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NURSE PRACTITIONER

Procedure Codes

eMedNY New York State Medicaid Provider Procedure Code Manual

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New York State Medicaid
Office of Health Insurance
Department of Health

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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.

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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/

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/

   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.

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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.)

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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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

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, 30-44 minutes of total time is spent on the date of the encounter.

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, 45-59 minutes of total time is spent on the date of the encounter.

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, 60-74 minutes of total time is spent on the date of the encounter.

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 medically appropriate history and/ or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

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 time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

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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 time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

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 time for code selection 40-54 minutes of total time is spent on the date of the encounter

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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

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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, 45 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, 15 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

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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

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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

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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 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

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
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

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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 globin, 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
90384	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
90385	Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
90386	Rho(D) immune globulin (RhIgIV), human, for intravenous use
90389	Tetanus immune globulin (TIg), human, for intramuscular use
90393	Vaccinia immune globulin, human, for intramuscular use
90396	Varicella-zoster immune globulin, human, for intramuscular use
90399	Unlisted immune globulin

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
90619 Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use
90620 *Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, (MenB-4C),2 dose schedule, for intramuscular use*
90621 Meningococcal recombinant lipoprotein vaccine, Serogroup B,(MenB-FHpb), 2 or 3 dose schedule, for intramuscular use
90630 Influenza vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use

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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
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, 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(ccIIV3), 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 (ccIIV4), 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
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,

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	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, (aIIV4), 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
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
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 (ccIIV4), 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)

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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
J0153 Adenosine, 1 mg
(Not to be used to report any adenosine phosphate compounds, instead use unlisted code)
J0171 Adrenalin, epinephrine, 0.1 mg
J0180 Agalsidase beta, 1 mg
J0185 Aprepitant, 1 mg
J0202 Alemtuzumab, 1 mg
J0205 Alglucerase, per 10 units
J0207 Amifostine, 500 mg
J0208 Sodium thiosulfate, 100 mg
J0210 Methyldopate HCl, up to 250 mg
J0215 Alefacept, 0.5 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
J0270 Alprostadil, per 1.25 mcg
(Administered under direct physician supervision, not for self-administration)
J0275 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
J0360 Hydralazine HCl, up to 20 mg
J0380 Metaraminol bitartrate, per 10 mg
J0390 Chloroquine HCl, up to 250 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 Benztropine mesylate, per 1 mg
J0517 Benralizumab, 1 mg
J0520 Bethanechol chloride, myotonachol or urecholine, up to 5 mg

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J0558 Penicillin G benzathine and penicillin G procaine, 100,000 units
J0561 Penicillin G benzathine, 100,000 units
J0565 Bezlotoxumab, 10 mg
J0584 Burosumab-twza, 1mg
J0585 OnabotulinumtoxinaA, 1 unit
J0586 AbobotulinumtoxinaA, 5 units
J0587 RimabotulinumtoxinB, 100 units
J0593 Lanadelumab-flys\o, 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 glucon (fresenius), per 10 mg
J0613 Calcium glucon (wg critical)
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
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
J0739 Cabotegravir, 1 mg
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

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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
J1020 Methylprednisolone acetate, 20 mg
J1030 Methylprednisolone acetate, 40 mg
J1040 Methylprednisolone acetate, 80 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
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
J0305 Evinacumab-dgnb, 5mg
J1306 Inclisiran,1 mg
J1320 Amitriptyline HCl, up to 20 mg
J1322 Elosulfase alfa, 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
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
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

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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)
J1840 Kanamycin sulfate, up to 500 mg
J1850 Kanamycin sulfate, up to 75 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, (cipla), 1 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

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J1952	Leuprolide injectable, camcevi, 1 mg
J1954	Lutrate depot 7.5 mg
J1955	Levocarnitine, per 1 gm
J1960	Levorphanol tartrate, up to 2 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 thereapeutically 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
J2278	Ziconotide, 1 mcg
J2281	Moxifloxacin (fresenius kabi) not therapeutically equivalent to J2280, 100 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
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
J2430	Pamidronate disodium, per 30 mg
J2440	Papaverine HCl, up to 60 mg
J2460	Oxytetracycline HCl, up to 50 mg

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J2469 Palonosetron HCl, 25 mcg
J2502 Pasireotide long acting, 1 mg
J2504 Pegademase bovine, 25 IU
J2506 Pegfilgrastim, excludes biosimilar, 0.5 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
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
J2760 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
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
J2800 Methocarbamol, up to 10 ml
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
J2920 Methylprednisolone sodium succinate, up to 40 mg¬
J2930 Methylprednisolone sodium succinate, up to 125 mg
J2940 Somatrem, 1 mg
J2941 Somatropin, 1 mg
J2995 Streptokinase, per 250,000 IU
J2998 Plasminogen, human-tvmh, 1 mg

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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
J3060 Taliglucerace alfa, 10 units
J3070 Pentazocine, 30 mg
J3090 Tedizolid phosphate, 1 mg
J3095 Televancin, 10 mg
J3105 Terbutaline sulfate, up to 1 mg
J3111 Romosozumab-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, 1 mg
J3397 Vestronidase alfa-vjbk, 1 mg
J3400 Triflupromazine HCl, up to 20 mg

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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
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
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

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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
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 mafodontin-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
J9331 Sirolimus protein-bound particles, 1 mg
J9332 Efgartigimod alfa-fcab, 2mg
J9349 Tafasitamab-CXIX, 2 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 Inflectra (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, (alymsys), 10 mg
Q5128 Cimerli, 0.1 mg
Q5129 Vegzelma, 10 mg
Q5130 Fylnetra, 0.5 mg
Q9991 Buprenorphone extended-release, less than or equal to 100 mg
Q9992 Buprenorphone 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

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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 indwelling 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

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J9035	Bevacizumab, 10 mg
J9036	Bendamustine hydrochloride, 1 mg
J9037	Belantamab mafodontin-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
J9055	Cetuximab, 10 mg
J9057	Copanlisib, 1 mg
J9060	Cisplatin, powder or solution, 10 mg
J9061	Amivantamab-vmjw, 2 mg
J9065	Cladribine, per 1 mg
J9070	Cyclophosphamide, 100 mg
J9071	Cyclophosphamide, (auromedics), 5 mg
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
J9160	Denileukin diftitox, 300 mcg
J9165	Diethylstilbestrol diphosphate, 250 mg
J9171	Docetaxel, 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

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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^ 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
J9250 Methotrexate sodium, 5 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
J9293 Mitoxantrone HCl, per 5 mg

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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
J9325	Talimogene laherparepvec, per 1 million plaque forming units
J9330	Temsirolimus, 1 mg
J9340	Thiotepa, 15 mg
J9348	Naxitamab-gqgk, 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
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
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)

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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

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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

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)

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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)

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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, non physician 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

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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
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

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

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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.

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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 additional 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

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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

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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.)

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