MIDWIFE
Procedure Codes

eMedNY New York State Medicaid Provider Procedure Code Manual

Adds:

Deletions:
G2023 – Code end dated 05/11/2023; removing as a correction- Reviewed 7/8/24 LDK

Changes:

New York State Medicaid
Office of Health Insurance
Department of Health

CONTACTS and LINKS:

eMedNY URL
https://www.emedny.org/

ePACES Reference Guide
https://www.emedny.org/selfhelp/ePACES/PDFS/5010_ePACES_Professional_Real_Time_Claim_Reference_Guide.pdf

eMedNY Contact Information
(800) 343-9000
eMedNY: Billing Questions, Remittance Clarification, Request for Claim Forms, ePACES Enrollment, Electronic Claim Submission Support (eXchange, FTP), Provider Enrollment, Requests for paper prior approval forms

eMedNY Contacts PDF

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1 DOCUMENT CONTROL PROPERTIES

Control Item	Value
Document Name	**Midwife Procedure Codes**
Document Control Number	2024-1
Document Type	Procedure Code Manual
Document Version	2024-V3
Document Status	
Effective date	July 2024

2 GENERAL INFORMATION

A. 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.

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

C. 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.

D. 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.

E. PRESCRIBER WORKSHEET: Enteral formula requires voice interactive telephone prior authorization from the Medicaid program. The prescriber must initiate the authorization through this system. The worksheet specifies the questions asked on the voice interactive telephone system and must be maintained in the patient's clinical record. The worksheet can be found in the Midwife Communications, available at: https://www.emedny.org/ProviderManuals/Midwife/communications.aspx

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

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

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

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

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

H. FEES: The fees are listed in the Midwife Fee Schedule, available at
http://www.emedny.org/ProviderManuals/Midwife/index.html

Listed fees are the maximum reimbursable Medicaid fees.

3 SERVICES PROVIDED IN ARTICLE 28 FACILITIES

The professional component for licensed midwife services provided in an Article 28 hospital outpatient clinic, emergency department, ambulatory surgery center and diagnostic and treatment center (D&TC) for Medicaid fee-for-service patients is included in the APG payment to the facility. However, licensed midwives may bill Medicaid for newborn deliveries (only) in the inpatient setting.

4 MMIS MODIFIERS

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

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

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

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

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

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

77 Repeat Procedure by Another Physician (or Practitioner): The practitioner may need to indicate that a basic procedure performed by another practitioner had to be repeated. This

situation may be reported by adding modifier -77 to the repeated service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

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

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

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

5 MEDICINE SECTION

5.1 GENERAL INFORMATION AND RULES

A. 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.

B. LEVELS OF E/M SERVICES: 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 Evaluation and Management guidelines in the CPT book should be referenced when selecting the level of E/M codes.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

6 EVALUATION AND MANAGEMENT CODES

6.1 OFFICE OR OTHER OUTPATIENT SERVICES

6.1.1 NEW PATIENT

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and low level of medical decision making. When using time for code selection, 30 minutes must be met or exceeded.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and moderate level of medical decision making. When using time for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and high level of medical decision making. When using time for code selection, 60 minutes must be met or exceeded.

6.1.2 ESTABLISHED PATIENT

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

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 Office or other outpatient visit for the evaluation and management of an established

patient, which requires a medically appropriate history and/ or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

6.2 HOSPITAL INPATIENT AND OBSERVATION CARE SERVICES

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

6.2.1 INITIAL HOSPITAL INPATIENT OR OBSERVATION CARE

6.2.1.1 NEW OR ESTABLISHED PATIENT

99221 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low-level medical decision making.
When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99222 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level medical decision making.
When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

99223 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level medical decision making.
When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

6.2.2 SUBSEQUENT HOSPITAL INPATIENT OR OBSERVATION CARE

99231 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.
When using total time on the date of the encounter for code selection, 25 minutes must be met or executed.

99232 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or executed.

99233 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 50 minutes must be met or executed.

