NEW YORK STATE
MEDICAID PROGRAM

ORDERED AMBULATORY

FEE SCHEDULE

Table of Contents

GENERAL INFORMATION

1. **INQUIRY**: Any questions regarding this section should be directed to the New York State Department of Health (See Inquiry Section 5.0).

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

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

   Reimbursement for supplies and materials (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.

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

3. **UNLISTED PROCEDURES**: The value and appropriateness of services not specifically listed in this Fee Schedule will be manually reviewed by medical professional staff. The MMIS procedure codes to be utilized when submitting claims for such services may be found in the RADIOLOGY and MEDICINE Sections of this Fee Schedule.

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

LABORATORY SERVICES INFORMATION

To claim payment for laboratory services performed on an ordered ambulatory basis, the applicable MMIS procedure codes and fees must be identified from the MMIS Laboratory Services Provider Manual Fee Schedule.

RADIOLOGY INFORMATION

Listed fees represent maximum allowances for reimbursement purposes in the Medical Assistance Program and include the administrative, technical and professional components of the service provided. To determine the fee applicable only to the technical and administrative component, multiply the listed dollar value by a maximum conversion factor of 60%. (See below for further reference to the administrative, technical and professional components of a radiology fee item.)

Fees attached hereto are to be considered as payment for the complete radiological procedure, unless otherwise indicated. In order to be paid for both the professional and the technical and administrative components of the radiology service, qualified facilities which provide radiology services on an ordered ambulatory basis must perform the professional component of radiology services and own or directly lease the equipment and must supervise and control the radiology technician who performs the radiology procedures.

Each State agency may determine, on an individual basis, fees for services or procedures not included in this fee schedule. Such fee determinations should be reported promptly to the Division of Health Care Financing of the State Department of Health for review by the Interdepartmental Committee on Health Economics for possible incorporation in the Radiology Fee Schedule.

TECHNICAL, ADMINISTRATIVE AND PROFESSIONAL RADIOLOGY COMPONENTS

When radiological services are rendered in hospital departments by radiologists who receive no salary/compensation from the facility for patient care and who bill separately, the charge for the professional component may not exceed 40% of the maximum fee in the Radiology Services Fee Schedule. The remaining 60% of the fee is the maximum amount applicable for the technical and administrative services provided by the hospital. No payment will be made to a qualified facility solely for the professional component.

The professional component (see modifier -26) for radiological services is intended to cover professional services, when applicable, as listed below:

1. Determination of the problem, including interviewing the patient, obtaining the history and making appropriate physical examination to determine the method of performing the radiologic procedure.

2. Study and evaluation of results obtained in diagnostic or therapeutic procedures, interpretation of radiographs or radioisotope data-estimation resultant from treatment.

3. Dictating report of examination or treatment.

4. Consultation with referring physician regarding results of diagnostic or therapeutic procedures.

The technical or administrative component (see modifier -TC) includes items such as: cost or charges for technologists, clerical staff, films, opaques, radioactive materials, chemicals, drugs or other materials, purchase, rental use or maintenance of space, equipment, telephone services or other facilities or supplies.

Certain radiological procedures require the performance of a medical or surgical procedure (eg, studies necessitating an injection of radiopaque media, fluoroscopy, consultation) which must be performed by the radiologist and is not separable into technical and professional components for billing purposes. In these instances, reimbursement for the medical or surgical procedure will be made to the physician via the appropriate procedure code listed in the MMIS Physician Fee Schedule.

GENERAL RULES

General rules which apply to all procedure codes in the Radiology Services Fee Schedule sections of Diagnostic Radiology, Diagnostic Ultrasound, Radiation Oncology and Nuclear Medicine are as follows:

1. Dollar values include usual contrast media, equipment and materials. An additional charge may be warranted when special materials are provided.

2. Dollar values include consultation and a written report to the referring physician.

3. When multiple X-ray examinations are performed during the same visit, reimbursement shall be limited to the greater fee plus 60% of the lesser fee(s). When more than one part of the body is included in a single X-ray for which reimbursement is claimed, the charge shall be only for a single X-ray. When bilateral X-ray examinations are performed during the same visit, reimbursement shall be limited to 160% of the procedure value (see modifier -50). The above provisions regarding fee reductions for multiple X-rays are applicable to X-rays taken of all parts of the body.

4. When repeat X-ray examinations of the same part and for the same illness are required because of technical or professional error in the original X-rays, such repeat X-rays are not eligible for payment. (See Rule 5 below.)

5. When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it should be identified by use of modifier -76.

6. RADIOLOGICAL SUPERVISION AND INTERPRETATION CODES: The MAXIMUM FEE-NYS is applicable when the facility incurs the costs of both the technical/administrative and professional components of the imaging procedure. (For the technical or administrative component of imaging procedures, see modifier -TC). When the procedure is performed on an ordered ambulatory basis by a non-salaried/non-compensated physician, reimbursement will be made for the technical /administrative component of the imaging procedure via the use of modifier -TC on the appropriate "radiological supervision and interpretation" code.

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

   When the value of a procedure is to be determined "By Report" (BR) , information concerning the nature, extent and need for the procedure or service must be furnished in addition to the time, skill and equipment necessitated. Appropriate documentation (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.

8. SEPARATE PROCEDURES**:** Some of the listed procedures are commonly carried out as an integral part of a total service, and as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

MMIS MODIFIERS

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier -26 to the usual procedure number. (Reimbursement will not exceed 40% of the maximum State Medical Fee Schedule amount.)

-TC Technical Component: Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier -TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. (Reimbursement will not exceed 60% of the maximum State Medical Fee Schedule amount.)

-76 Repeat X-ray Procedure: When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it will be identified by adding modifier -76. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-FP Service Provided as Part of a 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.)

