

# NURSE PRACTITIONER Procedure Codes

eMedNY New York State Medicaid Provider Procedure  
Code Manual

## Adds:

J0391 - Code previously added (01/01/2024); corrected

J0217, J0391, J0402, J0688, J0873, J1304, J1939, J2508, J2679, J2799, J3401, J9052, J9072, J9172, J9255, J9258, J9286, J9321, J9333, J9334, Q5132 – Code previously added (01/01/2024); corrected Reviewed 7/8/24 LDK

J0401 – Code previously added 01/01/2014); corrected Reviewed 7/8/24 LDK

J1305 - Code previously added (10/01/2023); corrected Reviewed was listed as J0305, fixed it to J1305 LDK

J1960 – Code previously added (11/01/1990); corrected Reviewed 7/8/24 LDK

Q2056 – Code previously added (10/01/2022); corrected Reviewed 7/8/24 LDK

## Deletions:

90653 (flu vaccine code set to \$0.00 eff 1/1/22; removed from PCM) – KLS 7/2/24 Reviewed 7/8/24 LDK

J1020, J1030, J1040, J1840, J1850, J2920, J2930, J9070, J9250, – code end dated 3/31/24 but was not deleted; corrected Reviewed 7/8/24 LDK

## Changes:

## New York State Medicaid

Office of Health Insurance  
Department of Health

CONTACTS and LINKS:

eMedNY URL

<https://www.emedny.org/>

eMedNY Contact Information

(800) 343-9000

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

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## 1 DOCUMENT CONTROL PROPERTIES

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## 2 GENERAL INFORMATION

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

- F. **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.

- G. **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.

- H. **PRESCRIBER WORKSHEET:** Enteral formula requires voice interactive telephone prior authorization from the Medicaid program. The prescriber must initiate the authorization through this system. The worksheet specifies the questions asked on the voice interactive telephone system and must be maintained in the patient's clinical record. The worksheet

can be found on the Provider Communication link. [eMedNY : Provider Manuals : Nurse Practitioner Provider Communications](#)

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

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

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

Additional information is available at:

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

- K. **DVS AUTHORIZATION (#):** Codes followed by # require an authorization via the dispensing validation system (DVS) before services are rendered.
- L. **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.
- M. **FEES:** The fees are listed in the Nurse Practitioner Fee Schedule, available at <http://www.emedny.org/ProviderManuals/NursePractitioner/index.html>

Listed fees are the maximum reimbursable Medicaid fees. Fees for the MOMS Program and PPAC Program can be found in the Enhanced Program Fee Schedule.

### 3 SERVICES PROVIDED IN ARTICLE 28 FACILITIES

The professional component for all services provided by a nurse practitioner in an Article 28 hospital outpatient clinic, hospital inpatient setting, emergency department, ambulatory surgery setting and diagnostic and treatment center (D&TC) for Medicaid fee-for-service patients is included in the APG or APR-DRG payment to the facility. Nurse practitioners may not bill Medicaid separately for professional services provided in an Article 28 facility.



## 4 MMIS MODIFIERS

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

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

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

- 24** Unrelated Evaluation and Management Service by the Same Practitioner during a Postoperative Period: The practitioner may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier -24 to the appropriate level of E/M service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- 25** Significant, Separately Identifiable Evaluation and Management Service by the Same Practitioner on the Day of a Procedure: (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.  
**NOTE:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)
- 77** Repeat Procedure by Another 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 Vaccines for Children Program (VFC) for children under 19 years of age). When administering vaccine supplied by the state (VFC program), you **must** append modifier –SL State Supplied Vaccine to the procedure code number representing the vaccine administered. Omission of this modifier on claims for recipients under 19 years of age will cause your claim to deny. (Reimbursement will not exceed \$17.85, the administration fee for the VFC program.)

## 5 EVALUATION/ MANAGEMENT SERVICES

### 5.1 GENERAL RULES AND INFORMATION

- A. **PRIMARY CARE**: Primary care is first contact care, the type furnished to individuals when they enter the health care system. Primary care is comprehensive in that it deals with a wide range of health problems, diagnosis and modes of treatment. Primary care is continuous in that an ongoing relationship is established with the primary care practitioner who monitors and provides the necessary follow-up care and is coordinated by linking patients with more varied specialized services when needed. Consultations and care provided on referral from another practitioner is not considered primary care.
- B. **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.
- C. **LEVELS OF E/M SERVICES**: Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. **The Evaluation and Management guidelines in the CPT book should be referenced when selecting the level of E/M codes.**
- D. **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.

- E. **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**.

## **5.2 OFFICE OR OTHER OUTPATIENT SERVICES**

### **5.2.1 NEW PATIENT**

- 99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and low level of medical decision making. When using time for code selection, 30 minutes must be met or exceeded.
- 99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and moderate level of medical decision making. When using time for code selection, 45 minutes must be met or exceeded.
- 99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and high level of medical decision making. When using time for code selection, 60 minutes must be met or exceeded.

### **5.2.2 ESTABLISHED PATIENT**

- 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.
- 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

- 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

## **5.3 HOSPITAL INPATIENT AND OBSERVATION CARE SERVICES**

### **5.3.1 INITIAL HOSPITAL INPATIENT OR OBSERVATION CARE**

#### **5.3.1.1 NEW OR ESTABLISHED PATIENT**

- 99221 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.  
When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99222 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.  
When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
- 99223 Initial hospital inpatient or observation care , per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.  
When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

#### **5.3.2 SUBSEQUENT HOSPITAL INPATIENT OR OBSERVATION CARE**

- 99231 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.  
When using total time on the date of the encounter for code selection, 25 minutes must be met or executed.
- 99232 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.  
When using total time on the date of the encounter for code selection, 35 minutes must be met or executed.
- 99233 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.  
When using total time on the date of the encounter for code selection, 50 minutes must be

met or executed.

### **5.3.3 HOSPITAL INPATIENT OR OBSERVATION CARE SERVICES (INCLUDING ADMISSION AND DISCHARGE SERVICES)**

- 99234 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making  
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99235 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making  
When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
- 99236 Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making  
When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.

### **5.3.4 HOSPITAL INPATIENT OR OBSERVATION DISCHARGE SERVICES**

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

## **5.4 EMERGENCY DEPARTMENT SERVICES**

### **5.4.1 NEW OR ESTABLISHED PATIENT**

- 99281 Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
- 99282 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
- 99283 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
- 99284 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
- 99285 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

## **5.5 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)).

## **5.5.1 INITIAL NURSING FACILITY CARE**

### **5.5.1.1 NEW OR ESTABLISHED PATIENT**

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.

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

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.

## **5.5.2 SUBSEQUENT NURSING FACILITY CARE**

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

## **5.5.3 NURSING FACILITY DISCHARGE SERVICES**

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

## 5.6 HOME OR RESIDENCE SERVICES

### 5.6.1 NEW PATIENT

- 99341 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and straightforward medical decision making.  
When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- 99342 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and low-level of medical decision making.  
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99344 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.  
When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99345 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and high level of medical decision making.  
When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

### 5.6.2 ESTABLISHED PATIENT

- 99347 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and straightforward medical decision making.  
When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99348 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and low-level of medical decision making.  
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99349 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.  
When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99350 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and high level of medical

decision making.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

## 5.7 PROLONGED SERVICES

### 5.7.1 PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN EVALUATION AND MANAGEMENT SERVICE

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

## 5.8 PREVENTIVE MEDICINE SERVICES

### 5.8.1 NEW PATIENT

99381 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)

99382 early childhood (age 1 through 4 years)

99383 late childhood (age 5 through 11 years)

99384 adolescent (age 12 through 17 years)

99385 18-39 years

99386 40-64 years

99387 65 years and older

### 5.8.2 ESTABLISHED PATIENT

99391 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)

99392 early childhood (age 1 through 4 years)

99393 late childhood (age 5 through 11 years)

99394 adolescent (age 12 through 17 years)

99395 18 - 39 years

99396 40 - 64 years

99397 65 years and older

### 5.8.3 COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

#### 5.8.3.1 NEW OR ESTABLISHED PATIENT

##### 5.8.3.1.1 BEHAVIOR CHANGE INTERVENTIONS, INDIVIDUAL

99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 intensive, greater than 10 minutes



## 5.8.3.2 OTHER PREVENTATIVE MEDICINE SERVICES

99429 Unlisted preventive medicine

## 5.9 NON-FACE-TO-FACE SERVICES

### 5.9.1 TELEPHONE SERVICES

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

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

### 5.9.2 ONLINE DIGITAL EVALUATION AND MANAGEMENT SERVICES

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422 11-20 minutes

99423 21 or more minutes

### 5.9.3 INTERPROFESSIONAL TELEPHONE/INTERNET/ELECTRONIC HEALTH RECORD CONSULTATION

99451 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

### 5.9.4 DIGITALLY STORED DATA SERVICES/REMOTE PHYSIOLOGIC MONITORING

99453 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

99454 device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

### 5.10 NEWBORN CARE SERVICES

99460 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant

99462 Subsequent hospital care, per day, for evaluation and management of normal newborn

99463 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date

### 5.11 OTHER EVALUATION AND MANAGEMENT SERVICES

99459 Pelvic examination (List separately in addition to code for primary procedure)

## 6 LABORATORY SERVICES PERFORMED IN THE OFFICE

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

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

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

For detection of pregnancy, use code 81025.