6.2.3 HOSPITAL INPATIENT OR OBSERVATION CARE SERVICES (INCLUDING ADMINISSION AND DISCHARGE SERVICES)

99234 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99235 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making
When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.

99236 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making

When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.

6.2.4 HOSPITAL INPATIENT OR OBSERVATION DISCHARGE SERVICES

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

6.3 EMERGENCY DEPARTMENT SERVICES

6.3.1 NEW OR ESTABLISHED PATIENT

99281 Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional

99282 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making

99283 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making

99284 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical

decision making

99285 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

6.4 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)).

6.4.1 INITIAL NURSING FACILITY CARE

6.4.1.1 NEW OR ESTABLISHED PATIENT

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and straightforward or low level of medical decision making.
When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.

6.4.2 SUBSEQUENT NURSING FACILITY CARE

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low-level of medical decision making.
When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

6.4.3 NURSING FACILITY DISCHARGE SERVICES

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

6.5 HOME OR RESIDENCE SERVICES

6.5.1 NEW PATIENT

99341 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99342 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and low-level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99344 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

99345 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

6.5.2 ESTABLISHED PATIENT

99347 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99348 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and low-level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99349 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99350 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

6.6 PROLONGED SERVICES

6.6.1 PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN OFFICE VISIT OR OTHER OUTPATIENT SERVICE

99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)

6.7 PREVENTIVE MEDICINE SERVICES

The following codes are used to report well visit services provided to patients ages 12–64 years old.

6.7.1 NEW PATIENT

99384 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)

99385 18-39 years

99386 40-64 years

6.7.2 ESTABLISHED PATIENT

99394 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)

99395 18-39 years

99396 40-64 years

6.7.3 COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

6.7.3.1.1 BEHAVIOR CHANGE INTERVENTIONS, INDIVIDUAL

99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes

up to 10 minutes
99407 intensive, greater than 10 minutes

6.7.3.1.2 OTHER PREVENTIVE MEDICINE SERVICES
99429 Other Preventive Medicine Services

6.8 NON-FACE-TO-FACE SERVICES
6.8.1 TELEPHONE SERVICES
99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442 11-20 minutes of medical discussion
99443 21-30 minutes of medical discussion

6.8.2 ONLINE DIGITAL EVALUATION AND MANAGEMENT SERVICES
99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5- 10 minutes
99422 11-20 minutes
99423 21 or more minutes

6.8.3 INTERPROFESSIONAL TELEPHONE/INTERNET/ELECTRONIC HEALTH RECORD CONSULTATION
99451 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5- 10 minutes
99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

6.8.4 DIGITALLY STORED DATA SERVICES/REMOTE PHYSIOLOGIC
99453 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454 device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

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

6.10 OTHER EVALUALATION AND MANAGEMENT SERVICES
99459 Pelvic examination (List separately in addition to code for primary procedure)

6.11 AUDIOLOGIC FUNCTION TESTS

92650 Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis

92651 for hearing status determination, broadband stimuli, with interpretation and report

6.12 OTHER SERVICES

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

98960 Education and training for patient self-management by a qualified, 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

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

99070 Supplies and material, provided by the practitioner over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)

99091 Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days

99170 Anogenital examination, magnified, in childhood for suspected trauma, including image recording when performed

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

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

G2252 Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

G8431 Screening for clinical depression is documented as being positive and a follow-up plan is documented

G8510 Screening for clinical depression is documented as being negative, a follow-up plan is not required

H0049 Alcohol and/or drug screening

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

Q3014 Telehealth originating site facility fee

S9445 Patient education, not otherwise classified, non-physician provider, individual, per session.

(The initial lactation counseling session should be a minimum of 45 minutes. Follow up session(s) should be a minimum of 30 minutes.)

S9446 Patient education, not otherwise classified, non-physician provider, group, per session. (Up to a maximum of 8 participants in a group session. 60 minute minimum session length. One prenatal and one postpartum class per recipient per pregnancy.) NYS Medicaid will provide reimbursement for separate and distinct breastfeeding services provided by International Board Certified Lactation Consultants (IBCLCs) credentialed by the IBCLCE. For additional information see: http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-03.htm#fee

T1013 Sign language or oral interpretive services, per 15 minutes

7 LABORATORY SERVICES PERFORMED IN THE OFFICE

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

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

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

For detection of pregnancy, use code 81025.

