NEW YORK STATE
MEDICAID PROGRAM

MIDWIFE

FEE SCHEDULE

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GENERAL INFORMATION

1. **MULTIPLE CALLS**: If an individual patient is seen on more than one occasion during a single day, the fee for each visit may be allowed.

2. **REFERRAL:** A referral is the transfer of the total or specific care of a patient from one practitioner to another and does not constitute a consultation. Initial evaluation and subsequent services are designated as listed in LEVELS of E/M SERVICE.

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

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

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

4. **BY REPORT:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate), diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

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

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

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

6. **FEES:** Listed fees are the maximum reimbursable Medicaid fees**.**

7. **PRESCRIBER WORKSHEET:**

NEW YORK STATE MEDICAID PROGRAM
ENTERAL FORMULA PRIOR AUTHORIZATION
PRESCRIBER WORKSHEET- REVISED 4/05

To facilitate the process, be prepared to answer these questions when you call the voice interactive Enteral Prior Authorization Call Line at **1-866-211-1736**. Documentation must be maintained in the patient's medical record.

PRESCRIBER IDENTIFIER Ordering Prescriber Medicaid ID # NYS Physician/PA/Resident NYS Nurse Practitioner/Midwife NYS Dentist Out of State Prescriber License	Complete one of the following prescriber identifiers: MMIS ID Number __ __ __ __ __ __ __ __ **0 0** __ __ __ __ __ __ **F** __ __ __ __ __ __ **0 0 0** __ __ __ __ __ __ __ __ __ __ __ __ __ (state abbreviation in first two spaces)
1. Recipient CIN (Client ID number is 2 alpha/5 numeric/1 alpha)	__ __ __ __ __ __ __ __ __
2. Recipient Date of Birth (MM/DD/YYYY)	__ __ / __ __ / __ __ __ __
3. Prescriber telephone number (where you can be reached)	**(**__ __ __**)** __ __ __ **-** __ __ __ __
4. Mode of administration	1 = Tube 2= Oral
5. If less than one year of age, does the patient require an added rice formula?	1 = Yes 2 = No
6. Are you prescribing more than one enteral formula?	1 = Yes 2 = No
7. Number of enteral formula calories prescribed per day.	__ __ __ __ __
8. Number of refills (up to 5)	___

Answer the following questions for oral administration only:

9. Is the enteral formula prescribed for an inborn metabolic disease or an infant formula for lactose intolerance, severe food allergy or gastroesophogeal reflux disease not responding to added rice formula?	1 = Yes 2 = No
10. Patient height in inches	__ __ inches
11. Patient weight in pounds	__ __ __ lbs

Coverage criteria for enteral formula explained on telephone system

12. Does this patient have a medical condition that prevents him/her from consuming normal table, and softened, mashed, pureed, or blenderized foods?	1 = Yes 2 = No
13. Have alternatives such as dietary changes, instant breakfast drinks, rice cereal, etc., been tried but were not successful?	1 = Yes 2 = No
14. Has the adult patient had a significant unintentional weight loss (>5%) over the past two months or the pediatric patient had no weight gain in six months?	1 = Yes 2 = No
15. Is there objective medical evidence in the medical record to support the need for enteral nutrition (e.g., malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones, physiological disorders resulting from surgery)?	1 = Yes 2 = No

Record the 11-digit prior authorization number here (for your records) and on top of the patient's enteral formula order/prescription.	__ __ __ __ __ __ __ __ __ __ __

STATE DEPARTMENT OF HEALTH CONDITIONS FOR PAYMENT

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

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

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

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

PRACTITIONER SERVICES PROVIDED IN HOSPITALS

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

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

MMIS MODIFIERS

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

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

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

-24 Unrelated Evaluation and Management Service by the Same Practitioner During a Postoperative Period: The practitioner may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier -24 to the appropriate level of E/M service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Practitioner on the Day of a Procedure: The practitioner may need to indicate that on the day a procedure or service identified by an MMIS code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier -25 to the appropriate level of E/M service.