-50 Bilateral Procedures (X-ray): When bilateral X-ray examinations are performed, the service will be identified by adding the modifier -50 to the usual procedure code number. (Reimbursement will not exceed 160% of the maximum State Medical Fee Schedule amount. One claim line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)

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

RADIOLOGY SERVICES

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

HEAD AND NECK

(To report CT guidance for cervical spine, see 72125, 72126)

70010	Myelography, posterior fossa; radiological supervision and interpretation	$62.50
70015	Cisternography, positive contrast; radiological supervision and interpretation	$75.00
70030	Radiologic examination, eye, for detection of foreign body (includes detection and localization)	$40.00
70100	Radiologic examination, mandible; partial, less than four views	$15.00
70110	complete, minimum of four views	$25.00
70120	Radiologic examination, mastoids; less than three views per side	$15.00
70130	complete, minimum of three views per side	$25.00
70134	Radiologic examination, internal auditory meati, complete	$25.00
70140	Radiologic examination, facial bones; less than three views	$15.00
70150	complete, minimum of three views	$25.00
70160	Radiologic examination, nasal bones, complete, minimum of three views	$15.00
70170	Dacryocystography, nasolacrimal duct; radiological supervision and interpretation	$20.00
70190	Radiologic examination; optic foramina	$15.00
70200	orbits, complete, minimum of four views	$25.00
70210	Radiologic examination, sinuses, paranasal; less than three views	$12.50
70220	complete, minimum of three views	$20.00
70240	Radiologic examination, sella turcica	$12.50
70250	Radiologic examination, skull; less than four views	$15.00
70260	complete, minimum of four views	$25.00
70300	Radiologic examination, teeth; single view	$5.00
70310	partial examination, less than full mouth	$10.00
70320	complete, full mouth	$15.00
70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	$12.50
70330	bilateral	$20.00
70332	Temporomandibular joint arthrography; radiological supervision and interpretation (Do not report 76003 in addition to 70332)	$35.00

70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint	$500.00
70350	Cephalogram, orthodontic	$10.00
70355	Orthopantogram	$13.00
70360	Radiologic examination; neck, soft tissue	$10.00
70370	pharynx or larynx, including fluoroscopy and/or magnification technique	$25.00
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording	BR
70373	Laryngography, contrast; radiological supervision and interpretation	$25.00
70380	Radiologic examination, salivary gland for calculus	$15.00
70390	Sialography; radiological supervision and interpretation	$20.00
70450	Computed tomography, head or brain; without contrast material	$120.00
70460	with contrast material(s)	$145.00
70470	without contrast material, followed by contrast material(s) and further sections	$217.00
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	$120.00
70481	with contrast material(s)	$145.00
70482	without contrast material, followed by contrast material(s) and further sections	$217.00
70486	Computed tomography, maxillofacial area; without contrast material	$120.00
70487	with contrast material(s)	$145.00
70488	without contrast material, followed by contrast material(s) and further sections	$217.00
70490	Computed tomography, soft tissue neck; without contrast material	$140.00
70491	with contrast material(s)	$170.00
70492	without contrast material, followed by contrast material(s) and further sections	$254.00
70496	Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$217.00
70498	Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$254.00
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and neck; without contrast materials	$500.00
70542	with contrast material	$500.00
70543	without contrast material(s), followed by contrast material(s) and further sequences	$500.00

70544	Magnetic resonance angiography, head; without contrast material(s)	$500.00
70545	with contrast material(s)	$500.00
70546	without contrast material(s), followed by contrast material(s) and further sequences	$500.00
70547	Magnetic resonance angiography, neck; without contrast material(s)	$500.00
70548	with contrast material	$500.00
70549	without contrast material(s), followed by contrast material(s) and further sequences	$500.00
70551	Magnetic resonance (eg, proton) imaging, brain, (including brain stem); without contrast material	$500.00
70552	with contrast material(s)	$500.00
70553	without contrast material, followed by contrast material(s) and further sequences	$500.00
70557	Magnetic resonance (eg, proton) imaging, brain, (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	$500.00
70558	with contrast material(s)	$500.00
70559	without contrast material(s), followed by contrast material(s) and further sequences	$500.00

CHEST

(For chest fluoroscopy (separate procedure), see 76000)

71010	Radiologic examination, chest; single view, frontal	$10.00
71015	stereo, frontal	$15.00
71020	Radiologic examination, chest, two views, frontal and lateral;	$15.00
71021	with apical lordotic procedure	$17.50
71022	with oblique projections	$20.00
71023	with fluoroscopy	$20.00
71030	Radiologic examination, chest, complete, minimum of four views;	$20.00
71034	with fluoroscopy	$20.00
71035	Radiologic examination, chest, special views, (eg, lateral decubitus, Bucky studies)	$15.00
71040	Bronchography, unilateral, radiological supervision and interpretation	$35.00
71060	Bronchography, bilateral, radiological supervision and interpretation	$40.00
71100	Radiologic examination, ribs, unilateral; two views	$15.00
71101	including posteroanterior chest, minimum of three views	$17.50
71110	Radiologic examination, ribs, bilateral; three views	$25.00
71111	including posteroanterior chest, minimum of four views	$27.50

71120	Radiologic examination; sternum, minimum of two views	$15.00
71130	sternoclavicular joint or joints, minimum of three views	$20.00
71250	Computed tomography, thorax; without contrast material	$140.00
71260	with contrast material(s)	$170.00
71270	without contrast material, followed by contrast material(s) and further sections	$254.00
71275	Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$140.00
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	$500.00
71551	with contrast material(s)	$500.00
71552	without contrast material(s), followed by contrast material(s) and further sequences	$500.00
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)	$500.00

SPINE AND PELVIS

72010	Radiologic examination, spine, entire, survey study, anteroposterior and lateral	$40.00
72020	Radiologic examination, spine, single view, specify level	$10.00
72040	Radiologic examination, spine, cervical; two or three views	$15.00
72050	minimum of four views	$20.00
72052	complete, including oblique and flexion and/or extension studies	$30.00
72069	Radiologic examination, spine, thoracolumbar, standing (scoliosis)	$15.00
72070	Radiologic examination, spine; thoracic, two views	$15.00
72072	thoracic, three views	$30.00
72074	thoracic, minimum of four views	$30.00
72080	thoracolumbar, two views	$15.00
72090	scoliosis study, including supine and erect studies	$40.00
72100	Radiologic examination, spine, lumbosacral; two or three views	$15.00
72110	minimum of four views	$30.00
72114	complete, including bending views	$30.00
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	$20.00
72125	Computed tomography, cervical spine; without contrast material	$140.00
72126	with contrast material(s)	$170.00
72127	without contrast material, followed by contrast material(s) and further sections	$254.00

