NEW YORK STATE
MEDICAID PROGRAM

NURSE PRACTITIONER

FEE SCHEDULE

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GENERAL INFORMATION

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

2. **CHARGES FOR DIAGNOSTIC PROCEDURES:** Charges for special diagnostic procedures which are not considered to be a routine part of an examination (eg, ECG) are reimbursable in addition to the usual visit fee.

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

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

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

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

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

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

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

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

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

7. **PRESCRIBER WORKSHEET: see next page**

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 the particular hospital or in the contractual arrangement with the salaried/compensated practitioner or group.

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

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

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

PRACTITIONER SERVICES PROVIDED IN HOSPITALS

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

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

MMIS MODIFIERS

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

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

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

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

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

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

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

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

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

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

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

MEDICINE SECTION

GENERAL INFORMATION AND RULES

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

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

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

   The E/M section is divided into broad categories such as office visits, hospital visits and consultations. Most of the categories are further divided into two or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (ie, history, examination, and

medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

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

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

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

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

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

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

operative report, procedure description, and/or itemized invoices) should accompany all claims submitted. Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

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

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

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

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

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

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

EVALUATION AND MANAGEMENT CODES

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

OFFICE OR OTHER OUTPATIENT SERVICES

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

For Evaluation and Management services rendered in the practitioner's private office, report place of service "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 are noted in parenthesis.

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

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

For observation care, see 99217-99220.

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

(For Medicine Section, General Information and Rules, see page 7). For reimbursement amounts for the Preferred Physician and Children's Program (PPAC) see page 32.

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 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 visit for the evaluation and management of an established patient, who presents for follow-up and/or periodic re-evaluation of problems or for evaluation and management of new problems. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	$30.00 (6.50)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history, a problem focused examination, and/or straightforward medical decision making. 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)
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 (6.50)
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 (6.50)
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 (6.50)

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 - NEW OR ESTABLISHED PATIENT

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

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

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

sites of service as well as in the observation setting. Evaluation and Management services on the same date provided in sites that are related to initiating "observation status" should NOT be reported separately.

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

99218	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history, adetailed 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**. **For services rendered in a hospital outpatient setting, see procedure codes 99201-99215 Office or Other Outpatient Services.**

INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

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

99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making that is straightforward or of low complexity. 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 management of a patient including admissionand discharge onthe 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 provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

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

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

99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making. 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 straightforward. 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 date, see 99435.

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

PREFERRED PHYSICIAN AND CHILDRENS PROGRAM (PPAC)(158)

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

OFFICE SERVICES

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

NEW PATIENT			ESTABLISHED PATIENT		
Procedure Code	Maximum Fee Co. Group A	Co. Group B	Procedure Code	Maximum Fee Co. Group A	Co. Group B
99201	$39.64	$ 33.63	99211	$39.64	$ 33.63
99202	39.64	33.63	99212	39.64	33.63
99203	39.64	33.63	99213	39.64	33.63
99204	39.64	33.63	99214	39.64	33.63
99205	39.64	33.63	99215	39.64	33.63

HOSPITAL OUTPATIENT SERVICES

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

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99201	$36.00	$ 30.00
99202	36.00	30.00
99203	36.00	30.00
99204	36.00	30.00
99205	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99211	$36.00	$ 30.00
99212	36.00	30.00
99213	36.00	30.00
99214	36.00	30.00
99215	36.00	30.00

HOSPITAL OBSERVATION SERVICES

OBSERVATION CARE DISCHARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99217	$36.00	$ 30.00

INITIAL OBSERVATION CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99218	$36.00	$ 30.00
99219	36.00	30.00
99220	36.00	30.00

HOSPITAL INPATIENT SERVICES

INITIAL HOSPITAL CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99221	$36.00	$ 30.00
99222	36.00	30.00
99223	36.00	30.00

SUBSEQUENT HOSPITAL CARE

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99231	$36.00	$ 30.00
99232	36.00	30.00
99233	36.00	30.00

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

99234	$36.00	$ 30.00
99235	36.00	30.00
99236	36.00	30.00

HOSPITAL DISCHARGE SERVICES

99238	$36.00	$ 30.00
99239	36.00	30.00

EMERGENCY DEPARTMENT SERVICES

NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99281	$36.00	30.00
99282	36.00	30.00
99283	36.00	30.00
99284	36.00	30.00
99285	36.00	30.00

NURSING FACILITY SERVICES

COMPREHENSIVE NURSING FACILITY ASSESSMENTS NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99301	$36.00	$ 30.00
99302	36.00	30.00
99303	36.00	30.00