NOTE: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

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

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

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

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

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

MEDICINE SECTION

GENERAL INFORMATION AND RULES

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

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

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

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

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

3. DEFINITIONS OF COMMONLY USED E/M TERMS: Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting.

NEW AND ESTABLISHED PATIENT: Solely for the purpose of distinguishing between new and established patients, professional services are those face-to-face services rendered by a practitioner and reported by a specific code. A new patient is one who has not received any professional services from the practitioner within the past three years. An established patient is one who has received professional services from the practitioner within the past three years.

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

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

CONCURRENT CARE: Is the provision of similar services, e.g., hospital visits, to the same patient by more than one practitioner on the same day. When concurrent care is provided, no special reporting is required.

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

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

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

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

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

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

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

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

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

SOCIAL HISTORY: an age appropriate review of past and current activities that include significant information about:

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

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

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

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

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

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

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

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

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

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

B. **Unit/floor time (inpatient hospital care):** For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the practitioner is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the practitioner establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

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

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

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

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

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

The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. **BY REPORT:** A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms, final diagnosis, pertinent physical findings (such as size, locations, and number of lesion(s), if appropriate), diagnostic and therapeutic procedures (including major supplementary surgical procedures, if appropriate), concurrent problems, and follow-up care.

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

7. **SEPARATE PROCEDURE:** Certain of the listed procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for “Separate Procedure” is applicable.
8. **MATERIALS SUPPLIED BY PRACTITIONER:** Supplies and materials provided by the practitioner, e.g., sterile trays/drugs, **over and above** those usually included with the procedures, office visit or other services rendered may be listed separately. List drugs, trays, supplies and materials provided. Identify as 99070.

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

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

10. **PRIOR APPROVAL**: Payment for those listed procedures where the MMIS code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

EVALUATION AND MANAGEMENT CODES

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

OFFICE OR OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the **practitioner's office or in an outpatient or other ambulatory facility**. A patient is considered an outpatient until inpatient admission to a health care facility occurs. When claiming for Evaluation and Management procedure codes 99201-99205 and 99211-99215 Office or Other Outpatient Services, report the place of service code that represents the location where the service was rendered in claim form field 24B Place of Service. **The maximum reimbursable amount for these codes is dependent on the Place of Service reported.**

For Evaluation and Management services rendered in the practitioners private office, report place of service "1". The Maximum Fee for Office Evaluation and Management services is $30.00. For services rendered in a Hospital Outpatient setting report place of service "7". The Maximum Fee for codes 99201-99205 and 99211-99215 in a Hospital Outpatient setting is noted in parenthesis in the Maximum Fee column.

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

To report services provided to a patient who is admitted to the hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or comprehensive nursing facility assessments.
For observation care, see 99217-99220.

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

OFFICE SERVICES

The following codes are used to report evaluation and management services provided in the **practitioners' office**. **For services provided to either hospital outpatients or inpatients, see Hospital Services 99221-99239**.

NEW PATIENT

99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.	$30.00 (6.50)
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making. Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 20 minutes face-to-face with the patient and/or family.	$30.00 (6.50)
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Practitioners typically spend 30 minutes face-to-face with the patient and/or family.	$30.00 (6.50)
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with the patient and/or family.	$30.00 (6.50)

99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.	$30.00 (6.50)

ESTABLISHED PATIENT

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

99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician practitioner). Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	$30.00 (5.00)
99212	Office or other outpatient visit for the evaluation and two of these three key components: a problem focused history, a problem focused examination, and/or straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.	$30.00 (5.00)
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination, and/or medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.	$30.00 (5.00)
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and/or medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.	$30.00 (5.00)

99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, and/or medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.	$30.00 (5.00)

HOSPITAL OBSERVATION SERVICES

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

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

OBSERVATION CARE DISCHARGE SERVICES

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

99217	Observation care discharge day management (This code is to be utilized by the practitioner to report all services provided to a patient on discharge from "observation status" if the discharge is on other that the initial date of "observation status". To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services (99234-99236)).	$5.00