72128	Computed tomography, thoracic spine; without contrast material	$140.00
72129	with contrast material(s)	$170.00
72130	without contrast material, followed by contrast material(s) and further sections	$254.00
72131	Computed tomography, lumbar spine; without contrast material	$140.00
72132	with contrast material(s)	$170.00
72133	without contrast material, followed by contrast material(s) and further sections	$254.00
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	$500.00
72142	with contrast material(s)	$500.00
	(For cervical spinal canal imaging without contrast material followed by contrast material, use 72156)	
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	$500.00
72147	with contrast material(s)	$500.00
	(For thoracic spinal canal imaging without contrast material followed by contrast material, use 72157)	
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	$500.00
72149	with contrast material(s)	$500.00
	(For lumbar spinal canal imaging without contrast material followed by contrast material, use 72158)	
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents without contrast material, followed by contrast material(s) and further sequences; cervical	$500.00
72157	thoracic	$500.00
72158	lumbar	$500.00
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	$500.00
72170	Radiologic examination, pelvis; one or two views	$12.50
72190	complete, minimum of three views	$20.00
	(For pelvimetry, see 74710)	
72191	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$254.00
72192	Computed tomography, pelvis; without contrast material	$140.00
72193	with contrast material(s)	$170.00
72194	without contrast material, followed by contrast material(s) and further sections	$254.00

72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	$500.00
72196	with contrast material(s)	$50.00
72197	without contrast material(s), followed by contrast material(s) and further sequences	$500.00
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)	$500.00
72200	Radiologic examination, sacroiliac joints; less than three views	$12.50
72202	three or more views	$20.00
72220	Radiologic examination, sacrum and coccyx, minimum of two views	$15.00

UPPER EXTREMITIES

73000	Radiologic examination; clavicle, complete	$10.00
73010	scapula, complete	$15.00
73020	Radiologic examination, shoulder; one view	$10.00
73030	complete, minimum of two views	$15.00
73040	Radiologic examination, shoulder, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73040)	$25.00
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	$17.50
73060	humerus, minimum of two views	$10.00
73070	Radiologic examination, elbow; two views	$10.00
73080	complete, minimum of three views	$12.50
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73085)	$25.00
73090	Radiologic examination; forearm, two views	$10.00
73092	upper extremity, infant, minimum of two views	$10.00
73100	Radiologic examination, wrist; two views	$10.00
73110	complete, minimum of three views	$12.50
73115	Radiologic examination, wrist, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73115)	$25.00
73120	Radiologic examination, hand; two views	$10.00
73130	minimum of three views	$12.50
73140	Radiologic examination, finger(s), minimum of two views	$7.50

73200	Computed tomography, upper extremity; without contrast material	$140.00
73201	with contrast material(s)	$170.00
73202	without contrast material, followed by contrast material(s) and further sections	$254.00
73206	Computed tomographic angiography, upper extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$254.00
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other that joint; without contrast material(s)	$500.00
73219	with contrast material(s)	$500.00
73220	without contrast material(s), followed by contrast material(s) and further sequences extremity, other than joint	$500.00
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	$500.00
73222	with contrast material(s)	$500.00
73223	without contrast material(s), followed by contrast material(s) and further sections	$500.00
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	$500.00

LOWER EXTREMITIES

73500	Radiologic examination, hip; unilateral, one view	$12.50
73510	complete, minimum of two views	$20.00
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	$24.00
73525	Radiologic examination, hip, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73525)	$25.00
73540	Radiologic examination, pelvis and hips, infant or child, minimum of two views	$15.00
73542	Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73542)	$25.00
73550	Radiologic examination, femur, two views	$15.00
73560	Radiologic examination, knee; one or two views	$10.00
73562	three views	$15.00
73564	complete, four or more views	$20.00
73565	both knees, standing, anteroposterior	$10.00
73580	Radiologic examination, knee, arthrography; radiological supervision and interpretation (Do not report 76003 in addition to 73580)	$25.00

73590	Radiologic examination; tibia and fibula, two views	$10.00
73592	lower extremity, infant, minimum of two views	$15.00
73600	Radiologic examination, ankle; two views	$10.00
73610	complete, minimum of three views	$12.50
73615	Radiologic examination, ankle, arthrography, radiological supervision and interpretation (Do not report 76003 in addition to 73615)	$25.00
73620	Radiologic examination, foot; two views	$10.00
73630	complete, minimum of three views	$12.50
73650	Radiologic examination; calcaneus, minimum of two views	$10.00
73660	toe(s), minimum of two views	$7.50
73700	Computed tomography, lower extremity; without contrast material	$140.00
73701	with contrast material(s)	$170.00
73702	without contrast material, followed by contrast material(s) and further sections	$254.00
73706	Computed tomographic angiography, lower extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$254.00
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	$500.00
73719	with contrast material(s)	$500.00
73720	without contrast material(s) followed by contrast material(s) and further sequences	$500.00
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	$500.00
73722	with contrast material(s)	$500.00
73723	without contrast material(s), followed by contrast material(s) and further sequence	$500.00
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	$500.00

ABDOMEN

74000	Radiologic examination, abdomen; single anteroposterior view	$10.00
74010	anteroposterior and additional oblique and cone views	$15.00
74020	complete, including decubitus and/or erect views	$20.00
74022	complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest	$26.00
74150	Computed tomography, abdomen; without contrast material	$140.00
74160	with contrast material(s)	$170.00
74170	without contrast material, followed by contrast material(s) and further sections	$254.00

74175	Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$254.00
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	$500.00
74182	with contrast material(s)	$500.00
74189	without contrast material(s), followed by contrast material(s) and further sequences	$500.00
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)	$500.00
74190	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation	$19.00

GASTROINTESTINAL TRACT

(For biliary duct stone extraction, percutaneous, see 74327)