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

- 81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- 81001           automated, with microscopy
- 81002           non-automated, without microscopy
- 81003           automated, without microscopy
- 81015 Urinalysis; microscopic only
- 81025 Urine pregnancy test, by visual color comparison methods
- 83655 Lead
- 85007 Blood count; blood smear, microscopic examination with manual differential WBC count
- 85013           spun microhematocrit
- 85018           hemoglobin (Hgb)
- 85025           complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
- 85041           red blood cell (RBC) automated
- 85048           leukocyte (WBC), automated
- 85651 Sedimentation rate, erythrocyte; non-automated
- 85652           automated
- 86701 Antibody; HIV-1
- 86703 HIV-1 and HIV-2, single result
- 87081 Culture, presumptive, pathogenic organisms, screening only;
- 87426 Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])
- 87428 Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric severe acute respiratory syndrome coronavirus (eg, SARS-

- CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B
- 87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
- 87636 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
- 87637 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique.
- 87651 Streptococcus, group A, amplified probe technique
- 87806 HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies
- 87811 Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
- 87880 Streptococcus, group A

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

## 7 DRUGS AND DRUG ADMINISTRATION

### 7.1 IMMUNIZATION GUIDELINES

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. 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.

### 7.2 IMMUNE GLOBULINS, SERUM OR RECOMBINANT PRODUCTS

- 90291 Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
- 90371 Hepatitis B immune globulin (HBIG), human, for intramuscular use
- 90375 Rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous

- 90376 Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use
- 90377 Rabies immune globulin, heat-and solvent/detergent-treated (RIg-HT S/D), human, for intramuscular and /or subcutaneous use
- 90378 Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
- 90380 Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use
- 90381 Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use
- 90384 Rho(D) immune globulin (Rhlg), human, full-dose, for intramuscular use
- 90385 Rho(D) immune globulin (Rhlg), human, mini-dose, for intramuscular use
- 90386 Rho(D) immune globulin (RhlgIV), human, for intravenous use
- 90389 Tetanus immune globulin (TIg), human, for intramuscular use
- 90393 Vaccinia immune globulin, human, for intramuscular use
- 90396 Varicella-zoster immune globulin, human, for intramuscular use
- 90399 Unlisted immune globulin

### 7.3 IMMUNIZATION ADMINISTRATION FOR VACCINES/TOXOIDS

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

### 7.4 VACCINES/TOXOIDS

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

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

administration is reimbursable under 90460 on a single date of service.

**NOTE:** The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the current acquisition cost of the antigen. For immunizations not supplied by the VFC Program insert acquisition cost in amount charged field on claim form. For codes listed **BR/Report required**, 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 in CPT when the schedule (number of doses or timing) differs for two or more products of the same vaccine type (eg, hepatitis A, Hib) or the vaccine product is available in more than one chemical formulation, dosage, or route of administration.

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.

- 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
- 90589 Chikungunya virus vaccine, live attenuated, for intramuscular use
- 90619 Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use
- 90623 Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y- tetanus toxoid carrier, and Men B-FHbp, for intramuscular use
- 90620 *Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, (MenB-4C), 2 dose schedule, for intramuscular use*
- 90621 *Meningococcal recombinant lipoprotein vaccine, Serogroup B, (MenB-FHpb), 2 or 3 dose schedule, for intramuscular use*
- 90630 Influenza vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
- 90632 Hepatitis A vaccine (HepA), adult dosage, for intramuscular use
- 90633 Hepatitis A vaccine (Hep A), pediatric/adolescent dosage-2 dose schedule, for intramuscular use
- 90636 Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
- 90647 Haemophilus influenza type b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use
- 90648 Haemophilus influenza type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use
- 90649 Human Papillomavirus vaccine, types 6, 11, 16, 18 quadrivalent (4vHPV), 3 dose schedule, for intramuscular use
- 90650 Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use
- 90651 Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2

- or 3 dose schedule, for intramuscular use
- 90655 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use
  - 90656 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5mL dosage, for intramuscular use
  - 90657 Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use
  - 90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage for intramuscular use
  - 90660 Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
  - 90661 Influenza virus vaccine trivalent(cclIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
  - 90662 Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
  - 90670 Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
  - 90671 Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
  - 90672 Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
  - 90673 Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
  - 90674 Influenza virus vaccine; quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
  - 90675 Rabies vaccine, for intramuscular use
  - 90676 Rabies vaccine, for intradermal use
  - 90677 Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
  - 90678 Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use
  - 90679 Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use
  - 90680 Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use
  - 90681 Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use
  - 90682 Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
  - 90685 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
  - 90686 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
  - 90687 Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
  - 90688 Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
  - 90690 Typhoid vaccine, live, oral
  - 90691 Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use
  - 90694 Influenza virus vaccine, quadrivalent, (allV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use.
  - 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine, (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use

- 90697 Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
- 90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type B, and inactivated poliovirus vaccine, (DTaP –IPV/Hib), for intramuscular use
- 90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
- 90702 Diphtheria and tetanus toxoids adsorbed (DT) when administered to individuals younger than 7 years, for intramuscular use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
- 90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
- 90713 Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
- 90611 Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use
- 90714 Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
- 90622 Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use
- 90716 Varicella virus vaccine (VAR), live, for subcutaneous use
- 90717 Yellow fever vaccine, live, for subcutaneous use
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine, (DTaP-HepB-IPV), for intramuscular use
- 90732 Pneumococcal polysaccharide vaccine, 23-valent,(PPSV23),adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 , quadrivalent (MCV4 or MenACWY), for intramuscular use
- 90736 Zoster (shingles) vaccine,(HZV),live, for subcutaneous injection
- 90738 Japanese encephalitis virus vaccine, inactivated, for intramuscular use
- 90739 Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use
- 90740 Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
- 90743 Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use
- 90744 Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
- 90746 Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
- 90748 Hepatitis B and Haemophilus influenza type b (Hib-HepB), for intramuscular use
- 90749 Unlisted vaccine/toxoid
- 90750 Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use
- 90756 Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic

- free, 0.5 ml dosage, for intramuscular use
- 90759 Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use

## 7.5 DRUGS ADMINISTERED OTHER THAN ORAL METHOD GUIDELINES

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

New York State Medicaid's policy for coverage of drugs administered by subcutaneous, intramuscular or intravenous methods in the physician's office is as follows: These drugs are covered for FDA approved indications and those recognized off-label indications listed in the drug compendia (the American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DrugDex information system or Facts and Comparisons). In the absence of such a recognized indication, an approved Institutional Review Board (IRB) protocol would be required with documentation maintained in the patient's clinical file. Drugs are not covered for investigational or experimental use.

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.

**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 as BR in the Fee Schedule, also attach an itemized invoice to claim form.