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

81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy

81001 automated, with microscopy

81002 non-automated, without microscopy

81003 automated, without microscopy

81015 Urinalysis; microscopic only

81025 Urine pregnancy test, by visual color comparison methods

83655 Lead

85007 Blood count; blood smear, microscopic examination with manual differential WBC count (includes RBC morphology and platelet estimation)

85013 spun microhematocrit

85018 hemoglobin (Hgb)

85025 complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count

85041	red blood cell (RBC) automated
85048	leukocyte (WBC), automated
85651	Sedimentation rate, erythrocyte; non-automated
85652	automated
86701	Antibody; HIV-1
86703	HIV-1 and HIV-2, single result
87081	Culture, presumptive, pathogenic organisms, screening only (throat only)
87426	Detection test by immunoassay technique for sever acute respiratory syndrome coronavirus
87428	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B
87635	Amplified DNA or RNA probe detection of severe acute respiratory syndrome coronavirus 2 (Covid-19) antigen
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
87637	Detection test by multiplex amplified probe technique for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19), influenza virus types A and B, and respiratory syncytial virus
87651	Detection test by nucleic acid for Strep (Streptococcus, group A), amplified probe technique
87806	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies
87811	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
87880	Infectious agent detection by immunoassay with direct optical observation; streptococcus, group A (throat only)

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

7.1 DRUGS AND DRUG ADMINISTRATION

7.1.1 IMMUNIZATIONS

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

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

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

Children Program (VFC), bill using the procedure code that represents the immunization(s) administered and append modifier –SL State Supplied Vaccine to receive the VFC administration fee. See MMIS Modifiers for further information.

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

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

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the estimated acquisition cost of the antigen. For immunizations not supplied by the VFC Program, insert actual acquisition cost in amount charged field on the claim form. For codes listed BR, also attach itemized invoice to claim form.
To meet the reporting requirements of immunization registries, vaccine distribution programs, and reporting systems (eg, Vaccine Adverse Event Reporting System) the exact vaccine product administered needs to be reported with modifier –SL. Multiple codes for a particular vaccine are provided when the schedule (number of doses or timing) differs for two or more products of the same vaccine type (eg, hepatitis A, Hib) or the vaccine product is available in more than one chemical formulation, dosage, or route of administration.

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

7.2 IMMUNE GLOBULINS

90380 Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use

90381 Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular 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

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

90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (Bill on one claim line for multiple injections)

7.3 VACCINES/TOXOIDS

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

90636 Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90649 Human Papillomavirus vaccine, types 6, 11, 16, 18 quadrivalent (4vHPV),3 dose schedule, for intramuscular use
90650 Human Papillomavirus vaccine, types 16, 18, bivalent, (2vHPCV), 3 dose schedule, for intramuscular use
90651 Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonvalent (9vHPV),2 or 3 dose schedule for intramuscular use
90630 Influenza vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90655 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90656 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90657 Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use
90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use
90660 Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
90672 Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use

90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
90674	Influenza virus vaccine; quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 ml dosage, for intramuscular use
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine(IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
90678	Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use
90679	Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use
90682	Influenza virus vaccine, quadrivalent (RIV4),derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90694	Influenza virus vaccine, quadrivalent, (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, 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 adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90734	Meningococcal vaccine, serogroups A, C, W, Y, diphtheria toxoid carrier vaccine
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup

B,(MenB-4C), 2 dose schedule, for intramuscular use
90621 Meningococcal recombinant lipoprotein vaccine, Serogroup B,(MenB-FHbp) 2 or 3 dose schedule, for intramuscular use
90739 Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use
90744 Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90746 adult dosage, 3 dose schedule, for intramuscular use
90759 Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use