74210	Radiologic examination; pharynx and/or cervical esophagus	$20.00
74220	esophagus	$20.00
74230	Swallowing function, with cineradiography/videoradiography	$20.00
74235	Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation	$60.00
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	$30.00
74241	with or without delayed films, with KUB	$35.00
74245	with small intestine, includes multiple serial films	$40.00
74246	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, without KUB	$50.00
74247	with or without delayed films, with KUB	$60.00
74249	with small intestine follow-through	$70.00
74250	Radiologic examination, small intestine, includes multiple serial films;	$30.00
74251	via enteroclysis tube	$30.00
74260	Duodenography, hypotonic	$40.00
74270	Radiologic examination, colon; barium enema, with or without KUB	$25.00
74280	air contrast with specific high density barium, with or without glucagon	$40.00
74283	Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus)	$25.00
74290	Cholecystography, oral contrast;	$20.00

74291	additional or repeat examination or multiple day examination	$20.00
74305	Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation	$22.50
74320	Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation	$25.00
74327	Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation	$55.00
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	$30.00
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	$30.00
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	$36.00
74340	Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation	$20.00
74350	Percutaneous placement of gastrostomy tube; radiological supervision and interpretation	$30.00
74355	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation	$40.00
74360	Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation	$40.00
74363	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation	$80.00

URINARY TRACT

74400	Urography (pyelography), intravenous, with or without KUB, with or without tomography	$35.00
74410	Urography, infusion, drip technique and/or bolus technique	$45.00
74420	Urography, retrograde, with or without KUB	$25.00
74425	Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	$20.00
74430	Cystography, minimum of three views, radiological supervision and interpretation	$20.00
74440	Vasography, vesiculography, or epididymography, radiological supervision and interpretation	$45.00
74445	Corpora cavernosography, radiological supervision and interpretation	$50.00
74450	Urethrocystography, retrograde, radiological supervision and interpretation	$20.00
74455	Urethrocystography, voiding, radiological supervision and interpretation	$35.00

GYNECOLOGICAL AND OBSTETRICAL

(For abdomen and pelvis, see 74000-74181, 72170-72190)

74710	Pelvimetry, with or without placental localization	$25.00
74740	Hysterosalpingography, radiological supervision and interpretation	$25.00
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	$57.00
74775	Perineogram (eg, vaginogram, for sex determination or extent of anomalies)	$30.00

HEART

75552	Cardiac magnetic resonance imaging for morphology; without contrast material	$500.00
75553	with contrast material	$500.00
75554	Cardiac magnetic resonance imaging for function, with or without morphology; complete study	$500.00
75555	limited study	$500.00

AORTA AND ARTERIES

75600	Aortography, thoracic, without serialography, radiological supervision and interpretation	$50.00
75605	Aortography, thoracic, by serialography, radiological supervision and interpretation	$50.00
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	$50.00
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	$75.00
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	$254.00
75650	Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation	$90.00
75658	Angiography, brachial, retrograde, radiological supervision and interpretation	$35.00
75660	Angiography, external carotid, unilateral, selective, radiological supervision and interpretation	$90.00
75662	Angiography, external carotid, bilateral, selective, radiological supervison and interpretation	$125.00

75665	Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation	$90.00
75671	Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation	$125.00
75676	Angiography, carotid, cervical, unilateral radiological supervision and interpretation	$90.00
75680	Angiography, carotid, cervical, bilateral radiological supervision and interpretation	$125.00
75685	Angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation	$90.00
75705	Angiography, spinal, selective, radiological supervision and interpretation	$130.00
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	$35.00
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	$56.00
75722	Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation	$80.00
75724	Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation	$110.00
75726	Angiography, visceral; selective or supraselective, (with or without flush aortogram), radiological supervision and interpretation (For selective angiography, additional visceral vessels studied after basic examination, see 75774)	$50.00
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	$80.00
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	$110.00
75736	Angiography, pelvic, selective or supraselective, supervision and interpretation	$80.00
75741	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation	$90.00
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	$120.00
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	$50.00
75756	Angiography, internal mammary, radiological supervision and interpretation	$50.00
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation	$25.00
75790	Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation	$35.00

VEINS AND LYMPHATICS

75801	Lymphangiography, extremity only, unilateral, radiological supervision and interpretation	$50.00
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	$50.00
75805	Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation	$50.00
75807	Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation	$50.00
75820	Venography, extremity, unilateral, radiological supervision and interpretation	$40.00
75822	Venography, extremity, bilateral, radiological supervision and interpretation	$64.00
75825	Venography, caval, inferior, with serialography, radiological supervision and interpretation	$40.00
75827	Venography, caval, superior, with serialography, radiological supervision and interpretation	$40.00
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation	$80.00
75833	Venography, renal, bilateral, selective, radiological supervision and interpretation	$110.00
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	$75.00
75842	Venography, adrenal, bilateral, selective, radiological supervision and interpretation	$135.00
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	$135.00
75870	Venography, superior sagittal sinus, radiological supervision and interpretation	$150.00
75872	Venography, epidural, radiological supervision and interpretation	$90.00
75880	Venography, orbital, radiological supervision and interpretation	$79.00
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	$90.00
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	$40.00

TRANSCATHETER THERAPY AND BIOPSY

75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	$235.00
75945	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel	$56.00
75946	each additional vessel	$31.00

75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, gastrointestinal system, genitourinary system, abscess), radiological supervision and interpretation	$30.00
75989	Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography) for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	$40.00
75998	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to primary procedure)	$21.00

MISCELLANEOUS PROCEDURES

(For arthrography: shoulder, see 73040; elbow, see 73085; wrist, see 73115; hip, see 73525; knee, see 73580; ankle, see 73615)

76000	Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	$10.00
76001	Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (eg, nephrolithotomy, ERCP, bronchoscopy, transbronchial biopsy)	$25.00
76003	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (Do not report 76003 in addition to 70332, 73040, 73085, 73115, 73525, 73580, 73615)	$25.00
76005	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction	$25.00
76010	Radiologic examination from nose to rectum for foreign body, single view, child	$10.00
76012	Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance	$25.00
76013	under CT guidance	$140.00
76020	Bone age studies	$15.00
76040	Bone length studies (orthoroentgenogram, scanogram)	$25.00
76061	Radiologic examination, osseous survey; limited (eg, for metastases)	$35.00
76062	complete (axial and appendicular skeleton)	$50.00