### 7.5.1 THERAPEUTIC INJECTIONS (Maximum fee includes cost of materials)

- J0121 Omadacycline, 1 mg
- J0129 Abatacept, 10 mg  
(Administered under direct physician supervision, not for self-administration)
- J0134 Acetaminophen (fresenius kabi) not therapeutically equivalent to J0131, 10 mg
- J0135 Adalimumab, 20 mg
- J0136 Acetaminophen (b braun) not therapeutically equivalent to J0131, 10 mg
- J0137 Acetaminophen (hikma) not therapeutically equivalent to j0131, 10 mg
- J0153 Adenosine, 1 mg  
(Not to be used to report any adenosine phosphate compounds, instead use unlisted code)
- J0171 Adrenalin, epinephrine, 0.1 mg
- J0172 Aducanumab-avwa, 2 mg



J0174	Lecanemab-irmb, 1 mg
J0180	Agalsidase beta, 1 mg
J0185	Aprepitant, 1 mg
J0202	Alemtuzumab, 1 mg
J0205	Alglucerase, per 10 units
J0206	Allopurinol sodium, 1 mg
J0207	Amifostine, 500 mg
J0208	Sodium thiosulfate (pedmark), 100 mg
J0210	Methyldopate HCl, up to 250 mg
J0215	Alefacept, 0.5 mg
J0217	Velmanase alfa-tycv, 1 mg
J0218	Olipudase alfa-rpcp, 1mg
J0219	Avalglucosidase alfa-ngpt, 4 mg
J0222	Patisiran, 0.1 mg
J0223	Givosiran, 0.5 mg
J0224	Lumasiran, 0.5mh
J0225	Vutrisiran, 1 mg
J0248	Remdesivir, 1 mg
J0256	Alpha 1proteinase inhibitor (human), not otherwise specified, 10 mg
<u>J0270</u>	Alprostadil, per 1.25 mcg (Administered under direct physician supervision, not for self-administration)
<u>J0275</u>	Alprostadil urethral suppository (Administered under direct physician supervision, not for self-administration)
J0280	Aminophylline, up to 250 mg
J0290	Ampicillin sodium, up to 500 mg
J0291	Plazomicin, 5 mg
J0295	Ampicillin sodium/sulbactam sodium, per 1.5 gm
J0300	Amobarbital, up to 125 mg
J0349	Rezafungin, 1 mg
J0360	Hydralazine HCl, up to 20 mg
J0380	Metaraminol bitartrate, per 10 mg
J0390	Chloroquine HCl, up to 250 mg
J0391	Artesunate, 1 mg
J0401	Aripiprazole, extended release, intramuscular, 1 mg
J0402	Aripiprazole (abilify asimtufii), 1 mg
J0456	Azithromycin, 500 mg
J0461	Atropine sulfate, 0.01 mg
J0470	Dimercaprol, per 100 mg
J0475	Baclofen, 10 mg
J0491	Anifrolumab-fnia, 1 mg
J0500	Dicyclomine HCl, up to 20 mg
J0515	Benzotropine mesylate, per 1 mg
J0517	Benralizumab, 1 mg
J0520	Bethanechol chloride, myotonachol or urecholine, up to 5 mg

J0558	Penicillin G benzathine and penicillin G procaine, 100,000 units
J0561	Penicillin G benzathine, 100,000 units
J0565	Bezlotoxumab, 10 mg
J0577	Buprenorphine extended release (brixadi), less than or equal to 7 days of therapy
J0578	Buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy
J0584	Burosumab-twza, 1mg
J0585	OnabotulinumtoxinA, 1 unit
J0586	AbobotulinumtoxinA, 5 units
J0587	RimabotulinumtoxinB, 100 units
J0593	Lanadelumab-flyso, 1 mg (Administered under direct physician supervision, not for self-administration)
J0599	C1 esterase inhibitor (human), (haegarda), 10 units
J0600	Edetate calcium disodium, up to 1000 mg
J0610	Calcium gluconate (Fresenius Kabi), per 10 ml
J0611	Calcium gluconate (wg critical care), per 10 ml
J0612	Calcium gluconate, not otherwise specified, 10 mg
J0613	Calcium gluconate (wg critical care), not therapeutically equivalent to j0612, 10 mg
J0620	Calcium glycerophosphate and calcium lactate, per 10 ml
J0630	Calcitonin salmon, up to 400 units
J0636	Calcitriol, 0.1 mcg
J0640	Leucovorin calcium, per 50 mg
J0641	Levoleucovorin, not otherwise specified, 0.5 mg
J0642	Levoleucovorin (khapzory), 0.5 mg
J0688	Cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg
J0689	Cefazolin sodium (baxter), not therapeutically equivalent to J0690, 500 mg
J0690	Cefezolin 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
J0701	Cefepime hydrochloride (baxter), not therapeutically equivalent to maxipime, 500 mg
J0702	Betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg
J0703	Cefepime hydrochloride (b braun), not therapeutically equivalent to maxipime, 500 mg
J0710	Cephapirin sodium, up to 1 gm
J0713	Ceftazidime, per 500 mg
J0715	Ceftizoxime sodium, per 500 mg
J0720	Chloramphenicol sodium succinate, up to 1 gm
J0725	Chorionic gonadotropin, per 1,000 USP units
J0736	Clindamycin phosphate, 300 mg
J0737	Clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg
J0739	Cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)
J0740	Cidofovir, 375 mg

J0741	Cabotegravir and rilpivirine, 2mg/3mg
J0744	Ciprofloxacin for intravenous infusion, 200 mg
J0745	Codeine phosphate, per 30 mg
J0770	Colistimethate sodium, up to 150 mg
J0780	Prochlorperazine, up to 10 mg
J0791	Crizanlizumab-tmca, 5mg
J0834	Cosyntropin 0.25 mg
J0873	Daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg
J0874	Daptomycin (baxter), not therapeutically equivalent to j0878, 1 mg
J0875	Dalbavancin, 5 mg
J0881	Darbepoetin alfa, 1 mcg (Non-ESRD use)
J0885	Epoetin alfa, (Non-ESRD use), 1000 units
J0888	Epoetin beta, 1 mcg (Non-ESRD-use)
J0893	Decitabine (sun pharma) not therapeutically equivalent to J0894, 1 mg
J0894	Decitabine, 1 mg
J0895	Deferoxamine mesylate, 500 mg
J0896	Luspatercept-aamt, 0.25 mg
J0945	Brompheniramine maleate, per 10 mg
J1000	Depo-estradiol cypionate, up to 5 mg
J1010	Methylprednisolone acetate, 1 mg
J1050	Injection, medroxyprogesterone acetate, 1 mg
J1071	Testosterone cypionate, 1 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 HCl, per 250 mg
J1200	Diphenhydramine HCl, up to 50 mg
J1202	Miglustat, oral, 65 mg
J1203	Cipaglucosidase alfa-atga, 5 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
J1300	Eculizumab, 10 mg
J1301	Edaravone, 1 mg
J1302	Sutimlimab-jome, 10 mg
J1304	Tofersen, 1 mg
J1305	Evinacumab-dgnb, 5mg

J1306	Inclisiran, 1 mg
J1320	Amitriptyline HCl, up to 20 mg
J1322	Elosulfase alfa, 1 mg
J1323	Elranatamab-bcmm, 1 mg
J1330	Ergonovine maleate, up to 0.2 mg
J1364	Erythromycin lactobionate, per 500 mg
J1380	Estradiol valerate, up to 10 mg
J1410	Estrogen conjugated, per 25 mg
J1427	Viltolarsen, 10 mg
J1435	Estrone, per 1 mg
J1436	Etidronate disodium, per 300 mg
J1437	Ferric derisomaltose, 10 mg
J1438	Etanercept, 25 mg (Administered under direct physician supervision, not self-administered)
J1439	Ferric Carboxymaltose, 1 mg
J1440	Fecal microbiota, live - jsIm, 1 ml
J1442	Filgrastim (G CSF), excludes biosimilars, 1 microgram
J1447	Tbo-Filgrastim, 1 microgram
J1448	Trilaciclib, 1mg
J1449	Eflapegrastim-xnst, 0.1mg
J1450	Fluconazole, 200 mg
J1452	Fomivirsen sodium, intraocular, 1.65 mg
J1453	Fosaprepitant, 1 mg
J1454	Fosnetupitant 235 mg and palonestron 0.25 mg
J1455	Foscarnet sodium, per 1000 mg
J1456	Fosaprepitant (teva), not therapeutically equivalent to J1453, 1 mg
J1458	Galsulfase, 1 mg
J1459	Immune globulin (Privigen), intravenous, non lyophilized (e.g. liquid), 500 mg
J1460	Gamma globulin, intramuscular, 1 cc
J1551	Immune globulin (Cutaquig), 100 mg
J1554	Immune globulin (Asceniv), 500 mg
J1555	Immune globulin (Cuvitru), 100 mg
J1556	Immune globulin (Bivigam), 500 mg
J1560	Gamma globulin, intramuscular, over 10 cc
J1561	Immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562	Immune globulin (Vivaglobin), 100 mg
J1566	Immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg
J1568	Immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1569	Immune globulin, (Gammagard Liquid), non-lyophilized, (e.g. liquid), 500 mg
J1570	Ganciclovir sodium, 500 mg
J1572	Immune globulin, (flebogamma/flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1573	Hepatitis B immune globulin (HepaGam B), intravenous, 0.5 ml
J1574	Ganciclovir sodium (exela) not therapeutically equivalent to J1570, 500 mg