7.4 DRUGS ADMINISTERED OTHER THAN ORAL METHOD

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

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

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

7.4.1 THERAPEUTIC INJECTIONS

(Maximum fee includes cost of materials)
J1050 Injection, medroxyprogesterone acetate, 1 mg
J1726 Injection, hydroxyprogesterone caproate, (Makena), 10mg
J1729 Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
J1741 Injection, ibuprofen, 100 mg
J7121 5% Dextrose in lactated ringers infusion, up to 1000 cc
J8499 Prescription drug, oral, nonchemotherapeutic, NOS
J8999 Prescription drug, oral, chemotherapeutic, NOS

7.4.2 MISCELLANEOUS DRUGS

J7294 Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each
J7295 Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each
J7296 Levonorgestrel-releasing intrauterine contraceptive system, (kyleena),19.5 mg

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
J7303 Contraceptive supply, hormone containing vaginal ring, each
J7304 Contraceptive supply, hormone containing patch, each
J7306 Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307 Etonogestrel (contraceptive) implant system, including implant and supplies

8 SURGERY

8.1 GENERAL INFORMATION AND RULES

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

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

C. 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)

D. 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.

E. 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.

F. 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.

G. ASSIST AT SURGERY: When a physician requests a nurse practitioner or a physician's assistant to participate in the management of a specific surgical procedure in lieu of another physician, or requests a licensed midwife to participate in the management of a Cesarean section, by prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 20 percent under these circumstances. The claim for these services will be submitted by the physician using the appropriate modifier.

H. MMIS MODIFIER: SURGERY SECTION:

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

8.2 INTEGUMENTARY SYSTEM
8.2.1 INTRODUCTION
11976 Removal, implantable contraceptive capsules
11981 Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)
11982 Removal, non-biodegradable drug delivery implant
11983 Removal with reinsertion, non-biodegradable drug delivery implant

8.3 MALE GENITAL SYSTEM
8.3.1.1 EXCISION
54150 Circumcision, using clamp or other device with regional dorsal penile or ring block

8.4 FEMALE GENITAL SYSTEM
8.4.1 VULVA, PERINEUM AND INTROITUS
8.4.1.1.1 INCISION
56420 Incision and drainage of Bartholin's gland abscess

8.4.1.1.2 DESTRUCTION

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

8.4.1.1.3 EXCISION

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

8.4.1.1.4 ENDOSCOPY

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

8.4.2 VAGINA

8.4.2.1.1 DESTRUCTION

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

8.4.2.1.2 EXCISION

57100 Biopsy of vaginal mucosa; simple (separate procedure)

8.4.2.1.3 INTRODUCTION

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

8.4.2.1.4 ENDOSCOPY

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

8.4.3 CERVIX UTERI

8.4.3.1.1 ENDOSCOPY

57452 Colposcopy of the cervix including upper/adjacent vagina;
57454 with biopsy(s) of the cervix and endocervical curettage
57455 with biopsy(s) of the cervix
57456 with endocervical curettage
57465 Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)

8.4.3.1.2 EXCISION

57511 Cautery of cervix; cryocautery, initial or repeat

8.4.4 CORPUS UTERI

8.4.4.1.1 EXCISION

58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)

58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to primary procedure)

8.4.4.1.2 INTRODUCTION

58300 Insertion of intrauterine device (IUD)

58301 Removal of intrauterine device (IUD)

8.5 MATERNITY CARE AND DELIVERY

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

8.5.1 FETAL INVASIVE SERVICES

59020 Fetal contraction stress test

59025 Fetal non-stress test

59030 Fetal scalp blood sampling

8.5.2 INTRODUCTION

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

8.5.3 REPAIR

59300 Episiotomy or vaginal repair, by other than attending

8.5.4 VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

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

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

59410 including (inpatient and outpatient) postpartum care

59412 External cephalic version, with or without tocolysis

59425 Antepartum care only; 4-6 visits

59426 7 or more visits

(For 6 or less antepartum encounters, see code 59425)

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

59430 Postpartum care only (outpatient) (separate procedure)

8.5.5 DELIVERY AFTER PREVIOUS CESAREAN DELIVERY

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

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

59614 including (inpatient and outpatient) postpartum care