76065	Radiologic examination osseous survey; infant	$35.00
76066	Joint survey, single view, two or more joints (specify)	$50.00
76070	Computed tomography, bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)	$100.00
76071	appendicular skeleton (peripheral)(eg, radius, wrist, heel)	$52.00
76075	Dual energy x-ray absorptiometry (dxa), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)	$100.00
76076	appendicular skeleton (peripheral) (eg, radius, wrist, heel)	$52.00
76078	Radiologic absorptiometry (eg, photodensitometry, radiogrammetry) one or more sites	$52.00
76080	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	$15.00
76086	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation	$30.00
76088	Mammary ductogram or galactogram, multiple ducts,radiological supervision and interpretation (To report as a bilateral procedure, use 76088)	$40.00
76090	Mammography; unilateral	$90.00
76091	bilateral	$90.00
76092	Screening mammography, bilateral ("Minimum" two view film study of each breast)	$90.00
76093	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral	$500.00
76094	bilateral	$500.00
76095	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection)each lesion, radiological supervision and interpretation	$105.00
76096	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	$70.00
76100	Radiological examination, single plane body section (eg, tomography), other than with urography	$30.00
76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	$45.00
76102	bilateral	$57.50
76120	Cineradiography/videoradiography, except where specifically included	$20.00
76125	Cineradiography/videoradiography, to complement routine examination (List separately in addition to primary procedure)	$20.00

76360	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	$90.00
76362	Computed tomography guidance for, and monitoring of, visceral tissue ablation	$90.00
76380	Computed tomography, limited or localized follow-up study	$75.00
76393	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	$500.00
76394	Magnetic resonance guidance for, and monitoring of, visceral tissue ablation	$500.00
76400	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	$500.00
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	BR
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	BR
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	BR
76499	UNLISTED diagnostic radiographic procedure	BR

DIAGNOSTIC ULTRASOUND SERVICES

A-mode: Implies a one-dimensional ultrasonic measurement procedure.

M-mode: Implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.

B-scan: Implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

Real-time scan: Implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

HEAD AND NECK

(To report complete A-mode echoencephalography, use 76999)

76506	Echoencephalography, B-scan and/or real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated	$30.00
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	$60.00
76511	Ophthalmic ultrasound, diagnostic; quantitative a-scan only	$40.00
76512	B-scan (with or without superimposed non-quantitative a-scan)	$60.00

76513	anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy	$60.00
76514	Corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	$4.00
76516	Ophthalmic biometry by ultrasound echography, A-scan;	$40.00
76519	with intraocular lens power calculation	$40.00
76529	Ophthalmic ultrasonic foreign body localization	$60.00
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation	$30.00

CHEST

(To report A-mode echography of the breast, use 76999)

76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation	$25.00
76645	Ultrasound, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation	$50.00

ABDOMEN AND RETROPERITONEUM

76700	Ultrasound, abdominal, B-scan and/or real time with image documentation; complete	$60.00
76705	limited (eg, single organ, quadrant, follow-up)	$40.00
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete	$60.00
76775	limited	$60.00
76778	Ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler studies	$60.00

SPINAL CANAL

76800	Ultrasound, spinal canal and contents	$60.00

PELVIS

OBSTETRICAL

Codes 76801 and 76802 include determination of the number of gestational sacs and fetuses, gestational sac/fetal measurements appropriate for gestation (<14 weeks 0 days), survey of visible fetal and placental anatomic structure, qualitative assessment of amniotic fluid volume/gestational sac shape and examination of the maternal uterus and adnexa.

Codes 76805 and 76810 include determination of number of fetuses and amniotic/chorionic sacs, measurements appropriate for gestational age (> or = 14 weeks 0 days), survey of intracranial/spinal/abdominal anatomy, 4 chambered heart, umbilical cord insertion site, placenta location and amniotic fluid assessment and, when visible, examination of maternal adnexa.

Codes 76811 and 76812 include all elements of codes 76805 and 76810 plus detailed anatomic evaluation of the fetal brain/ventricles, face, heart/outflow tracts and chest anatomy, abdominal organ specific anatomy, number/length/architecture of limbs and detailed evaluation of the umbilical cord and placenta and other fetal anatomy as clinically indicated.

Patient record should document the results of the evaluation of each element described above or the reason for non-visualization.

Code 76815 represents a focused "quick look" exam limited to the assessment of one or more of the elements listed in code 76815.

Code 76816 describes an examination designed to reassess fetal size and interval growth or re-evaluated one or more anatomic abnormalities of a fetus previously demonstrated on ultrasound, and should be coded once regardless of the number of fetuses.

Code 76817 describes a transvaginal obstetric ultrasound performed separately or in addition to one of the transabdominal examinations described above. For the transvaginal examinations performed for non-obstetrical purposes, use code 76830.

76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; (complete fetal and maternal evaluation), single or first gestation	$55.00
76802	each additional gestation (List separately in addition to primary procedure)	$41.00
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach (complete fetal and maternal evaluation); single of first gestation	$55.00
76810	each additional gestation (List separately in addition to primary procedure)	$41.00
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	$72.00
76812	each additional gestation (List separately in addition to primary procedure)	$36.00
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	$25.00

76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	$25.00
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal (For non-obstetrical transvaginal ultrasound, use 76830) (If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 76817 in addition to appropriate transabdominal exam code)	$60.00
76818	Fetal biophysical profile; with non-stress testing	$35.00
76819	without non-stress testing	$35.00
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;	$25.00
76826	follow-up or repeat study	$25.00
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete	$25.00
76828	follow-up or repeat study	$25.00

NON-OBSTETRICAL

76830	Ultrasound, transvaginal	$60.00
76831	Saline infusion sonohysterography (sis), including color flow doppler, when performed	$28.00
76856	Ultrasound, pelvic (non-obstetric), B-scan and/or real time with image documentation; complete	$55.00
76857	limited or follow-up (eg, for follicles)	$40.00

GENITALIA

76870	Ultrasound, scrotum and contents	$30.00
76872	Ultrasound, transrectal;	$60.00
76873	prostate volume study for brachytherapy treatment planning (separate procedure)	$60.00