SUBSEQUENT NURSING FACILITY CARE NEW OR ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99311	$36.00	$ 30.00
99312	36.00	30.00
99313	36.00	30.00

NURSING FACILITY DISCHARGE SERVICES

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99315	$36.00	30.00
99316	36.00	30.00

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

NEW PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99321	$36.00	$ 30.00
99322	36.00	30.00
99323	36.00	30.00

ESTABLISHED PATIENT

Procedure Code	Maximum Fee Co. Group A	Co. Group B
99331	$36.00	$ 30.00
99332	36.00	30.00
99333	36.00	30.00

HOME SERVICES

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

DRUG ADMINISTRATION

IMMUNIZATION INJECTIONS

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

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

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

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

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

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

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

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

IMMUNE GLOBULINS

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

90281	Immune globulin (Ig), human, for intramuscular use (per 1 ml)	
90823	Immune globulin (IgIV), human, for intravenous use (per 500 mg)	
90921	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use	BR
90371	Hepatitis B immune globulin (HBIg), human, for intramuscular use	
90375	Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use (150 IU/ml)	
90376	Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use	BR
90379	Respiratory syncytial virus immune globulin (RVS-IgIV), human, for intravenous use (per 50 mg)	
90384	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	
90385	Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use	
90386	Rho(D) immune globulin (RhIgIV), human, for intravenous use (per 1500 IU)	
90389	Tetanus immune globulin (TIg), human, for intramuscular use (up to 250 units)	
90393	Vaccinia immune globulin, human, for intramuscular use	BR
90396	Varicella-zoster immune globulin, human, for intramuscular use (per 62.5 u/ml)	
90399	Unlisted immune globulin	BR

VACCINES/TOXOIDS

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

90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586 Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632 Hepatitis A vaccine, adult dosage, for intramuscular use
90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636 Hepatitis A and Hepatitis B vaccine (Hep-A-Hep-B), adult dose for intramuscular use
90645 Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646 Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647 Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648 Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90655 Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90657 Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90665 Lyme disease vaccine, adult dosage, for intramuscular use
90669 Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use
90675 Rabies vaccine, for intramuscular use
90676 Rabies vaccine, for intradermal use
90690 Typhoid vaccine, live, oral
90691 Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use
90692 Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use
90700 Diptheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for use in individuals younger than 7 years, for intramuscular use
90701 Diptheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702 Diptheria and tetanus toxoids (DT) adsorbed for use in individuals younger than seven years, for intramuscular use
90703 Tentanus toxoid adsorbed, for intramuscular use
90704 Mumps virus vaccine, live, for subcutaneous use
90705 Measles virus vaccine, live, for subcutaneous use

90706	Rubella virus vaccine, live, for subcutaneous use	
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	
90708	Measles and rubella virus vaccine, live, for subcutaneous use	
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use	
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use	
90716	Varicella virus vaccine, live, for subcutaneous use	
90717	Yellow fever vaccine, live, for subcutaneous use	
90718	Tetanus and diptheria toxoids (Td) adsorbed for use in individuals seven years or older, for intramuscular use	
90720	Diptheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use	
90721	Diptheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use	
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (Dtap-HepB-IPV), for intramuscular use	
90725	Cholera vaccine for injectable use	
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older,for subcutaneous or intramuscular use	
90733	Meningococococcal polysaccharide vaccine (any group(s)), for subcutaneous use	
90734	Meningococococcal conjugate vaccine, serogroups A, C, Y and W-135 (Tetravalent), for intramuscular use	
90735	Japanese encephalitis virus vaccine, for subcutaneous use	
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	
90744	Hepatitis B vaccine; pediatric/adolescent dosage, (3 dose schedule) for intramuscular use	
90746	adult dose, for intramuscular use	
90747	dialysis or immunosuppressed patient, dosage (4 dose schedule), for intramuscular use	
90748	Hepatitis B and Hemophilus influenza B (Hep B -HIB), for intramuscular use	
90749	UNLISTED vaccine/toxoid	BR

THERAPEUTIC OR DIAGNOSTIC INFUSIONS (EXCLUDES CHEMOTHERAPY)

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

90780	Intravenous infusion therapy/diagnosis administered by physician or under direct supervision of physician; up to one hour	$35.00
90781	each additional hour, up to eight (8) hours	$5.00

