follow-up or limited study
- 93306 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography
- 93307 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
- 93308 follow-up or limited study
- 93312 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
- 93314 image acquisition, interpretation and report only
- 93315 Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
- 93317 image acquisition, interpretation and report only
- 93318 Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
- 93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete
- 93321 follow-up or limited study
(Use 93320, 93321 separately in addition to codes for echocardiographic imaging 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350)
- 93325 Doppler echocardiography color flow velocity mapping
(List separately in addition to codes for echocardiography)
- 93350 Echocardiography, transthoracic, real-time with image documentation (2D, with or without M-mode recording), during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
(The appropriate stress test code from the 93015-93017 series should be reported in addition to 93350 to capture the exercise stress portion of the study.)
- 93351 including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional
(Do not report 93351 in conjunction with 93015-93017, 93350)

MISCELLANEOUS VASCULAR STUDIES

- 93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)
- 93562 subsequent measurement of cardiac output
- 93644 Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for

- arrhythmia, termination, and programming or reprogramming of sensing or therapeutic parameters)
- 93660 Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention
- 93701 Bioimpedance-derived physiologic cardiovascular analysis
- 93724 Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)
- 93740 Temperature gradient studies
- 93750 Interrogation of ventricular assist device (vad), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and
- 93770 Determination of venous pressure
- 93784 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis; interpretation and report
- 93786 recording only
- 93797 Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ecg monitoring (per session)
- 93798 with continuous ECG monitoring (per session)

NON INVASIVE VASCULAR DIAGNOSTIC STUDIES

For procedure codes 93880- 93990, see Radiology Section General Instructions and General Information and Rules.

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided. The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported.

Duplex scan: An ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

CEREBROVASCULAR ARTERIAL STUDIES

- 93880 Duplex scan of extracranial arteries; complete bilateral study
- 93882 unilateral or limited study
- 93886 Transcranial Doppler study of the intracranial arteries; complete study
- 93888 limited study
- 93890 vasoreactivity study
- 93892 emboli detection without intravenous microbubble injection
- 93893 emboli detection with intravenous microbubble injection

93998 Unlisted noninvasive vascular diagnostic study

EXTREMITY ARTERIAL STUDIES (INCLUDING DIGITS)

- 93922 Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurements 1-2 levels)
- 93923 Complete bilateral non-invasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)
- 93924 Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study
(Do not report 93924 in conjunction with 93922, 93923)
- 93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
- 93926 unilateral or limited study
- 93930 Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
- 93931 unilateral or limited study

EXTREMITY VEIN STUDIES (INCLUDING DIGITS)

- 93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
- 93971 unilateral or limited study

VISCERAL AND PENILE VASCULAR STUDIES

- 93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
- 93976 limited study
- 93978 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
- 93979 unilateral or limited study
- 93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study

- 93981 follow-up or limited study
- 93982 Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report

EXTREMITY ARTERIAL VENOUS STUDIES

- 93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

PULMONARY

Codes 94010-94770 include laboratory procedure(s), interpretation and physician's services (except surgical and anesthesia services), unless otherwise stated.

- 94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- 94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
- 94012 Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age
- 94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV] in an infant or child through 2 years of age
- 94014 Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional
- 94015 recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)
- 94060 Bronchodilation responsiveness, spirometry as in 94010, pre-and post-bronchodilator administration
- 94070 Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg., antigen(s), cold air, methacholine)
- 94150 Vital capacity, total (separate procedure)
- 94200 Maximum breathing capacity, maximal voluntary ventilation
- 94250 Expired gas collection, quantitative, single procedure (separate procedure)
- 94375 Respiratory flow volume loop
- 94620 Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)
- 94621 complex (including measurements of CO₂ production, O₂ uptake, and electrocardiographic recordings)
- 94640 Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)
- 94642 Aerosol inhalation of pentamidine for pneumocystis pneumonia treatment or prophylaxis