J1575	Immune globulin/Hyaluronidase (HYQVIA), 100 mg
J1576	Immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1580	Garamycin, gentamicin, up to 80 mg
J1595	Glatiramer acetate, 20 mg
J1599	Immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg
J1600	Gold sodium thiomalate, up to 50 mg
J1602	Golimumab, per 1 mg for Intravenous use
J1610	Glucagon HCl, per 1 mg
J1611	Glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to J1610, per 1 mg
J1620	Gonadorelin HCl, per 100 mcg
J1626	Granisetron HCl, 100 mcg
J1627	Granisetron, extended-release, 0.1 mg
J1628	Guselkumab, 1 mg
J1630	Haloperidol, up to 5 mg
J1631	Haloperidol decanoate, per 50 mg
J1642	Heparin sodium, (heparin lock flush), per 10 units
J1643	Heparin sodium (pfizer), not therapeutically equivalent to J1644, per 1000 units
J1644	Heparin sodium, per 1000 units
J1645	Dalteparin sodium, per 2500 IU
J1652	Fondaparinux sodium, 0.5 mg
J1655	Tinzaparin sodium, 1000 IU
J1710	Hydrocortisone sodium phosphate, up to 50 mg
J1720	Hydrocortisone sodium succinate, up to 100 mg
J1726	Injection, hydroxyprogesterone caproate, (Makena), 10 mg
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
J1730	Diazoxide, up to 300 mg
J1738	Meloxicam, 1mg
J1740	Ibandronate sodium, 1 mg
J1741	Injection, ibuprofen, 100 mg
J1745	Infliximab, 10 mg
J1746	Ibalizumab-uiyk, 10 mg
J1747	Spesolimab-sbzo, 1 mg
J1750	Iron dextran, 50 mg
J1756	Iron sucrose, 1 mg
J1786	Imiglucerase, 10 units
J1790	Droperidol, up to 5 mg
J1800	Propranolol HCl, up to 1 mg
J1815	Insulin, per 5 units
J1817	Insulin (i.e., insulin pump) per 50 units (Administered under direct physician supervision, not for self-administration)
J1823	Inebilizumab-cdon, 1 mg
J1826	Interferon beta-1a, 30 mcg
J1830	Interferon beta-1b, 0.25 mg

(Administered under direct physician supervision, not for self-administration)

J1836	Metronidazole, 10 mg
J1885	Ketorolac tromethamine, per 15 mg
J1890	Cephalothin sodium, up to 1 gm
J1930	Lanreotide, 1 mg
J1931	Laronidase, 0.1 mg
J1932	Lanreotide, (ciplá), 1 mg
J1939	Bumetanide, 0.5 mg
J1940	Furosemide, up to 20 mg
J1943	Aripiprazole lauroxil (aristada initio), 1 mg
J1944	Aripiprazole lauroxil (aristada), 1 mg
J1950	Leuprolide acetate (for depot suspension), per 3.75 mg
J1951	Leuprolide acetate for depot suspension (fensolvi), per .25 mg
J1952	Leuprolide injectable, camcevi, 1 mg
J1954	Lutrate depot 7.5 mg
J1955	Levocarnitine, per 1 gm
J1960	Levorphanol tartrate, up to 2 mg
J1961	Lenacapavir, 1 mg
J1980	Hyoscyamine sulfate, up to 0.25 mg
J1990	Chlordiazepoxide HCl, up to 100 mg
J2001	Lidocaine HCl for intravenous infusion, 10 mg
J2010	Lincomycin HCl, up to 300 mg
J2021	Linezolid (hospira) not therapeutically equivalent to J2020, 200 mg
J2060	Lorazepam, 2 mg
J2150	Mannitol, 25% in 50 ml
J2175	Meperidine HCl, per 100 mg
J2184	Meropenem (b. braun) not therapeutically equivalent to J2185, 100 mg
J2210	Methylergonovine maleate, up to 0.2 mg
J2247	Micafungin sodium (par pharm) not therapeutically equivalent to J2248, 1 mg
J2248	Micafungin sodium, 1 mg
J2260	Milrinone lactate, per 5 mg
J2270	Morphine sulfate, up to 10 mg
J2272	Morphine sulfate (fresenius kabi) not therapeutically equivalent to J2270, up to 10 mg
J2274	Morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg
J2277	Motixafortide, 0.25 mg
J2278	Ziconotide, 1 mcg
J2281	Moxifloxacin (fresenius kabi) not therapeutically equivalent to J2280, 100 mg
J2782	Avacincaptad pegol, 0.1 mg
J2310	Naloxone hydrochloride, per 1 mg
J2311	Naloxone hydrochloride (zimhi), 1 mg
J2320	Nandrolone decanoate, up to 50 mg
J2323	Natalizumab, 1 mg
J2327	Risankizumab-rzaa, intravenous, 1 mg
J2329	Ublituximab-xiiy, 1mg

J2350	Ocrelizumab, 1 mg
J2353	Octreotide, depot form for intramuscular injection, 1 mg
J2355	Oprelvekin, 5 mg
J2356	Tezepelumab-ekko, 1 mg
J2357	Omalizumab, 5 mg
J2358	Olanzapine, long-acting, 1 mg
J2360	Orphenadrine citrate, up to 60 mg
J2370	Phenylephrine HCl, up to 1 ml
J2405	Ondansetron HCl, per 1 mg
J2406	Oritavancin (kimyrsa), 10 mg
J2407	Oritavancin, 10 mg
J2410	Oxymorphone HCl, up to 1 mg
J2425	Palifermin, 50 mg
J2426	Paliperidone palmitate extended release, 1 mg
J2427	Paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg
J2430	Pamidronate disodium, per 30 mg
<u>J2440</u>	Papaverine HCl, up to 60 mg
J2460	Oxytetracycline HCl, up to 50 mg
J2469	Palonosetron HCl, 25 mcg
J2502	Pasireotide long acting, 1 mg
J2504	Pegademase bovine, 25 IU
J2506	Pegfilgrastim, excludes biosimilar, 0.5 mg
J2508	Pegunigalsidase alfa-iwxj, 1 mg
J2510	Penicillin G procaine, aqueous, up to 600,000 units
J2513	Pentastarch, 10% solution, 100 ml
J2515	Pentobarbital sodium, per 50 mg
J2540	Penicillin G potassium, up to 600,000 units
J2545	Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg
J2550	Promethazine HCl, up to 50 mg
J2560	Phenobarbital sodium, up to 120 mg
J2590	Oxytocin, up to 10 units
J2597	Desmopressin acetate, per 1 mcg
J2650	Prednisolone acetate, up to 1 ml
J2670	Tolazoline HCl, up to 25 mg
J2675	Progesterone, per 50 mg
J2679	Fluphenazine hcl, 1.25 mg
J2680	Fluphenazine decanoate, up to 25 mg
J2690	Procainamide HCl, up to 1 gm
J2700	Oxacillin sodium, up to 250 mg
J2710	Neostigmine methylsulfate, up to 0.5 mg
J2720	Protamine sulfate, per 10 mg
J2730	Pralidoxime chloride, up to 1 gm
<u>J2760</u>	Phentolamine mesylate, up to 5 mg