EXTREMITIES

76880	Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation	$30.00
76885	Ultrasound, infant hips, real time with imaging documentation; dynamic (eg, requiring physician manipulation)	$30.00
76886	limited, static (not requiring physician manipulation)	$25.00

VASCULAR STUDIES

(For vascular studies, see 93875-93981)

ULTRASONIC GUIDANCE PROCEDURES

76930	Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	$25.00
76932	Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation supervision and interpretation	$25.00
76937	Ultrasonic guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to primary procedure)	$55.00
76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation	$48.00
76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	$39.00
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$55.00
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	$32.00
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	$20.00
76950	Ultrasonic guidance for placement of radiation therapy fields	$35.00
76965	Ultrasonic guidance for interstitial radioelement application	$90.00
76975	Gastrointestinal endoscopic ultrasound, supervision and interpretation	$30.00
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	$30.00

MISCELLANEOUS ULTRASONIC PROCEDURE

76999	UNLISTED ultrasound procedure (eg, diagnostic, interventional)	BR

RADIATION ONCOLOGY SERVICES

Listings for Radiation Oncology provide for teletherapy and brachytherapy to include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during course of treatment and for three months following its completion.

For treatment by injectable or ingestible isotopes, see subsection **Nuclear Medicine.**

CLINICAL TREATMENT PLANNING (EXTERNAL AND INTERNAL SOURCES)

The clinical treatment planning process is a complex service including interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size, of treatment ports, selection of appropriate treatment devices, and other procedures.

DEFINITIONS:

Simple - planning requiring single treatment area of interest encompassed in a single port or simple parallel opposed ports with simple or no blocking.
Intermediate - planning requiring three or more converging ports, two separate treatment areas, multiple blocks, or special time dose constraints.
Complex - planning requiring highly complex blocking, custom shielding blocks, tangential ports, special wedges or compensators, three or more separate treatment areas, rotational or special beam considerations, combination of therapeutic modalities.

77261	Therapeutic radiology treatment planning; simple	$54.00
77262	intermediate	$230.00
77263	complex	$311.80

(Simulation may be carried out on a dedicated simulator, a radiation therapy treatment unit, or diagnostic x-ray machine.)

DEFINITIONS:

Simple - simulation of a single treatment area with either a single port or parallel opposed ports. Simple or no blocking.
Intermediate – simulation of three or more converging ports, two seperate treatment areas, multiple blocks.
Complex – simulation of tangential portals, three or more treatment areas, rotation or arc therapy, complex blocking, custom shielding blocks, brachytherapy source verification, hyperthermia probe verification, any use of contrast materials.

Three-dimensional computer-generated three dimensional reconstruction of tumor volume and surrounding critical normal tissue structures from direct CT scans and/or MRI data in preparation for non-coplanar or coplanar therapy. The stimulation utilizes documented three-dimensional beam's eye view volume-dose displays of multiple or moving beams. Documentation with three-dimensional volume reconstruction and dose distribution is required.

(Simulation may be carried out on a dedicated simulator, a radiation therapy treatment unit, or diagnostic x-ray machine.)

77280	Therapeutic radiology simulation-aided field setting; simple	$47.40
77285	intermediate	$73.80
77290	complex	$103.60
77295	three-dimensional	$103.60
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	BR

MEDICAL RADIATION PHYSICS, DOSIMETRY, TREATMENT DEVICES AND SPECIAL SERVICES

77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose as required during course of treatment, only when prescribed by the treating physician	$31.00
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)	$45.20
77310	intermediate (three or more treatment ports directed to a single area of interest)	$63.40
77315	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)	$89.60
77321	Special teletherapy port plan, particles, hemi-body, total body (Only one teletherapy isodose plan may be reported for a given course of therapy to a specific treatment area.)	$70.00
77326	Brachytherapy isodose plan; simple (calculation made from single plane, one to four source/ribbon application, remote afterloading brachytherapy, 1 to 8 sources) (For definition of sources/ribbon, see Clinical Brachytherapy section.)	$58.20
77327	intermediate (multiplane dosage calculations, application involving five to ten sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)	$76.00

77328	complex (multiplane isodose plan, volume implant calculations, over ten sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)	$101.00
77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician	$66.80
77332	Treatment devices, design and construction; simple (simple block,simple bolus)	$34.80
77333	intermediate (multiple blocks, stents, bite blocks, special bolus)	$58.40
77334	complex (irregular blocks, special shields, compensators, wedges, molds or casts)	$79.20
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	$41.80
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	BR

RADIATION TREATMENT DELIVERY

Radiation treatment delivery (77401-77416) recognizes the technical component and the various energy levels.

77401	Radiation treatment delivery, superficial and/or ortho voltage	$53.40
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV	$48.60
77403	6-10 MeV	$48.60
77404	11-19 MeV	$48.60
77406	20 MeV or greater	$48.60
77407	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV	$57.50
77408	6-10 MeV	$57.50
77409	11-19 MeV	$57.50
77411	20 MeV or greater	$57.50
77412	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); up to 5 MeV	$63.70
77413	6-10 MeV	$63.70
77414	11-19 MeV	$63.70
77416	20 MeV or greater	$63.70

77417	Therapeutic radiology port film(s)	$21.60

RADIATION TREATMENT MANAGEMENT

Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consists of:

- Review of port films;
- Review of dosimetry, dose delivery; and treatment parameters;
- Review of patient treatment set-up;
- Examination of patient for medical evaluation and management (eg, assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab results).