Ordered Ambulatory Procedure Codes

- 94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (Report 94664 one time only per day of service)
- 94680 Oxygen uptake, expired gas analysis; rest and exercise, direct, simple
94681 including CO₂ output, percentage oxygen extracted
94690 rest, indirect (separate procedure)
- 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance
(Do not report 94726 in conjunction with 94727, 94728)
- 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes
(Do not report 94727 in conjunction with 94726)
- 94728 Airway resistance by impulse oscillometry
(Do not report 94728 in conjunction with 94010, 94060, 94070, 94375, 94726)
- 94729 Diffusing capacity (eg, carbon monoxide, membrane)
(List separately in addition to primary procedure)
(Report 94729 in conjunction with 94010, 94060, 94070, 94375, 94726-94728)
- 94750 Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)
- 94770 Carbon dioxide, expired gas determination by infrared analyzer

ALLERGY AND CLINICAL IMMUNOLOGY

ALLERGY SENSITIVITY TESTS: the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the same number of sensitivity tests. Maximum fees include observation and interpretation of the tests by an allergist.

ALLERGY TESTING

- 95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
(**Note:** Must bill with paper claim on tests over 60. Report total number of tests on your documentation. Calculate total amount due as follows: full fee listed in Fee Schedule for each test up to 60 tests and 50% of the fee listed for each test over 60 tests).
- 95024 Intracutaneous (intra-dermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
- 95028 Intracutaneous (intra-dermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
- 95060 Ophthalmic mucous membrane tests
- 95065 Direct nasal mucous membrane test

ALLERGEN IMMUNOTHERAPY

- 95165 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

SENSITIVITY TESTING

- 86485 Skin test; candida

86486	unlisted antigen, each
86490	coccidioidomycosis
86510	histoplasmosis
86580	tuberculosis, intradermal

NEUROLOGY AND NEUROMUSCULAR PROCEDURES

ROUTINE ELECTROENCEPHALOGRAPHY (EEG)

EEG codes 95812-95822 include hyperventilation and/or photic stimulation when appropriate. Routine EEG codes 95816-95822 include 20-40 minutes of recording. Extended EEG codes 95812-95813 include reporting times longer than 40 minutes.

95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813	greater than 1 hour
95816	Electroencephalogram (EEG); including recording awake and drowsy
95819	including recording awake and asleep
95822	recording in coma or sleep only
95827	all night recording
95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (eeg) recording

NERVE CONDUCTION TESTS

95907	Nerve conduction studies; 1-2 studies
95908	3-4 studies
95909	5-6 studies
95910	7-8 studies
95911	9-10 studies
95912	11-12 studies
95913	13 or more studies

MUSCLE AND RANGE OF MOTION TESTING

95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95832	hand, with or without comparison with normal side
95833	total evaluation of body, excluding hands
95834	total evaluation of body, including hands
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
95852	hand, with or without comparison with normal side
95857	Cholinesterase inhibitor challenge test for myasthenia gravis
95860	Needle electromyography; one extremity with or without related paraspinal areas
95861	two extremities with or without related paraspinal areas
95863	three extremities with or without related paraspinal areas
95864	four extremities with or without related paraspinal areas

Ordered Ambulatory Procedure Codes

- 95865 larynx
- 95866 hemidiaphragm
- 95867 cranial nerve supplied muscle(s); unilateral
- 95868 bilateral
- 95869 thoracic paraspinal muscles (excluding T1 or T2)
- 95870 limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters
- 95872 Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied
- 95875 Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)
- 95885 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited
(List separately in addition to primary procedure)
- 95886 complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels
(List separately in addition to primary procedure)
- 95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study
(List separately in addition to primary procedure)

NERVE CONDUCTION TESTS

- 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report

AUTONOMIC FUNCTION TESTS

- 95921 Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval Valsalva ratio, and 30:15 ratio
- 95922 vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt
- 95923 sudomotor, including one or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential

EVOKE POTENTIALS AND REFLEX TESTS

- 95925 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
- 95926 in lower limbs
- 95938 in upper and lower limbs
- 95927 in the trunk or head
- 95928 Central motor evoked potential study (transcranial motor stimulation); upper limbs

- 95929 lower limbs
- 95939 in upper and lower limbs
- 95930 Visual evoked potential (VEP) testing central nervous system, checkerboard or flash
- 95933 Orbicularis oculi (blink) reflex, by electrodiagnostic testing
- 95937 Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