J2765	Metoclopramide HCl, up to 10 mg
J2777	Faricimab-svoa, 0.1 mg
J2779	Ranibizumab, via intravitreal implant (susvimo), 0.1 mg
J2780	Ranitidine HCl, 25 mg
J2781	Pegcetacoplan, intravitreal, 1 mg
J2783	Rasburicase, 0.5 mg
J2794	Risperidone, (Risperdal consta), 0.5 mg
J2796	Romiplostim, 10 micrograms
J2797	Rolapitant, 0.5 mg
J2798	Risperidone (perseris), 0.5 mg
J2799	Risperidone (uzedy), 1 mg
J2800	Methocarbamol, up to 10 ml
J2801	Risperidone (rykindo), 0.5 mg
J2820	Sargramostim (GM-CSF), 50 mcg
J2860	Siltuximab, 10 mg
J2910	Aurothioglucose, up to 50 mg
J2916	Sodium ferric gluconate complex in sucrose injection, 12.5 mg
J2919	Methylprednisolone sodium succinate, 5 mg
J2940	Somatrem, 1 mg
J2941	Somatropin, 1 mg
J2995	Streptokinase, per 250,000 IU
J2998	Plasminogen, human-tvmh, 1 mg
J3000	Streptomycin, up to 1 gm
J3030	Sumatriptan succinate, 6 mg
J3031	Fremanezumab-vfrm, 1 mg (Administered under direct physician supervision, not for self-administration)
J3032	Eptinezumab-jjmr, 1 mg
J3055	Talquetamab-tgvs, 0.25 mg
J3060	Taliglucerase alfa, 10 units
J3070	Pentazocine, 30 mg
J3090	Tedizolid phosphate, 1 mg
J3095	Televancin, 10 mg
J3105	Terbutaline sulfate, up to 1 mg
J3111	Romozumab-aqqg, 1 mg
J3121	Testosterone, enanthate, 1 mg
J3145	Testosterone, undecanoate, 1 mg
J3230	Chlorpromazine HCl, up to 50 mg
J3240	Thyrotropin alpha, 0.9 mg. provided in 1.1 mg
J3241	Teprotumumab-trbw, 10 mg
J3244	Tigecycline (accord) not therapeutically equivalent to J3243, 1 mg
J3245	Tildrakizumab, 1 mg
J3250	Trimethobenzamide HCl, up to 200 mg
J3260	Tobramycin sulfate, up to 80 mg
J3262	Tocilizumab, 1 mg



J3265	Torsemide, 10 mg/ml
J3280	Thiethylperazine maleate, up to 10 mg
J3285	Treprostinil, 1 mg
J3299	Triamcinolone acetonide (xipere), 1 mg
J3300	Triamcinolone acetonide, preservative free, 1 mg
J3301	Triamcinolone acetonide, not otherwise specified, 10 mg
J3302	Triamcinolone diacetate, per 5 mg
J3303	Triamcinolone hexacetonide, per 5 mg
J3305	Trimetrexate glucuronate, per 25 mg
J3310	Perphenazine, up to 5 mg
J3315	Triptorelin pamoate, 3.75 mg
J3316	Triptorelin, extended-release, 3.75 mg
J3320	Spectinomycin dihydrochloride, up to 2 gm
J3357	Ustekinumab, for subcutaneous injection, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg
J3360	Diazepam, up to 5 mg
J3364	Urokinase, 5000 IU vial
J3370	Vancomycin HCl, 500 mg
J3371	Vancomycin hcl (mylan) not therapeutically equivalent to J3370, 500 mg
J3372	Vancomycin hcl (xellia) not therapeutically equivalent to J3370, 500 mg
J3380	Vedolizumab, intravenous, 1 mg
J3397	Vestronidase alfa-vjvk, 1 mg
J3400	Triflupromazine HCl, up to 20 mg
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal $5 \times 10^9$ pfu/ml vector genomes, per 0.1 ml
J3410	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
J3425	Hydroxocobalamin, intramuscular, 10 mcg
J3430	Phytonadione, (vitamin K), per 1 mg
J3470	Hyaluronidase, up to 150 units
J3475	Magnesium sulfate, per 500 mg
J3480	Potassium chloride, per 2 meq
J3489	Zoledronic acid, 1 mg
J3490	Unclassified drugs
J3520	Edetate disodium, per 150 mg
J3590	Unclassified Biologics
J3591	Unclassified drug or biological used for ESRD on dialysis
J7213	Coagulation factor ix (recombinant), ixinity, 1 i.u.
J7294	Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hour
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each
J7296	Levonorgestrel-releasing intrauterine contraceptive system,(kyleena), 19.5 mg

- J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration
- J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration

## 7.5.2 MISCELLANEOUS DRUGS AND SOLUTIONS

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

- A4216^ Sterile water, saline and/or dextrose diluent/flush, 10 ml
- A4218^ Sterile saline or water, metered dose dispenser, 10 ml
- J7030 Infusion, normal saline solution (or water), 1000 cc
- J7040 Infusion, normal saline solution (or water), sterile (500 ml = 1 unit)
- J7042 5% dextrose/normal saline (500 ml = 1 unit)
- J7050 Infusion, normal saline solution (or water), 250 cc
- J7060 5% dextrose/water (500 ml = 1 unit)
- J7070 Infusion, D5W, 1000 cc
- J7100 Infusion, Dextran 40, 500 ml
- J7110 Infusion, dextran 75, 500 ml
- J7120 Ringers lactate infusion, up to 1000 cc
- J7121 5% Dextrose in lactated ringers infusion, up to 1000 cc
- J7131 Hypertonic saline solution, 1 ml
- J7300 Intrauterine copper contraceptive
- J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
- J7304 Contraceptive supply, hormone containing patch, each
- J7306 Levonorgestrel (contraceptive) implant system, including implants and supplies
- J7307 Etonogestrel (contraceptive) implant system, including implant and supplies
- J7308 Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
- J7321^ Hyaluronan or derivative, Hyalgan or Supartz, or visco-3, for intra-articular injection, per dose
- J7323^ Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
- J7326 Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
- J7336 Capsaicin 8% patch, per square centimeter
- J7345 Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg
- J7354 Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)
- J7501 Azathioprine, parenteral (eg Imuran), 100 mg
- J7504 Lymphocyte immune globulin, antithymocyte globulin equine, parenteral, 250 mg
- J7606 Formoterol fumarate, inhalation solution, non-compounded, administered through DME, unit dose form, 20 mcg
- J7611 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1mg
- J7612 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
- J7613 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
- J7614 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME. Unit dose. 0.5 mg
- J7620 Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final

	product, non-compounded, administered through DME
J7627	Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg
J7628	Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per mg
J7631	Cromolyn sodium, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7640	Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 mcg
J7644	Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7648	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7649	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7658	Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7668	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 10 mg
J7669	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7674	Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg
J7682	Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, 300 mg
J7999	Compounded drug, not otherwise classified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8999	Prescription drug, oral, chemotherapeutic, NOS
J8501	Aprepitant, oral, 5 mg
J8540	Dexamethasone, oral, 0.25 mg
J8650	Nabilone, oral, 1 mg
J9037	Belantamab mafodotin-BLMF, 0.5 mg
J9041	Bortezomib, 0.1 mg
J9046	Bortezomib, (dr. reddy's), not therapeutically equivalent to J9041, 0.1 mg
J9048	Bortezomib (fresenius kabi), not therapeutically equivalent to J9041, 0.1 mg
J9049	Bortezomib (hospira), not therapeutically equivalent to J9041, 0.1 mg
J9226	Histrelin implant (Supprelin LA), 50 mg
J9322	Pemetrexed (bluepoint) not therapeutically equivalent to j9305, 10 mg
J9323	Pemetrexed ditromethamine, 10 mg
J9331	Sirolimus protein-bound particles, 1 mg
J9332	Efgartigimod alfa-fcab, 2mg
J9345	Retifanlimab-dlwr, 1 mg
J9347	Tremelimumab-actl, 1 mg
J9349	Tafasitamab-CXIX, 2 mg