77427	Radiation treatment management, five treatments	$145.80
77431	Radiation therapy management with complete course of therapy consisting of one or two factions only (77431 is not to be used to fill in the last week of a long course of therapy)	$75.80
77432	Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)	$100.00
77470	Special treatment procedure (eg, total body irradiation, hemibody irradiation, per oral,endocavitary or intra-operative cone irradiation) (77470 assumes that the procedure is performed one or more times during the course of therapy, in addition to daily or weekly patient management)	$77.40
77499	Unlisted procedure, therapeutic radiology clinical treatment management	BR

HYPERTHERMIA

Hyperthermia treatments as listed in this section include external (superficial and deep), interstitial, and intracavitary. Radiation therapy when given concurrently is listed separately. Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy. It may be induced by a variety of sources, (eg, microwave, ultrasound, low energy radio-frequency conduction, or by probes). The listed treatments include management during the course of therapy and follow-up care for three months after completion. Physics planning and interstitial insertion of temperature sensors, and use of external or interstitial heat generating sources are included. The following descriptors are included in the treatment schedule:

77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)	BR
77605	deep (ie, heating to depths greater than 4 cm)	BR
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	BR
77615	more than 5 interstitial applicators	BR

CLINICAL INTRACAVITARY HYPERTHERMIA

77620	Hyperthermia generated by intracavitary probe(s)	BR

CLINICAL BRACHYTHERAPY

Clinical brachytherapy requires the use of either natural or man-made radioelements applied into or around a treatment field of interest. The supervision of radioelements and dose interpretation are performed solely by the therapeutic radiologist. When a procedure requires the service of a surgeon, see appropriate codes from the Surgery Section Services 77750-77799 include admission to the hospital and daily visits.

DEFINITIONS:

(Sources refer to intracavitary placement or permanent interstitial placement; ribbons refer to temporary interstitial placement.)

Simple - application with one to four sources/ribbons

Intermediate - application with five to ten sources/ribbons

Complex - application with greater than ten sources/ribbons

77750	Infusion or instillation of radioelement solution (includes three months follow-up care)	$209.60
77761	Intracavitary radiation source application; simple	$316.60
77762	intermediate	$371.20
77763	complex	$427.60

77776	Interstitial radiation source application; simple	$390.60
77777	intermediate	$453.40
77778	complex	$519.60
77781	Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters	$619.80
77782	5-8 source positions or catheters	$659.80
77783	9-12 source positions or catheters	$719.40
77784	over 12 source positions or catheters	$809.10
77789	Surface application of radiation source	$85.00
77799	Unlisted procedure, clinical brachytherapy	BR

NUCLEAR MEDICINE SERVICES

The services listed do not include the provision of radium or other radioelements. Those materials supplied by the provider should be billed separately and identified by the specific code describing the diagnostic radiopharmaceutical(s) and/or the therapeutic radiopharmaceutical(s) which are listed under ***Miscellaneous Procedures***.

DIAGNOSTIC

ENDOCRINE SYSTEM

78000	Thyroid uptake; single determination	$15.00
78001	multiple determinations	$20.00
78003	stimulation, suppression or discharge (not including initial uptake studies)	$25.00
78006	Thyroid imaging, with uptake; single determination	$40.00
78007	multiple determinations	$37.00
78010	Thyroid imaging; only	$25.00
78011	with vascular flow	$35.00
78015	Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)	$45.00
78016	with additional studies (eg, urinary recovery)	$60.00
78018	whole body	$90.00
78020	Thyroid carcinoma metastases uptake (List separately in addition to primary procedure) (Use 78020 in conjunction with code 78018 only)	$40.00
78070	Parathyroid imaging	$60.00
78075	Adrenal imaging, cortex and/or medulla	$60.00
78099	UNLISTED endocrine procedure, diagnostic nuclear medicine	BR

HEMATOPOIETIC, RETICULOENDOTHELIAL AND LYMPHATIC SYSTEM

78102	Bone marrow imaging; limited area	$45.00
78103	multiple areas	$45.00
78104	whole body	$60.00
78110	Plasma volume, radio-pharmaceutical volume-dilution technique (separate procedure); single sampling	$20.00
78111	multiple samplings	$32.00
78120	Red cell volume determination (separate procedure); single sampling	$30.00
78121	multiple samplings	$48.00
78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radio-pharmaceutical volume-dilution technique)	$42.00
78130	Red cell survival study	$50.00
78135	Differential organ/tissue kinetics, (eg, splenic and/or hepatic sequestration)	$75.00
78160	Plasma radioiron disappearance (turnover) rate	$30.00
78162	Radioiron oral absorption	$30.00
78170	Radioiron red cell utilization	$50.00
78172	Chelatable iron for estimation of total body iron	BR
78185	Spleen imaging only, with or without vascular flow (If combined with liver study, use procedures 78215, 78216)	$70.00
78190	Kinetics, study of platelet survival, with or without differential organ/tissue localization	BR
78191	Platelet survival study	BR
78195	Lymphatics and lymph nodes imaging	$40.00
78199	UNLISTED hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	BR

GASTROINTESTINAL SYSTEM

78201	Liver imaging; static only	$40.00
78202	with vascular flow	$50.00
78205	Liver imaging (SPECT)	$115.00
78206	with vascular flow	$125.00
78215	Liver and spleen imaging; static only	$60.00
78216	with vascular flow	$70.00
78220	Liver function study with hepatobiliary agents, with serial images	$30.00

78223	Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function	$30.00
78230	Salivary gland imaging;	$35.00
78231	with serial images	$35.00
78232	Salivary gland function study	$35.00
78258	Esophageal motility	$40.00
78261	Gastric mucosa imaging	$40.00
78262	Gastroesophageal reflux study	$40.00
78264	Gastric emptying study	$40.00
78270	Vitamin B-12 absorption study (eg, Schilling test); without intrinsic factor	$25.00
78271	with intrinsic factor	$30.00
78272	Vitamin B-12 absorption studies combined, with and without intrinsic factor	$50.00
78278	Acute gastrointestinal blood loss imaging	$40.00
78290	Intestine imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)	$40.00
78291	Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt)	$40.00
78299	UNLISTED gastrointestinal procedure, diagnostic nuclear medicine	BR

MUSCULOSKELETAL SYSTEM

78300	Bone and/or joint imaging; limited area	$60.00
78305	multiple areas	$60.00
78306	whole body	$60.00
78315	three phase study	$80.00
78320	tomographic (SPECT)	$115.00
78350	Bone density (bone mineral content) study; one or more sites; single photon absorptiometry	$40.00
78351	dual photon absorptiometry, one or more sites (For radiological bone density (photodensitometry), use 76078)	$64.00
78399	UNLISTED musculoskeletal procedure, diagnostic nuclear medicine	BR