INITIAL OBSERVATION CARE- <u>NEW OR ESTABLISHED PATIENT</u>

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

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

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

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

99218	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination and medical decision making that is straightforward or of low complexity Usually the problem(s) requiring admission to "observation status" are of low severity.	$6.50
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of moderate complexity Usually the problem(s) requiring admission to "observation status" are of moderate severity.	$6.50
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination and medical decision making of high complexity Usually the problem(s) requiring admission to "observation status" are of high severity.	$6.50

HOSPITAL INPATIENT SERVICES

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

INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

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

99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making that is straightforward or of low complexity. Usually, the problem(s) requiring admission are of low severity. Practitioners typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.	$6.50
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity. Usually, the problem(s) requiring admission are of moderate severity. Practitioners typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.	$6.50
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the problem(s) requiring admission are of high severity. Practitioners typically spend 70 minutes at the bedside and on the patients hospital floor or unit.	$6.50

SUBSEQUENT HOSPITAL CARE

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

99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination, and/or medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. Practitioners typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.	$5.00
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Practitioners typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.	$5.00
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of high complexity. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Practitioners typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.	$5.00

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

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

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

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

99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity Usually the presenting problem(s) requiring admission are of low severity.	$6.50
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity Usually the presenting problem(s) requiring admission are of moderate severity.	$6.50
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity Usually the presenting problem(s) requiring admission are of high severity.	$6.50

HOSPITAL DISCHARGE SERVICES

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

99238	Hospital discharge day management; 30 minutes or less	$5.00
99239	more than 30 minutes	$5.00

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

(For Observation Care Discharge, use 99217)

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

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

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

EMERGENCY DEPARTMENT SERVICES – NEW OR ESTABLISHED PATIENT

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

An emergency department is defined as an organized hospital-based facility for the providion of unscheduled episodic services to patients who present for immediate medical attention. The facilty must be available 24 hours a day.

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

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

99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor.	$6.50

99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity.	$6.50
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate severity.	$6.50
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the practitioner but do not pose an immediate significant threat to life or physiologic function.	$6.50
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$6.50

NURSING FACILITY SERVICES

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

COMPREHENSIVE NURSING FACILITY ASSESSMENTS –
NEW OR ESTABLISHED PATIENT

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

99301	Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components: a detailed interval history, a comprehensive examination, and medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Practitioners typically spend 30 minutes at the bedside and on the patient's facility floor or unit.	$8.00
99302	Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history, a comprehensive examination, and medical decision making of moderate to high complexity. Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required. Practitioners typically spend 40 minutes at the bedside and on the patient's facility floor or unit.	$8.00
99303	Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate to high complexity. The creation of a medical plan of care is required. Practitioners typically spend 50 minutes at the bedside and on the patient's facility floor or unit.	$8.00

SUBSEQUENT NURSING FACILITY CARE - NEW OR ESTABLISHED PATIENT

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

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

99311	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination, and/or medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. Practitioners typically spend 15 minutes at the bedside and on the patient's facility floor or unit.	$7.00
99312	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Practitioners typically spend 25 minutes at the bedside and on the patient's facility floor or unit.	$7.00
99313	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of moderate to high complexity. Usually, the patient has developed a significant complication or a significant new problem. Practitioners typically spend 35 minutes at the bedside and on the patient's facility floor or unit.	$7.00

NURSING FACILITY DISCHARGE SERVICES

The nursing facility discharge day management codes are to be used to report the total duration of time spent by a practitioner for the final nursing facility discharge of patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the practitioner on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

99315	Nursing facility discharge day management; 30 minutes or less	$8.00
99316	more than 30 minutes	$8.00

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

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component. Typical times have not yet been established for this category of services.