J9350	Mosunetuzumab-axgb, 1 mg
J9359	Loncastuximab tesirine-lpyl, 0.075 mg
J9393	Fulvestrant (teva) not therapeutically equivalent to J9395, 25 mg
J9394	Fulvestrant (fresenius kabi) not therapeutically equivalent to J9395, 25 mg
Q0138	Ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)
Q5101	Filgrastim -sndz, biosimilar, (zarxio), 1 microgram
Q5103	Infliximab-dyyb, biosimilar, 10 mg
Q5104	Renflexis (Infliximab-abda), biosimilar, 10 mg
Q5108	Pegfilgrastim-jmdb, biosimilar, 0.5 mg
Q5111	Pegfilgrastim-cbqv, biosimilar, 0.5 mg
Q5112	Trastuzumab-dttb, biosimilar, 10 mg
Q5119	Rituximab-pvvr, biosimilar, 10 mg
Q5120	Pegfilgrastim-bmez, biosimilar, 0.5 mg
Q5121	Infliximab-axxq, biosimilar, 10 mg
Q5123	Rituximab-arrx, biosimilar, (riabni), 10 mg
Q5125	Filgrastim-ayow, biosimilar, (releuko), 1 microgram
Q5126	Bevacizumab-maly, biosimilar, (alymysys), 10 mg
Q5127	Pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg
Q5128	Cimerli, 0.1 mg
Q5129	Vegzelma, 10 mg
Q5130	Fylnetra, 0.5 mg
Q5131	Adalimumab-aacf (idacio), biosimilar, 20 mg
Q5132	Adalimumab-afzb (abrilada), biosimilar, 10 mg
Q9991	Buprenorphine extended-release, less than or equal to 100 mg
Q9992	Buprenorphine extended-release, greater than or 100 mg

## 8 MEDICINE/ HYDRATION, INJECTIONS & INFUSION SERVICES

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

#### 8.1.1 HYDRATION

96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	each additional hour

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

96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drugs); up to 1 hour
96366	each additional hour
96367	additional sequential infusion of a new drug/substance, up to 1 hour

- 96368 concurrent infusion
- 96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
- 96370 each additional hour
- 96371 additional pump set-up with establishment of new subcutaneous infusion site(s)
- 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (Bill on one claim line for multiple injections)

### **8.1.3 CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG OR HIGHLY COMPLEX BIOLOGIC AGENT 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. Preparation of chemotherapy agent(s) is included in the service for administration of the agent.

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

- 96405 Chemotherapy administration; intralesional; up to and including 7 lesions
- 96406 intralesional, more than 7 lesions
- 96409 intravenous, push technique, single or initial substance/drug
- 96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
- 96415 each additional hour
- 96416 initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump

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

- 96420 Chemotherapy administration, intra-arterial; push technique
- 96422 infusion technique, up to 1 hour
- 96423 infusion technique, each additional hour
- 96425 infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

#### **8.1.3.3 OTHER INJECTION AND INFUSION SERVICES**

- 96440 Chemotherapy administration into pleural cavity, requiring and including thoracentesis
- 96446 Chemotherapy administration into the peritoneal cavity via implanted port or catheter
- 96450 Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
- 96521 Refilling and maintenance of portable pump
- 96522 Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic, (eg, intravenous, intra-arterial)
- 96542 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir,

- single or multiple agents
- 96549 Unlisted chemotherapy procedure
- J9999 Not otherwise classified, antineoplastic drugs

## 9 CHEMOTHERAPY DRUGS

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

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

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

- J9000 Doxorubicin HCL (Adriamycin), 10 mg
- J9015 Aldesleukin, per single use vial
- J9017 Arsenic trioxide, 1 mg (Trisenox)
- J9020 Asparaginase (Elspar) 10,000 units
- J9021 Asparaginase, recombinant, (rylaze), 0.1 mg
- J9022 Atezolizumab, 10 mg
- J9023 Avelumab, 10 mg
- J9025 Azacitidine, 1 mg
- J9027 Clofarabine, 1 mg
- J9030 BCG (intravesical) per 1mg
- J9032 Belinostat, 10 mg
- J9033 Bendamustine HCL (Treanda), 1 mg
- J9034 Bendamustine HCL (Bendeka), 1 mg
- J9035 Bevacizumab, 10 mg
- J9036 Bendamustine hydrochloride, 1 mg
- J9037 Belantamab mafodotin-blmf, 0.5 mg
- J9039 Blinatumomab, 1 microgram
- J9040 Bleomycin sulfate (Blenoxane), 15 units
- J9041 Bortezomib, 0.1 mg
- J9043 Carboplatin, 50 mg
- J9045 Carboplatin, 50 mg
- J9050 Carmustine, 100 mg

J9052	Carmustine (accord), not therapeutically equivalent to j9050, 100 mg
J9055	Cetuximab, 10 mg
J9056	Bendamustine hydrochloride (vivimusta), 1 mg
J9057	Copanlisib, 1 mg
J9058	Bendamustine hydrochloride (apotex), 1 mg
J9059	Bendamustine hydrochloride (baxter), 1 mg
J9060	Cisplatin, powder or solution, 10 mg
J9061	Amivantamab-vmjw, 2 mg
J9063	Mirvetuximab soravtansine-gynx, 1 mg
J9065	Cladribine, per 1 mg
J9071	Cyclophosphamide, (auromedics), 5 mg
J9072	Cyclophosphamide (dr. reddy's), 5 mg
J9073	Cyclophosphamide (ingenus), 5 mg
J9074	Cyclophosphamide (sandoz), 5 mg
J9075	Cyclophosphamide, not otherwise specified, 5mg
J9098	Cytarabine liposome, 10 mg
J9100	Cytarabine (Cytosar-U), 100 mg
J9118	Calaspargase pegol-mknl, 10 units
J9119	Cemiplimab-rwlc, 1 mg
J9120	Dactinomycin (Cosmegen), 0.5 mg
J9130	Dacarbazine, 100 mg
J9144	Daratumumab, 10 mg and hyaluronidase-fihj
J9145	Daratumumab, 10 mg
J9150	Daunorubicin HCL, 10 mg
J9151	Daunorubicin citrate, liposomal formulation, 10 mg
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
J9155	Degarelix, 1 mg
J9165	Diethylstilbestrol diphosphate, 250 mg
J9171	Docetaxel, 1 mg
J9172	Docetaxel (ingenus), not therapeutically equivalent to j9171, 1 mg
J9173	Injection, durvalumab, 10 mg
J9176	Elotuzumab, 1 mg
J9177	Enfortumab vedotin-ejfv 0.25mg
J9178	Epirubicin HCL, 2 mg
J9179	Eribulin mesylate, 0.1mg
J9181	Etoposide, 10 mg
J9185	Fludarabine phosphate, 50 mg
J9190	Fluorouracil, 500 mg
J9196	Gemcitabine hcl (accord)
J9198	Gemcitabine hydrochloride, (infugem), 100 mg
J9200	Floxuridine (FUDR), 500 mg
J9201	Gemcitabine HCl, not otherwise specified, 200 mg
J9202	Goserelin acetate implant per 3.6 mg
J9203	Gemtuzumab ozogamicin, 0.1 mg

J9204	Mogamulizumab-kpkc, 1 mg
J9205	Irinotecan liposome, 1 mg
J9206	Irinotecan, 20 mg
J9207	Ixabepilone, 1 mg
J9208	Ifosfamide, 1 gm
J9209	Mesna, 200 mg
J9210	Emapalumab-lzsg, 1 mg
J9211	Idarubicin HCl, 5 mg
J9212	Interferon Alfacon-1, Recombinant, 1 mcg
J9213	Interferon, Alfa-2A, Recombinant, 3 million units
J9214	Interferon, Alfa-2B, Recombinant, 1 million units
J9215	Interferon, Alfa-N3, (Human Leukocyte Derived), 250,000 IU
J9216	Interferon, Gamma 1-B, 3 million units
J9217	Leuprolide acetate (for Depot Suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219 <sup>^</sup>	Leuprolide acetate implant, 65 mg
J9223	Lurbinectedin, 0.1 mg
J9225	Histrelin implant (Vantas), 50 mg
J9226	Histrelin implant (Supprelin LA), 50 mg
J9227	Isatuximab-irfc, 10 mg
J9228	Ipilimumab, 1mg
J9229	Injection, inotuzumab ozogamicin, 0.1 mg
J9230	Mechlorethamine HCl (nitrogen mustard), 10 mg
J9245	Melphalan HCl, 50 mg
J9246	Melphalan (evomela), 1 mg
J9255	Methotrexate (accord), not therapeutically equivalent to j9260, 50 mg
J9258	Paclitaxel protein-bound particles (teva), not therapeutically equivalent to j9264, 1 mg
J9259	Paclitaxel protein-bound particles (american regent) not therapeutically equivalent to j9264, 1 mg
J9260	Methotrexate sodium, 50 mg
J9261	Nelarabine, 50 mg
J9263	Oxaliplatin (Eloxatin), 0.5 mg
J9264	Paclitaxel protein-bound particles, 1 mg
J9266	Pegaspargase, per single dose vial
J9267	Paclitaxel, 1 mg
J9268	Pentostatin, per 10 mg
J9269	Tagrxofusp-erzs, 10 micrograms
J9270	Plicamycin, 2.5 mg
J9271	Pembrolizumab, 1 mg
J9272	Dostarlimab-gxly, 10 mg
J9273	Tisotumab vedotin-tftv, 1 mg
J9274	Tebentafusp-tebn, 1 mcg
J9280	Mitomycin, 5 mg
J9281	Mitomycin pyelocalyceal instillation, 1 mg