THERAPEUTIC PROPHYLACTIC OR DIAGNOSTIC INJECTIONS

90799	UNLISTED therapeutic, prophylactic or diagnostic injection (injectable material)	BR

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

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

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

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

THERAPEUTIC INJECTIONS **(Maximum fee includes cost of materials)**

A4216	Sterile water/saline, 10 ml
A4260	Levonorgestrel contraceptive implants system (Norplant System), including implants and supplies
J0135	Adalimumab, 20 mg
J0150	Adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270)
J0170	Adrenalin, Epinephrine, up to 1 ml ampule
J0180	Agalsidase beta, 1 mg
J0205	Alglucerase, per 10 units
J0207	Amifostine, 500 mg
J0210	(Aldomet) Methyldopate HCL, up to 250 mg
J0215	Alefacept (Amevive), 0.5 mg
J0256	Alpha 1-Proteinase Inhibitor-Human, 10 mg
J0270	Alprostadil, per 1.25 mcg (administered under direct physician supervision, excludes self-administration)
J0275	Alprostadil urethral suppository (administered under direct supervision of a physician, not for self-administration)
J0280	Aminophyllin, up to 250 mg
J0290	Ampicillin Sodium, up to 500 mg

J0295 Ampicillin Sodium/Sulbactam Sodium, per 1.5 gm
J0300 Amobarbital, up to 125 mg
J0360 Hydralazine HCL, up to 20 mg
J0380 Metaraminol Bitartrate, per 10 mg
J0390 Chloroquine Hydrochloride, up to 250 mg
J0456 Azithromycin, 500 mg
J0460 Atropine Sulfate, up to 0.3 mg
J0470 Dimercaprol, per 100 mg
J0475 Baclofen, 10 mg
J0500 Dicyclomine HCl, up to 20 mg
J0515 Benztropine Mesylate, per 1 mg
J0520 Bethanechol Chloride, Mytonachol or Urecholine, up to 5 mg
J0530 Penicillin G Benzathine and Penicillin G Procaine, up to 600,000 units
J0540 Penicillin G Benzathine and Penicillin G Procaine, up to 1,200,000 units
J0550 Penicillin G Benzathine and Penicillin G Procaine, up to 2,400,000 units
J0560 Penicillin G Benzathine, up to 600,000 units
J0570 Penicillin G Benzathine, up to 1,200,000 units
J0580 Penicillin G Benzathine, up to 2,400,000 units
J0585 Botulinum Toxin Type A, per 100 units
J0587 Botulinum Toxin Type B, per 100 units
J0600 (Calcium Disodium Versenate) Edetate Calcium Disodium, up to 1000 mg
J0610 Calcium Gluconate, per 10 ml
J0620 Calcium Glycerophosphate and Calcium Lactate, per 10 ml
J0636 Calcitriol, 0.1 mcg
J0640 Leucovorin Calcium, per 50 mg
J0690 Cefazolin Sodium, up to 500 mg
J0694 Cefoxitin Sodium, 1 gm
J0696 Ceftriaxone Sodium, per 250 mg
J0697 Sterile Cefuroxime Sodium, per 750 mg
J0698 Cefotaxime Sodium, per gm
J0702 Betamethasone Acetate and Betamethasone Sodium Phosphate, per 3 mg (1 unit= 3 mg of Betamethasone Acetate and 3 mg of Betamethasone Sodium Phosphate)
J0704 Betamethasone Sodium Phosphate, per 4 mg
J0710 Cephapirin Sodium (Cefadyl) up to 1 gm
J0713 Ceftazidime, per 500 mg
J0715 Ceftizoxime Sodium, per 500 mg
J0720 (Chloromycetin Sodium Succinate) Chloramphenicol Sodium Succinate, up to 1 gm
J0725 Chorionic Gonadotropin, per 1,000 USP units
J0740 Cidofovir, 375 mg
J0744 Ciprofloxacin for intravenous infusion, 200 mg
J0745 Codeine Phosphate, per 30 mg
J0760 Colchicine, per 1 mg
J0770 (Coly-Mycin M) Colistimethate Sodium, up to 150 mg
J0780 (Compazine) Prochlorperazine, up to 10 mg
J0835 Cosyntropin, per 0.25 mg
J0895 Deferoxamine Mesylate, 500 mg