NEW PATIENT

99321	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and medical decision making that is straightforward or of low complexity. Usually, the presenting problem(s) are of low severity.	$8.00
99322	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate severity.	$8.00
99323	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of high complexity.	$8.00

ESTABLISHED PATIENT

99331	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination, and/or medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving.	$7.00

99332	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication.	$7.00
99333	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of high complexity. Usually, the patient is unstable or has developed a significant complication or a significant new problem.	$7.00

HOME SERVICES

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

NEW PATIENT

99341	Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, an problem focused examination, and medical decision making that is straightfoward. Usually the presenting problem(s) are of low severity. Practitioners typically spend 20 minute face-to-face with the patient and/or family.	$7.00
99342	Home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Practitioners typically spend 30 minutes face-to-face with the patient and/or family.	$7.00
99343	Home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with patient and/or family.	$8.00

99344	Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity. Usually the presenting problem(s) are of high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.	$8.00
99345	Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making of high complexity. Usually the patient is unstable or has developed a significant new problem requiring immediate Practitioner attention. Practitioners typically spend 75 minutes face-to-face with the patient and/or family.	$8.00

ESTABLISHED PATIENT

99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination and straightforward medical decision making. Usually the presenting problem(s) are self-limited or minor. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.	$7.00
99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Usually the presenting problem(s) are of low to moderate severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.	$7.00
99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.	$8.00

99350	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity. Usually the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate practitioner attention. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.	$8.00

NEWBORN CARE

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

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

DRUG ADMINISTRATION

IMMUNIZATIONS

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

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

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

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

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the estimated acquisition cost of the antigen. For immunizations not supplied by the VFC Program, insert actual acquisition cost per dose plus a two dollar ($2.00) administration fee in amount charged field on the claim form. For codes listed **BR**, also attach itemized invoice to claim form.

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

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

IMMUNE GLOBULINS

90384 Rho (D) immune globulin (RhIg), human, full-dose, for intramuscular use

90385 Rho (D) immune globulin (RhIg), human, mini-dose, for intramuscular use

IMMUNIZATION INJECTIONS

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

90636	Hepatitis A and hepatitis B vaccine (Hep-A – Hep-b), adult dosage, for intramuscular use
90703	Tentanus toxoid adsorbed, for intramuscular use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90708	Measles and rubella virus vaccine, live, for subcutaneous use
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IVP)
90718	Tetanus and diptheria toxoids (Td) adsorbed for use in individuals seven years or older, for intramuscular use
90744	Hepatitis B vaccine; pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746	adult dosage, for intramuscular use

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

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

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

THERAPEUTIC INJECTIONS

(Maximum fee includes cost of materials)

A4260	Levonorgestrel contraceptive implants system (Norplant System), including implants and supplies
J1055	(Depo-Provera Ag.) Medroxyprogesterone Acetate for contraceptive use, 150 mg
J1056	Medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (Lunelle)

SPECIAL SERVICES

92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	$25.00

99070	Supplies and material, provided by the practitioner over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	BR
99170	Angogenital examination with colposcopic magnification in childhood for suspected trauma	$27.00

SURGERY SECTION

GENERAL INFORMATION AND RULES

1. **FEES:** Fees or values for office, home and hospital visits, and other medical services are listed in the section entitled MEDICINE.

2. **FOLLOW-UP DAYS**: Listed dollar values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "Follow-Up Days". Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. (See Modifier -24)

3. **ADDITIONAL SERVICES:** Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis. (See modifiers -24, -25, -79)

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

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

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

6. **PRIOR APPROVAL**: Payment for those listed procedures where the MMIS Code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made.

7. **MMIS MODIFIERS: SURGERY SECTION:**

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

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

		Follow Up Days	
SURGERY SERVICES			
INTEGUMENTARY SYSTEM			
INTRODUCTION			
11975	Insertion, implantable contraceptive capsules		$81.00
11976	Removal, implantable contraceptive capsules		$57.00
11977	Removal with reinsertion, implantable contraceptive capsules		$109.50
A4260	Levonorgestrel contraceptive implants system		
MALE GENITAL SYSTEM			
EXCISION			
54150	Circumcision, using clamp or other device; newborn	15	$12.00
FEMALE GENITAL SYSTEM			
VULVA, PERINEUM AND INTROITUS			
INCISION			
56420	Incision and drainage of Bartholin's gland abscess	15	$20.00
DESTRUCTION			
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)		$8.00
EXCISION			
56605	Biopsy of vulva or perineum (separate procedure); one lesion	15	$16.00
56606	each separate additional lesion (list separately in addition to code for primary procedure)		$8.00