J9285	Olaratumab, 10 mg
J9286	Glofitamab-gxbm, 2.5 mg
J9293	Mitoxantrone HCl, per 5 mg
J9294	Pemetrexed, hospira 10mg
J9295	Necitumumab, 1 mg
J9296	Pemetrexed (accord) 10mg
J9297	Pemetrexed (sandoz) 10mg
J9298	Nivolumab and relatlimab-rmbw, 3 mg/1 mg
J9299	Nivolumab, 1 mg
J9301	Obinutuzumab, 10 mg
J9302	Ofatumumab, 10 mg
J9303	Panitumumab, 10 mg
J9304	Pemetrexed (pemfexy), 10 mg
J9305	Pemetrexed, 10 mg
J9307	Pralatrexate, 1 mg
J9308	Ramucirumab, 5 mg
J9309	Polatuzumab vedotin-piiq, 1 mg
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Rituximab, 10 mg
J9313	Moxetumomob pasudotox-tdfk, 0.01 mg
J9314	Pemetrexed (teva) 10mg
J9316	Pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg
J9317	Sacituzumab govitecan-hziy, 2.5 mg
J9318	Romidepsin, non-lyophilized, 0.1 mg
J9319	Romidepsin, lyophilized, 0.1 mg
J9320	Streptozocin, 1 gm
J9321	Epcoritamab-bysp, 0.16 mg
J9325	Talimogene laherparepvec, per 1 million plaque forming units
J9330	Temsirolimus, 1 mg
J9333	Rozanolixizumab-noli, 1 mg
J9334	Efgartigimod alfa, 2 mg and hyaluronidase-qvfc
J9340	Thiotepa, 15 mg
J9348	Naxitamab-ggqk, 1 mg
J9349	Tafasitamab-CXIX, 2 mg
J9351	Topotecan, 0.1 mg
J9352	Trabectedin, 0.1 mg
J9353	Margetuximab-cmkb, 5 mg
J9354	Ado-trastuzumab emtansine, 1 mg
J9355	Trastuzumab, 10 mg
J9356	Trastuzumab, 10 mg/Hyaluronidase-oysk
J9357	Valrubicin, intravesical, 200 mg
J9358	Fam-trastuzumab deruxtecan-nxki,1mg
J9360	Vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg

J9376	Pozelimab-bbfg, 1 mg
J9380	Teclistamab-cqyv, 0.5 mg
J9381	Teplizumab-mzww, 5 mcg
J9390	Vinorelbine Tartrate, 10 mg
J9395	Fulvestrant (Faslodex), 25 mg
J9600	Porfimer sodium, 75 mg
J9999	Not Otherwise Classified, Antineoplastic Drugs
Q0174	Thiethylperazine Maleate, 10 mg, oral
Q0177	Hydroxyzine Pamoate, 25 mg, oral
Q2017	Teniposide, 50 mg
Q2050	Doxorubicin HCL liposomal, NOS, 10 mg
Q2056	Ciltacabtagene autoleucl, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Q5107	Bevacizumab-awwb, biosimilar, 10 mg
Q5113	Trastuzumab pkrb, biosimilar, 10 mg
Q5114	Trastuzumab-dkst, biosimilar, 10 mg
Q5115	Rituximab-abbs, biosimilar, 10 mg
Q5116	Trastuzumab-qyyp, biosimilar, 10 mg
Q5117	Trastuzumab-anns, biosimilar, 10 mg
Q5118	Bevacizumab-bvzr, biosimilar, 10 mg

## 10 MEDICINE/ PSYCHIATRY SERVICES

### 10.1 PSYCHIATRY

Note: To bill for the following codes, you must be certified by the NYS Education Department as a Nurse Practitioner in Psychiatry (Profession Code 040)

#### 10.1.1 INTERACTIVE COPLEXITY

90785 Interactive complexity (List separately in addition to primary procedure)

#### 10.1.2 PSYCHIATRIC DIAGNOSTIC PROCEDURES

90791 Psychiatric diagnostic evaluation

90792 Psychiatric diagnostic evaluation with medical services

#### 10.1.2.1 PSYCHOTHERAPY

90832 Psychotherapy, 30 minutes with patient

90833 Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

90834 Psychotherapy, 45 minutes with patient

90836 Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

90837 Psychotherapy, 60 minutes, with patient

90838 Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

## 10.1.2.2 OTHER PSYCHOTHERAPY

- 90846 Family psychotherapy (without the patient present), 50 minutes
- 90847 Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
- 90849 Multiple-family group psychotherapy
- 90853 Group psychotherapy (other than of a multiple-family group)

## 10.1.2.3 OTHER PSYCHIATRIC SERVICES OR PROCEDURES

- 90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to primary procedure)

## 11 MEDICINE/ OPHTHALMOLOGY SERVICES

### 11.1 OPHTHALMOLOGY

#### 11.1.1 SPECIAL OPHTHALMOLOGICAL SERVICES

- 92071 Fitting of contact lens for treatment of ocular surface disease
- 92072 Fitting of contact lens for management of keratoconus, initial fitting

## 12 MEDICINE/ SPECIAL OTORHINOLARYNGOLOGIC SERVICES

### 12.1 SPECIAL OTORHINOLARYNGOLOGIC SERVICES

#### 12.1.1 VESTIBULAR FUNCTION TESTS, WITH RECORDING (eg, ENG)

- 92537 Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)
- 92538                   monothermal (ie, one irrigation in each ear for a total of two irrigations)
- 92540 Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording
- 92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
- 92542 Positional nystagmus test, minimum of 4 positions, with recording
- 92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
- 92545 Oscillating tracking test, with recording
- 92546 Sinusoidal vertical axis rotational testing
- 92517 Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)
  - 92518                   Ocular (oVEMP)
  - 92519                   Cervical (cVEMP) and ocular (oVEMP)

#### 12.1.2 AUDIOLOGIC FUNCTION TESTS

- 92550 Tympanometry and reflex threshold measurements
- 92551 Screening test, pure tone, air only

- 92552 Pure tone audiometry (threshold); air only
- 92553 air and bone
- 92555 Speech audiometry threshold
- 92556 with speech recognition
- 92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
- 92563 Tone decay test
- 92565 Stenger test, pure tone
- 92567 Tympanometry (impedance testing)
- 92568 Acoustic reflex testing; threshold
- 92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
- 92571 Filtered speech test
- 92587 Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
- 92650 Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis
  - 92651 for hearing status determination, broadband stimuli, with interpretation and report
  - 92652 for threshold estimation at multiple frequencies, with interpretation and report
  - 92653 neurodiagnostic, with interpretation and report

## 13 MEDICINE/ CARDIOVASCULAR SERVICES

### 13.1 CARDIOVASCULAR

#### 13.1.1 CARDIOGRAPHY

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

#### 13.1.2 PHRENIC NERVE STIMULATION

- 93150 Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming
- 93151 Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system
- 93152 Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography
- 93153 Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography

## 14 MEDICINE/ PULMONARY SERVICES

### 14.1 PULMONARY

#### 14.1.1 PULMONARY DIAGNOSTIC TESTING, REHABILITATION, AND THERAPIES

- 94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- 94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
- 94012 Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age
- 94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV] in an infant or child through 2 years of age
- 94014 Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation
- 94016 physician review and interpretation only
- 94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
- 94200 Maximum breathing capacity, maximal voluntary ventilation
- 94625 Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)
- 94626       with continuous oximetry monitoring (per session)
- 94644 Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour
- 94645       each additional hour (List separately in addition to primary procedure)
- 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)