J0900 Testosterone Enanthate and Estradiol Valerate, up to 1 cc
J0945 Brompheniramine maleate, per 10 mg
J0970 (Delestrogen) Estradiol Valerate, up to 40 mg
J1000 Depo-Estradiol Cypionate, up to 5 mg
J1020 (Depo-Medrol) Methylprednisolone Acetate, 20 mg
J1030 (Depo-Medrol) Methylprednisolone Acetate, 40 mg
J1040 (Depo-Medrol) Methylprednisolone Acetate, 80 mg
J1051 (Depo-Provera Aq.) Medroxyprogesterone Acetate, 50 mg
J1055 (Depo-Provera Ag.) Medroxyprogesterone Acetate for contraceptive use, 150 mg
J1056 Medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg
J1060 (Depo-Testadiol) Testosterone Cypionate and Estradiol Cypionate, up to 1 ml
J1070 (Depo-Testosterone Cypionate) Testosterone Cypionate, up to 100 mg
J1080 (Depo-Testosterone Cypionate) Testosterone Cypionate, 1 cc, 200 mg
J1094 Dexamethasone Acetate, 1 mg
J1100 Dexamethasone Sodium Phosphate, 1 mg
J1110 Dihydroergotamine Mesylate, per 1 mg
J1120 Acetazolamide Sodium, up to 500 mg
J1160 Digoxin, up to 0.5 mg
J1165 Phenytoin Sodium, per 50 mg
J1170 Hydromorphone, up to 4 mg
J1180 Dyphylline, up to 500 mg
J1190 Dexrazoxane Hydrochloride, per 250 mg
J1200 Diphenhydramine HCL, up to 50 mg
J1205 Chlorothiazide Sodium, per 500 mg
J1212 DMSO, Dimethyl Sulfoxide, 50%, 50 ml
J1230 Methadone HCL, up to 10 mg
J1240 Dimenhydrinate, up to 50 mg
J1260 Dolasetron Mesylate, 10 mg
J1320 (Elavil HCL) Amitriptyline HCL, up to 20 mg
J1330 Ergonovine Maleate, (Ergotrate Maleate) up to 0.2 mg
J1364 Erythromycin Lactobionate, per 500 mg
J1380 Estradiol Valerate, up to 10 mg
J1390 Estradiol Valerate, up to 20 mg
J1410 Estrogen Conjugated, per 25 mg
J1435 Estrone, per 1 mg
J1436 Etidronate Disodium, per 300 mg
J1438 Etanercept, 25 mg, (administered under direct supervision of physician, not self administered)
J1440 Filgrastim (G-CSF), 300 mcg
J1441 Filgrastim (G-CSF), 480 mcg
J1450 Fluconazole, 200 mg
J1452 Fomivirsen Sodium, intraocular, 1.65 mg
J1455 Foscarnet Sodium, per 1000 mg
J1570 Ganciclovir Sodium, 500 mg
J1580 Garamycin, Gentamicin, up to 80 mg
J1590 Gatifloxacin, 10 mg

J1595	Glatiramer acetate, 20 mg	
J1600	Gold Sodium Thiomaleate, up to 50 mg	
J1610	Glucagon Hydrochloride, per 1 mg	
J1620	Gonadorelin Hydrochloride, per 100 mcg	
J1626	Granisetron Hydrochloride, 100 mcg	
J1630	(Haldol) Haloperidol, up to 5 mg	
J1631	(Haldol) Haloperidol Decanoate, per 50 mg	
J1642	Heparin Sodium, (heparin lock flush), per 10 units	
J1644	Heparin Sodium, per 1000 units	
J1645	Dalteparin Sodium, per 2500 IU	
J1652	Fondaparinux sodium, 0.5 mg	
J1655	Tinzaparin sodium, 1000 IU	
J1710	(Hydrocortone Phosphate) Hydrocortisone Sodium Phosphate, up to 50 mg	
J1720	Hydrocortisone Sodium Succinate, (Solu-Cortef) up to 100 mg	
J1730	(Hyperstat) Diazoxide, up to 300 mg	
J1745	Infliximab, 10 mg	
J1750	Iron dextran, 50 mg	
J1756	Iron sucrose, 1 mg	
J1785	Imiglucerase, per unit (per vial)	BR
J1790	Droperidol, up to 5 mg	
J1800	(Inderal) Propranolol HCL, up to 1 mg	
J1815	Insulin, per 5 units	
J1817	Insulin (i.e., insulin pump) per 50 units	
J1825	Interferon beta-la, 33 mcg (administered under direct physician supervision, not for self administration)	
J1830	Interferon Beta-1b, 0.25 mg, (administered under direct physician supervision, not for self-administration)	
J1840	(Kantrex) Kanamycin Sulfate, up to 500 mg	
J1850	(Kantrex Pediatric) Kanamycin Sulfate, up to 75 mg	
J1885	Ketorolac Tromethamine, per 15 mg	
J1890	(Keflin) Cephalothin Sodium, up to 1 gm	
J1931	Laronidase, 0.1 mg	
J1940	(Lasix) Furosemide, up to 20 mg	
J1950	Leuprolide Acetate (for depot suspension), per 3.75 mg	
J1955	Levocarnitine, per 1 gm	
J1960	(Levo-Dromoran) Levorphanol Tartrate, up to 2 mg	
J1980	(Levsin) Hyoscyamine Sulfate, up to 0.25 mg	
J1990	(Librium) Chlordiazepoxide HCL, up to 100 mg	
J2001	Lidocaine HCL for intravenous infusion, 10 mg	
J2010	(Lincocin) Lincomycin HCL up to 300 mg	
J2060	Lorazepam, 2 mg	
J2150	Mannitol, 25% in 50 ml	
J2175	Meperidine Hydrochloride, per 100 mg	
J2210	(Methergine Maleate) Methylergonovine Maleate, up to 0.2 mg	
J2260	Milrinone lactate, per 5 ml	
J2270	Morphine Sulfate, up to 10 mg	