		Follow Up Days	
ENDOSCOPY			
56820	Colposcopy of the vulva;	30	$35.00
56821	with biopsy(s)	30	$45.00
VAGINA			
DESTRUCTION			
57061	Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)		$8.00
EXCISION			
57100	Biopsy of vaginal mucosa; simple (separate procedure)	15	$12.00
INTRODUCTION			
57150	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease		$4.00
57160	Fitting and insertion of pessary or other intravaginal support device		$12.00
57180	Introduction of any hemostatic agent or pack for spontaneous or traumatic non-obstetrical vaginal hemorrhage (separate procedure)		$12.00
ENDOSCOPY			
57420	Colposcopy of the entire vagina, with cervix if present;		$36.00
57421	with biopsy(s)		$40.00
CERVIX UTERI			
ENDOSCOPY			
57452	Colposcopy of the cervix including upper/adjacent vagina;		$44.00
57454	with biopsy(s) of the cervix and endocervical curettage		$73.00
57455	with biopsy(s) of the cervix		$44.00
57456	with endocervical curettage		$41.00
EXCISION			
57511	Cautery of cervix; cryocautery, initial or repeat		$76.00
CORPUS UTERI			
EXCISION			
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	15	$40.00

		Follow Up Days	
INTRODUCTION			
58300	Insertion of intrauterine device (IUD)		$49.00
58301	Removal of intrauterine device (IUD)		$36.00
J7300	Intrauterine copper contraceptive		
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg		
J7303	Contraceptive supply, hormone containing vaginal ring, each		
J7304	Contraceptive supply, hormone containing patch, each		

MATERNITY CARE AND DELIVERY

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

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

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

ANTEPARTUM SERVICES

59020	Fetal contraction stress test		$20.00
59025	Fetal non-stress test (MOMS $70.00)		$15.00
59030	Fetal scalp blood sampling		$20.00
INTRODUCTION			
59200	Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)		$12.00
REPAIR			
59300	Episiotomy or vaginal repair by other than attending physician	45	$60.00

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

VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (**inpatient and outpatient**) postpartum care (total, all-inclusive, “global” care) (MOMS $1,440.00)	45	$1037.00

		Follow Up Days	
59409	Vaginal delivery only (with or without episiotomy and/or forceps); (MOMS $883.00) (When only **inpatient** postpartum care is provided in addition to delivery, **see appropriate HOSPITAL E/M Code(s) for postpartum care visits**)		$630.00
59410	including (**inpatient and outpatient**) postpartum care (MOMS $960.00)	45	$679.00
59425	Antepartum care only; 4-6 visits (MOMS $364.00) (Procedure code 59425 includes reimbursement for one initial antepartum encounter ($54.00) and five subsequent encounters ($31.00). If less than 6 antepartum encounters were provided, adjust the amount charged accordingly)		$209.00
59426	7 or more visits (MOMS $541.00) (Procedure code 59426 includes reimbursement for one initial antepartum encounter ($54.00) and eight subsequent encounters ($31.00). If less than 9 antepartum encounters were provided, adjust the amount charged accordingly.) For 6 or less antepartum encounters, see code 59425.		$302.00
59430	Postpartum are only (**outpatient**) (separate procedure) (MOMS $59.00)		$31.00

DELIVERY AFTER PREVIOUS CESAREAN DELIVERY

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

59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and (**inpatient and outpatient**) postpartum care, after previous cesarean delivery (total, all-inclusive, “global” care) (MOMS $1,440.00)	45	$1037.00
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); (MOMS $883.00) (When only **inpatient** postpartum care is provided in addition to delivery, **see appropriate HOSPITAL E/M code(s) for postpartum care visits**)		$630.00
59614	including (**inpatient and outpatient**) postpartum care (MOMS $960.00)	45	$679.00