## 15 ALLERGY AND CLINICAL IMMUNOLOGY SERVICES

### 15.1 SENSITIVITY\_TESTING (Maximum fees include reading of test)

- 86580 Skin test; tuberculosis, intradermal

### 15.2 ALLERGEN IMMUNOTHERAPY

- 95115 Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
- 95117       2 or more injections

## 16 ENDOCRINOLOGY SERVICES

- 95250 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified healthcare professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording
- 95251       analysis, interpretation and report

## 17 MISCELLANEOUS SERVICES

- 93797 Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
- 93798       with continuous ECG monitoring (per session)
- 95990 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed
- 96040 Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
- 96110 Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
- 97542# Wheelchair management (eg, assessment, fitting, training), each 15 minutes (up to a maximum of 2 hours)
- 98960 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
- 98961       2-4 patients
- 98962       5-8 patients
- 99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
- 99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
- 99070 Supplies and 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)
- 99091 Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
- 99170 Anogenital examination, magnified in childhood for suspected trauma, including image recording when performed
- 99188 Application of topical fluoride varnish by a physician or other qualified health care professional
- G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109       group session (2 or more), per 30 minutes
- G0372 Physician service required to establish and document the need for a power mobility device
- G2252 Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to

- an established patient, not originating from a related service provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
- G8431 Screening for clinical depression is documented as being positive and a follow-up plan is documented
- G8510 Screening for clinical depression is documented as being negative, a follow-up plan is not required
- G9919 Screening performed and positive and provision of recommendations
- G9920 Screening performed and negative
- H0049 Alcohol and/or drug screening
- H0050 Alcohol and/or drug services, brief intervention, per 15 minutes
- Q3014 Telehealth originating site facility fee
- Q5106 Injection, epoetin alfa-epbx, biosimilar; (retacrit) (for non-ESRD use), 1000 units
- S0013 Esketamine, nasal spray, 1 mg
- S0189 Testosterone pellet, 75 mg
- S9445 Patient education, not otherwise classified, non-physician provider, individual, per session. (The initial lactation counseling session should be a minimum of 45 minutes. Follow up session(s) should be a minimum of 30 minutes.)
- S9446 Patient education, not otherwise classified, non-physician provider, individual, per session. (The initial lactation counseling session should be a minimum of 45 minutes. Follow up session(s) should be a minimum of 30 minutes.)  
NYS Medicaid will provide reimbursement for separate and distinct breastfeeding services provided by International Board Certified Lactation Consultants (IBCLCs) credentialed by the IBCLCE. For additional information see:  
[http://www.health.ny.gov/health\\_care/medicaid/program/update/2013/2013-03.htm#fee](http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-03.htm#fee)
- T1013 Sign language or oral interpretive services, per 15 minutes

## 18 SURGERY SERVICES

### 18.1 GENERAL INFORMATION AND RULES

- A. **FEES:** Fees for office, home and hospital visits and other medical services are listed in the section entitled MEDICINE.
- B. **FOLLOW UP (F/U) DAYS:** Listed dollar values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "F/U Days". Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. (See modifier -24)
- C. **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:

1. Diagnosis (post-operative)
  2. Size, location and number of lesion(s) or procedure(s) where appropriate
  3. Major surgical procedure and supplementary procedure(s)
  4. Whenever possible, list the nearest similar procedure by number according to these studies
  5. Estimated follow-up period
  6. Operative time
  7. Failure to submit an Operative Report when billing for a "By Report" procedure will cause your claim to be denied by MMIS.
- D. **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). 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.
- E. **MULTIPLE SURGICAL PROCEDURES:**
1. 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.
  2. 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.
- F. **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.

## 18.2 INTEGUMENTARY SYSTEM

### 18.2.1 SKIN, SUBCUTANEOUS AND ACCESSORY TISSUES

#### 18.2.1.1 INCISION AND DRAINAGE

- 10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
- 10061                      complicated or multiple
- 10120 Incision and removal of foreign body, subcutaneous tissues; simple
- 10140 Incision and drainage of hematoma, seroma or fluid collection



10160 Puncture aspiration of abscess, hematoma, bulla, or cyst

### 18.2.1.2 BIOPSY

- 11102 Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
- 11103 each separate/additional lesion (List separately in addition to code for primary procedure)
- 11104 Punch biopsy of skin (including simple closure, when performed); single lesion
- 11105 each separate/additional lesion (List separately in addition to code for primary procedure)
- 11106 Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion
- 11107 each separate/additional lesion (List separately in addition to code for primary procedure)

### 18.2.1.3 REMOVAL OF SKIN TAGS

- 11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
- 11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less

### 18.2.1.4 INTRODUCTION

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

## 18.2.2 REPAIR (CLOSURE)

### 18.2.2.1 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
- 12002 2.6 cm to 7.5 cm
- 12004 7.6 cm to 12.5 cm
- 12005 12.6 cm to 20.0 cm
- 12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
- 12013 2.6 cm to 5.0 cm
- 12014 5.1 cm to 7.5 cm
- 12015 7.6 cm to 12.5 cm
- 12016 12.6 cm to 20.0 cm

### 18.2.2.2 BURNS, LOCAL TREATMENT

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

## 18.2.3 DESTRUCTION

### 18.2.3.1 DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS

- 17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
- 17003           second through 14 lesions, each (List separately in addition to code for first lesion)
- 17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions
- 17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
- 17107           10.0 to 50.0 sq cm
- 17108           over 50.0 sq cm
- 17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
- 17111           15 or more lesions
- 17250 Chemical cauterization of granulation tissue (ie, proud flesh)

## 18.3 DIGESTIVE SYSTEM

### 18.3.1 STOMACH

#### 18.3.1.1 INTRODUCTION

- 43762 Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract

## 18.4 FEMALE GENITAL SYSTEM

### 18.4.1 VULVA AND INTROITUS

#### 18.4.1.1 DESTRUCTION

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

#### 18.4.1.2 ENDOSCOPY

- 56820 Colposcopy of the vulva;

### 18.4.2 VAGINA

#### 18.4.2.1 INTRODUCTION

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

#### 18.4.2.2 ENDOSCOPY/ LAPAROSCOPY

- 57420 Colposcopy of the entire vagina, with cervix if present

### 18.4.3 CERVIC UTERI

#### 18.4.3.1 ENDOSCOPY

- 57452 Colposcopy of the cervix including upper/adjacent vagina;

- 57454 with biopsy(s) of the cervix and endocervical curettage
- 57455 with biopsy(s) of the cervix
- 57456 with endocervical curettage
- 57460 with loop electrode (biopsy(s) of the cervix
- 57461 with loop electrode conization of the cervix
- 57465 Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)

## 18.4.4 CORPUS UTERI

### 18.4.4.1 INTRODUCTION

(For materials supplied by a practitioner, see General Information)

- 58300 Insertion of intrauterine device (IUD)
- 58301 Removal of intrauterine device (IUD)

## 18.5 MATERNITY CARE AND DELIVERY

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.

### 18.5.1 VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

Reimbursement amounts for the Medicaid Obstetrical and Maternal Services Program (MOMS) are noted in the **Enhanced Program Fee Schedule**. For information on the MOMS Program see Policy Guidelines.

- 59412 External cephalic version, with or without tocolysis
- 59425 Antepartum care only; 4-6 visits
- 59426 7 or more visits  
(For 6 or less antepartum encounters, see code 59425)

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

- 59430 Postpartum care only (separate procedure)  
(When inpatient postpartum care is provided, see appropriate Hospital Evaluation and Management code(s).)

## 18.6 NERVOUS SYSTEM

## 18.6.1 SPINE AND SPINAL CORD

### 18.6.1.1 RESERVOIR/PUMP IMPLANTATION

- 62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refilling
- 62368                   with reprogramming
- 62369                   with reprogramming and refill

## 18.7 AUDITORY SYSTEM

### 18.7.1 EXTERNAL EAR

#### 18.7.1.1 REMOVAL

- 69200 Removal foreign body from external auditory canal; without general anesthesia
- 69210 Removal impacted cerumen requiring instrumentation (report one unit for unilateral OR bilateral procedure.)