SPECIAL EEG TESTS

- 95950 Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours
- 95951 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation, (eg, for presurgical localization), each 24 hours

NEUROSTIMULATORS, ANALYSIS-PROGRAMMING

- 95980 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming
- 95981 subsequent, without reprogramming
- 95982 subsequent, with reprogramming

OTHER PROCEDURES

- 95990 Refilling and maintenance on implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed

MOTION ANALYSIS

- 96002 Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
- 96003 Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle (Do not report 96002, 96003 in conjunction with 95860-95864, 95869-95872)

FUNCTIONAL BRAIN MAPPING

- 96020 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional (**Report required**)
(Do not report 96020 in conjunction with 96101, 96116-96118)
(Evaluation and Management services codes should not be reported on the same day as 96020)

CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS (e.g., NEURO COGNITIVE, MENTAL STATUS, SPEECH TESTING)

(When billing for procedure codes 96105 thru 96118, the total time billed to New York State Medicaid should reflect the face-to-face contact time with the patient. Reimbursement for all work performed before and after the face-to-face encounter (e.g., analysis of tests, reviewing records, etc.) is included in the maximum reimbursable amount for the face-to-face encounter.)

- 96105 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
- 96111 Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report
- 96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
- 96118 Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

MISCELLANEOUS ORDERED AMBULATORY SERVICES

- 36430 Transfusion, blood or blood components
- 36511 Therapeutic apheresis; for white blood cells
- 36512 for red blood cells
- 36513 for platelets
- 36514 for plasma pheresis
- 36515 with extracorporeal immunoabsorption and plasma reinfusion
- 36516 with extracorporeal selective adsorption or selective filtration and plasma reinfusion
- 36522 Photopheresis, extracorporeal (For technical component see Modifier –TC)
- 38242 Allogeneic lymphocyte infusions
- 54240 Penile plethysmography
- 59020 Fetal contraction stress test
- 59025 Fetal non-stress test
- 98960 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
- 98961 2-4 patients
- 98962 5-8 patients
- 99170 Anogenital examination magnified, in childhood for suspected trauma, including image recording when performed
(99170 should not be billed in addition to the all-inclusive clinic rate or emergency room rate)
- 99195 Phlebotomy, therapeutic (separate procedure)
- A0225 Ambulance service, neonatal transport, base rate, emergency transport, one way
(Service limited to Hospital Based Ordered Ambulatory with a 740 specialty (Regional Perinatal Transportation))
- A4264 Permanent implantable contraceptive intratubal occlusion device(s) and delivery system
- G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 group session (2 or more), per 30 minutes
- S9445 Patient education, not otherwise classified, non-physician provider, individual, per session
(The initial lactation counseling session should be a minimum of 45 minutes. Follow up sessions(s) should be a minimum of 30 minutes. Three sessions within 12-month period immediately following delivery.)
- S9446 Patient education, not otherwise classified, non-physician provider, group, per session (Up to a maximum of eight participants in a group session. 60 minute minimum session length. One prenatal and one postpartum class per recipient per pregnancy.)

REHABILITATION SERVICES

Inclusion of Modifier **GN** (Services delivered under an outpatient speech-language pathology plan of care), **GO** (Services delivered under an outpatient occupational therapy plan of care), or **GP** (Services delivered under an outpatient physical therapy plan of care) is required when billing for rehabilitation services.

SPEECH LANGUAGE PATHOLOGY

Ordered Ambulatory Procedure Codes

- 92507# Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual, (includes aural rehabilitation); (each half hour)
- 92521 Evaluation of speech fluency (eg, stuttering, cluttering)
- 92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
- 92523 with evaluation of language comprehension and expression (eg, receptive and expressive language)
- 92524 Behavioral and qualitative analysis of voice and resonance

PHYSICAL THERAPY SERVICES/OCCUPATIONAL THERAPY

- 97530# Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes (up to a maximum of 2 hours)

USE OF THE OPERATING ROOM

For information regarding the application process required for the Hospital-Based Ambulatory Surgery Program, please contact the hospital services representative in the appropriate OHSM Area Office for consultation. Current addresses and telephone numbers for the OHSM Area Offices are provided in the Inquiry Section of the manual.