J2275 Morphine Sulfate (preservative-free sterile solution), per 10 mg
J2320 Nandrolone Decanoate, up to 50 mg
J2321 Nandrolone Decanoate, up to 100 mg
J2322 Nandrolone Decanoate, up to 200 mg
J2353 Octreotide, depot form for intramuscular injection, 1 mg
J2355 Oprelvekin 5 mg
J2357 Omalizumab (Xolair), 5 mg
J2360 (Norflex) Orphenadrine, up to 60 mg
J2370 (Neo-Synephrine) Phenylephrine HCL, up to 1 ml
J2405 Odansetron Hydrochloride (Zofran), per 1 mg
J2410 (Numorphan) Oxymorphone HCL, up to 1 mg
J2430 Pamidronate Disodium, per 30 mg
J2440 Papaverine HCL, up to 60 mg
J2460 Oxytetracycline HCL, up to 50 mg
J2469 Palonosetron HCL, 25 mcg
J2505 Pegfilgrastim (Neulasta), 6 mg
J2510 Penicillin G Procaine, Aqueous, up to 600,000 units
J2515 Pentobarbital Sodium, per 50 mg
J2540 (Pfizerpen) Penicillin G Potassium, up to 600,000 units
J2545 Pentamidine Isethionate, inhalation solution, per 300 mg
J2550 (Phenergan) Promethazine HCL, up to 50 mg
J2560 Phenobarbital Sodium, up to 120 mg
J2590 (Pitocin) Oxytocin, up to 10 units
J2597 Desmopressin Acetate, per 1 mcg
J2650 Prednisolone Acetate, up to 1 ml
J2670 (Priscoline HCL) Tolazoline HCL, up to 25 mg
J2675 Progesterone (Injection), per 50 mg
J2680 (Prolixin Decanoate) Fluphenazine Decanoate, up to 25 mg.
J2690 (Pronestyl) Procainamide HCL, up to 1 gm
J2700 (Prostaphlin) Oxacillin Sodium, up to 250 mg
J2710 (Prostigmin) Neostigmine Methylsulfate, up to 0.5 mg
J2720 Protamine Sulfate, per 10 mg
J2730 (Protopam Chloride) Pralidoxime Chloride, up to 1 gm
J2760 (Regitine) Phentolamine Mesylate, up to 5 mg
J2765 (Reglan) Metoclopramide HCL, up to 10 mg
J2780 Ranitidine HCL, 25 mg
J2783 Rasburicase, 0.5 mg
J2800 (Robaxin) Methocarbamol, up to 10 ml
J2820 Sargramostim (GM-CSF), 50 mcg
J2910 (Solganal) Aurothioglucose, up to 50 mg
J2912 Sodium Chloride, 0.9%, per 2 ml
J2920 (Solu-Medrol) Methylprednisolone Sodium Succinate, up to 40 mg
J2930 (Solu-Medrol) Methylprednisolone Sodium Succinate, up to 125 mg
J2940 Somatrem, 1 mg
J2941 Somatropin, 1 mg
J2995 Streptokinase, per 250,000 IU

J3000 Streptomycin, up to 1 gm
J3030 Sumatriptan Succinate, 6 mg
J3070 Pentazocine, 30 mg
J3105 Terbutaline Sulfate, up to 1 mg
J3120 Testosterone Enanthate, up to 100 mg
J3130 Testosterone Enanthate, up to 200 mg
J3140 Testosterone Suspension, up to 50 mg
J3150 Testosterone Propionate, up to 100 mg
J3230 (Thorazine) Chlorpromazine HCL, up to 50 mg
J3240 Thyrotropin alpha, 0.9 mg. Provided in 1.1 mg
J3250 (Tigan) Trimethobenzamide HCL, up to 200 mg
J3260 Tobramycin Sulfate, (Nebcin) up to 80 mg
J3265 Torsemide, 10 mg/ml
J3280 (Torecan) Thiethylperazine Maleate, up to 10 mg
J3301 Triamcinolone Acetonide, per 10 mg
J3302 Triamcinolone Diacetate, per 5 mg
J3303 Triamcinolone Hexacetonide, per 5 mg
J3305 Trimetrexate Glucoronate, per 25 mg
J3310 (Trilafon) Perphenazine, up to 5 mg
J3315 Triptorelin pamoate, 3.75 mg
J3320 (Trobicin) Spectinomycin Dihydrochloride, up to 2 gm
J3360 (Valium) Diazepam, up to 5 mg
J3364 Urokinase, 5000 IU vial
J3370 Vancomycin HCL, up to 500 mg
J3400 (Vesprin) Triflupromazine HCL, up to 20 mg
J3410 (Vistaril) Hydroxyzine HCL, up to 25 mg
J3411 Thiamine HCL, 100 mg
J3415 Pyridoxine HCL, 100 mg
J3420 Vitamin B-12 Cyanocobalamin, up to 1000 mcg
J3430 Phytonadione, (Vitamin K), per 1 mg
J3470 (Wydase) Hyaluronidase, up to 150 units
J3475 Magnesium sulfate, per 500 mg
J3480 Potassium Chloride, per 2 mEq
J3487 Zoledronic acid (Zometa), 1 mg
J3520 Edetate Disodium, per 150 mg
J3590 Unclassified biologics BR

MISCELLANEOUS DRUGS AND SOLUTIONS

J7030 Infusion, normal saline solution (or water), 1000 cc
J7040 Infusion, normal saline solution (or water), sterile (500 ml = 1 unit)
J7042 5% dextrose/normal saline (500 ml = 1 unit)
J7050 Infusion, normal saline solution (or water), 250 cc
J7051 Sterile saline or water, up to 5 cc
J7060 5% dextrose/water (500 ml = 1 unit)
J7070 Infusion, D5W, 1000 cc
J7100 Infusion, Dextran 40, 500 ml

J7110	Infusion, Dextran 75, 500 ml	
J7120	Ringers Lacetate Infusion, up to 1000 cc	
J7130	Hypertonic saline solution, 50 or 100 mEq, 20 cc vial	
J7300	Intrauterine Copper Contraceptive	
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	
J7303	Contraceptive supply, hormone containing vaginal ring, each	
J7304	Contraceptive supply, hormone containing patch, each	
J7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354 mg)	
J7317	Sodium hyaluronate, per 20 to 25 mg dose for intra-articular injection	
J7320	Hylan G-F 20, 16 mg, for intra-articular injection	
J7501	Azathioprine, parenteral (eg Imuran), 100 mg	
J7504	Lymphocyte immune globulin, anti-thymyocyte globulin equine, parenteral, 250 mg	
J7611	Albuterol, inhalation solution, administered through DME, concentrated form, 1 mg	
J7612	Levalbuterol, inhalation solution, administered through DME, concentrated form 0.5 mg	
J7613	Albuterol, inhalation solution, administered through DME, unit dose 1 mg	
J7614	Levalbuterol, inhalation solution, administered through DME, unit dose 0.5 mg	
J7616	Albuterol, up to 5 mg and ipratropium bromide, up to 1 mg, compounded inhalation solution, administered through DME	
J7628	Bitolterol mesylate, inhalation solution, concentrated form, per mg	
J7631	Cromolyn sodium, inhalation solution, unit dose form, per 10 mg	
J7644	Ipratropium bromide, inhalation solution, unit dose form, per mg	
J7648	Isoetharine HCL, inhalation solution, concentrated form, per mg	
J7649	Isoetharine HCL, inhalation solution, unit dose form, per mg	
J7658	Isoproterenol HCL, inhalation solution, concentrated form, per mg	
J7668	Metaproterenol sulfate, inhalation solution, concentrated form, per 10 mg	
J7669	Metaproterenol sulfate, inhalation solution, unit dose form, per 10 mg	
J7674	Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg	
J7682	Tobramycin, unit dose form, 300 mg, inhalation solution	
J8501	Aprepitant, oral, 5 mg	
L8603	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies	BR
Q0136	Epoetin alpha, (for non ESRD use), per 1000 units	
Q0137	Darbepoetin alfa, 1 mcg (non-ESRD use)	
Q2012	Pegademase bovine, 25 IU	
Q3031	Collagen skin test	BR
90799	UNLISTED therapeutic, prophylactic or diagnostic injection (injectable material)	BR

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures, eg, otoscopy, rhinoscopy, tuning fork test, does not apply.
Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using descriptors from the Audiologic Function Tests listed below.

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

AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION

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

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

CARDIOVASCULAR

CARDIOGRAPHY

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

PULMONARY

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

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

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

ALLERGY AND CLINICAL IMMUNOLOGY

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

SENSITIVITY TESTING (Maximum fees include reading of test)

86580	Skin test; tuberculosis, intradermal	$5.00
86585	tuberculosis, tine test	$1.88

CHEMOTHERAPY ADMINISTRATION

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

96405	Chemotherapy administration, intralesional; up to and including 7 lesions	$10.00
96406	more than 7 lesions	$15.00
96408	Chemotherapy administration, intravenous; push technique	$15.00
96410	infusion technique, up to one hour	$35.00
96412	infusion technique, one to 8 hours, each additional hour (use 96412 in conjunction with code 96410)	$5.00
96414	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	$35.00
96420	Chemotherapy administration, intra-arterial; push technique	$15.00
96422	infusion technique, up to one hour	$35.00
96423	infusion technique, one to 8 hours, each additional hour (use 96423 in conjunction with code 96422)	$5.00
96425	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	$35.00
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	$47.00
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	$47.00
96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture	$42.00
96520	Refilling and maintenance of portable pump	$15.00

96530	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic, (intravenous, intra-arterial) (Access of pump port is included in filling of implantable pump)	$15.00
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir,single or multiple agents	$15.00
96545	Provision of chemotherapy agent (not otherwise listed)	BR
96549	UNLISTED chemotherapy procedure	BR

CHEMOTHERAPY DRUGS

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

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

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

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

J9092 Cyclophosphamide (Cytoxan, Neosar) 2.0 gm
J9093 Cyclophosphamide, Lyophilized (Cytoxan) 100 mg
J9094 Cyclophosphamide, Lyophilized (Cytoxan) 200 mg
J9095 Cyclophosphamide, Lyophilized (Cytoxan) 500 mg
J9096 Cyclophosphamide, Lyophilized (Cytoxan) 1.0 gm
J9097 Cyclophosphamide, Lyophilized (Cytoxan) 2.0 gm
J9098 Cytarabine Liposome, 10 mg
J9100 Cytarabine (Cytosar-U) 100 mg
J9110 Cytarabine (Cytosar-U) 500 mg
J9120 Dactinomycin, (Cosmegen) 0.5 mg
J9130 Dacarbazine, 100 mg
J9140 Dacarbazine, 200 mg
J9150 Daunorubicin HCL, 10 mg
J9151 Daunorubicin citrate, liposomal formulation, 10 mg
J9160 Denileukin diftitox, 300 mcg
J9165 Diethylstilbestrol Diphosphate, 250 mg
J9170 Docetaxel, 20 mg
J9178 Epirubicin HCL, 2 mg
J9181 Etoposide, 10 mg
J9182 Etoposide, 100 mg
J9185 Fludarabine phosphate, 50 mg
J9190 Fluorouracil, 500 mg
J9200 Floxuridine (FUDR) 500 mg
J9201 Gemcitabine HCL, 200 mg
J9202 Goserelin Acetate Implant per 3.6 mg
J9206 Irinotecan, 20 mg
J9208 Ifosfomide, 1 gm
J9209 Mesna, 200 mg
J9211 Idarubicin Hydrochloride, 5 mg
J9212 Interferon Alfacon-1, recombinant, 1 mcg
J9213 Interferon, Alfa-2A, Recombinant, 3 million units
J9214 Interferon, Alfa-2B, Recombinant, 1 million units
J9215 Interferon, Alfa-N3, (Human Leukocyte Derived), 250,000 IU
J9216 Interferon, Gamma 1-B, 3 million units
J9217 Leuprolide Acetate (for Depot Suspension) 7.5 mg
J9218 Leuprolide Acetate, per 1 mg
J9219 Leuprolide Acetate Implant, 65 mg
J9230 Mechlorethamine Hydrochloride, (Nitrogen Mustard) 10 mg
J9245 Melphalan Hydrochloride, 50 mg
J9250 Methotrexate Sodium, 5 mg
J9260 Methotrexate Sodium, 50 mg
J9263 Oxaliplatin (Eloxatin), 0.5 mg
J9265 Paclitaxel, 30 mg
J9266 Pegaspargase, per single dose vial
J9268 Pentostatin, per 10 mg
J9270 Plicamycin 2.5 mg

J9280	Mitomycin, 5 mg	
J9290	Mitomycin, 20 mg	
J9291	Mitomycin, 40 mg	
J9293	Mitoxantrone Hydrochloride, per 5 mg	
J9300	Gemtuzumab ozogamicin, 5 mg	
J9305	Pemetrexed, 10 mg	
J9310	Rituximab, 100 mg	
J9320	Streptozocin, 1 gm	
J9340	Thiotepa 15 mg	
J9350	Topotecan, 4 mg	
J9355	Trastuzumab, 10 mg	
J9357	Valrubicin, intravesical, 200 mg	
J9360	Vinblastine Sulfate, 1 mg	
J9370	Vincristine Sulfate, 1 mg	
J9375	Vincristine Sulfate, 2 mg	
J9380	Vincristine Sulfate, 5 mg	
J9390	Vinorelbine Tartrate, per 10 mg	
J9395	Fulvestrant (Faslodex), 25 mg	
J9600	Porfimer Sodium, 75 mg	
J9999	Not otherwise classified, antineoplastic drugs	BR
Q0165	Prochlorperazine maleate, 10 mg, oral	
Q0174	Thiethylperazine maleate, 10 mg, oral	
Q0177	Hydroxyzine pamoate, 25 mg, oral	
Q2017	Teniposide, 50 mg	
96545	Provision of chemotherapy agent (not listed above)	BR

SPECIAL SERVICES

MISCELLANEOUS SERVICES

99052	Services requested between 10:00 PM and 8:00 AM in addition to basic service (Procedure code 99052 is not reimbursable when the Practitioner is contractually obligated to provide the basic service (eg, emergency room physicians, etc.))	$5.00
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	BR
99082	Unusual travel (mileage, per mile, one way, beyond 10 mile radius of point of origin (office or home))	$.50
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma	$27.00

SURGERY SECTION

GENERAL INFORMATION AND RULES

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

2. **FOLLOW-UP 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. **BY REPORT:** When the value of a procedure is indicated as "By Report" (BR), an Operative Report must be submitted with the MMIS claim form for a payment determination to be made. The Operative Report must include the following information:

    a. Diagnosis (post-operative)

    b. Size, location and number of lesion(s) or procedure(s) where appropriate

    c. Major surgical procedure and supplementary procedure(s)

    d. Whenever possible, list the nearest similar procedure by number according to these studies

    e. Estimated follow-up period

    f. Operative time

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

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

5. When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

6. **MULTIPLE SURGICAL PROCEDURES:**

    a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total dollar value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified.

b. When an incidental procedure (eg, incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the fee will be that of the major procedure only.

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

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

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

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

SURGERY SERVICES

INTEGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND AREOLAR TISSUES

		Follow Up Days	
INCISION			
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single		$8.00
10061	complicated or multiple		$24.00
10120	Incision and removal of foreign body, subcutaneous tissues; simple		$8.00
10140	Incision and drainage of hematoma, seroma or fluid collection		$8.00
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst		$4.00
EXCISION - BENIGN LESIONS			
Excision (including simple closure) of benign lesions of skin or subcutaneous tissues (eg, cicatricial, fibrous, inflammatory, congenital, cystic lesions), including local anesthesia. See appropriate size and area below.			
(For electrosurgical and other methods, see 17110 et seq)			
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	30	$18.00
11400	Excision, benign lesion, including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	30	$16.00
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 implant system (Norplant System), including implants and supplies		BR

REPAIR

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

Instructions for listing services at time of wound repair.

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

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

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

REPAIR – SIMPLE

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

BURNS, LOCAL TREATMENT

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

List percentage of body surface involved and depth of burn.

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

16000	Initial treatment, first degree burn, when no more than local treatment is required	$6.00
16020	Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small	$8.00

DESTRUCTION

		Follow Up Days	
17110	Destruction (eg, laser surgery, electrosurgery,cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum or milia; up to 14 lesions (Retreatment same as office visit)	10	$8.00

		Follow Up Days	
17111	15 or more lesions	10	$11.00
	(For excision of fibrocutaneous tags, see 11200)		
17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)		$8.00

DIGESTIVE SYSTEM

STOMACH

43760	Change of gastrostomy tube		$20.00

FEMALE GENITAL SYSTEM

VULVA AND INTROITUS

DESTRUCTION

56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)		$8.00

REPAIR

56820	Colposcopy of the vulva;	30	$35.00

VAGINA

INTRODUCTION

57150	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease		$4.00

ENDOSCOPY

57420	Colposcopy of the entire vagina, with cervix If present		$36.00
57452	Colposcopy of the cervix including upper/adjacent vagina;		$44.00

CORPUS UTERI

INTRODUCTION

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

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

MATERNITY CARE

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

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

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

ANTEPARTUM AND POSTPARTUM CARE

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

59425	Antepartum care only; 4-6 visits (MOMS $364.00)	$209.00
	(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)	
59426	7 or more visits (MOMS $541.00)	$302.00
	(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.	
59430	Postpartum care only **(outpatient)** (separate procedure) (MOMS $59.00)	$31.00
	(When inpatient postpartum care is provided, see appropriate Hospital Evaluation and Management code(s).)	