CARDIOVASCULAR SYSTEM

78455	Venous thrombosis study (eg, radioactive fibrinogen)	$60.00
78456	Acute venous thrombosis imaging, peptide	$60.00

78457	Venous thrombosis imaging, venogram; unilateral	$30.00
78458	bilateral	$48.00
78460	Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification	$60.00
78461	multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification	$186.00
78464	tomographic (spect), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification	$186.00
78465	tomographic (spect), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification	$186.00
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	$60.00
78468	with ejection fraction by first pass technique	$60.00
78469	tomographic SPECT with or without quantification	$115.00
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or with stress (exercise and/or pharmalogic), wall motion study plus ejection fraction, with or without additional quantitative processing (For assessment of cardiac function by first pass technique, use 78496)	$150.00
78473	multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	$150.00
78478	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to primary procedure) (Use only for codes 78460-78465)	$30.00
78480	Myocardial perfusion study with ejection fraction (List separately in addition to primary procedure) (Use only codes 78460-78465)	$30.00
78481	Cardiac blood pool imaging, (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	$150.00
78483	multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification (For cerebral blood flow study, see 78615)	$240.00

78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	$186.00
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (Use 78496 in conjunction with code 78472)	$166.00
78499	UNLISTED cardiovascular procedure, diagnostic nuclear medicine	BR

RESPIRATORY SYSTEM

78580	Pulmonary perfusion imaging; particulate	$60.00
78584	Pulmonary perfusion,imaging, particulate, with ventilation; single breath	$116.00
78585	rebreathing and washout, with or without single breath	$116.00
78586	Pulmonary ventilation imaging, aerosol; single projection	$80.00
78587	multiple projections (eg, anterior, posterior, lateral views)	$80.00
78588	Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, one or multiple projections	$116.00
78591	Pulmonary ventilation imaging, gaseous, single breath, single projection	$80.00
78593	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection	$80.00
78594	multiple projections (eg, anterior, posterior, lateral views)	$80.00
78596	Pulmonary quantitative differential function (ventilation/perfusion) study	$120.00
78599	UNLISTED respiratory procedure; diagnostic nuclear medicine	BR

NERVOUS SYSTEM

78600	Brain imaging, limited procedure; static	$60.00
78601	with vascular flow	$70.00
78605	Brain imaging, complete study; static	$60.00
78606	with vascular flow	$70.00
78607	tomographic (SPECT)	$115.00
78610	Brain imaging, vascular flow only	$40.00
78615	Cerebral vascular flow	$80.00
78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	$75.00
78635	ventriculography	$75.00
78645	shunt evaluation	$75.00
78647	tomographic (SPECT)	$115.00
78650	Cerebrospinal fluid leakage detection and localization	$75.00

78660	Radio-pharmaceutical dacryocystography	$20.00
78699	UNLISTED nervous system procedure, diagnostic nuclear medicine	BR

GENITOURINARY SYSTEM

78700	Kidney imaging; static only	$40.00
78701	with vascular flow	$50.00
78704	with function study (ie, imaging renogram)	$85.00
78707	Kidney imaging with vascular flow and function; single study without pharmacological intervention	$95.00
78708	single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	$100.00
78709	multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	$104.00
78710	Kidney imaging tomographic (SPECT)	$115.00
78715	Kidney vascular flow only	$40.00
78725	Kidney function study, non-imaging radioisotopic study	$25.00
78730	Urinary bladder residual study	$25.00
78740	Ureteral reflux study (radio-pharmaceutical voiding cystogram)	$85.00
78760	Testicular imaging;	$40.00
78761	with vascular flow	$50.00
78799	UNLISTED genitourinary procedure, diagnostic nuclear medicine	BR

MISCELLANEOUS PROCEDURES

(For imaging bone infectious or inflammatory disease, see 78300, 78305, 78306)

78800	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area	$60.00
78801	multiple areas	$60.00
78802	whole body, single day imaging	$60.00
78803	tomographic (SPECT)	$115.00
78804	whole body, requiring two or more days imaging	$60.00
78805	Radiopharmaceutical localization of inflammatory process, limited area	$60.00
78806	whole body	$60.00
78807	tomographic (SPECT)	$115.00
78999	UNLISTED miscellaneous procedure, diagnostic nuclear medicine	BR

Diagnostic radiopharmaceticals;

A4641	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified	BR

A4642	Satumomab pendetide, per dose	BR
A9500	Technetium tc-99m, sestamibi, per dose	BR
A9502	Technetium tc-99m tetrofosmin, per unit dose	BR
A9503	Technetium tc-99m medronate, up to 30 mci	BR
A9504	Technetium tc-99m apcitide	BR
A9505	Thallous chloride TL 201, per mci	BR
A9507	Indium-111 capromab pendetid, per dose	BR
A9508	Iobenguane sulfate I-131, per 0.5 mci	BR
A9510	Technetium tc-99m disofenin, per vial	BR
A9511	Technetium tc-99m depreotide, per mci	BR
A9512	Technetium tc-99m pertechnetate, per mci	BR
A9513	Technetium tc-99m mebrofenin, per mci	BR
A9514	Technetium tc-99m pyrophosphate, per mci	BR
A9515	Technetium tc-99m pentetate, per mci	BR
A9516	I-123 sodium iodide capsule, per 100 uci	BR
A9519	Technetium tc-99m macroaggregated albumin, per mci	BR
A9520	Technetium tc-99m sulfur colloid, per mci	BR
A9521	Technetium tc-99m exametazine, per dose	BR
A9522	Indium-111 ibritumomab tiuxetan, per mci	BR
A9524	Iodinated I-131 serum albumin, 5 microcuries	BR
A9526	Ammonia N-13, per dose	BR
A9528	I-131 sodium iodide capsule, per mci	BR
A9529	I-131 sodium iodide solution, per mci	BR
A9531	I-131 sodium iodide, per mci (up to 100 mci)	BR
A9533	I-131 tositumomab, per mci	BR
C1091	Indium 111 oxyquinoline, per 0.5 mci	BR
C1092	Indium 111 pentetate, per 0.5 mci	BR
C9102	51 sodium chromate, per 50 mci	BR
C9103	Sodium iothalamate 1-125 injection, per 10 uci	BR
Q3003	Technetium tc-99m bicisate, per unit dose	BR
Q3004	Xenon xe 133, per 10 mci	BR
Q3005	Technetium tc-99m mertiatide, per mci	BR
Q3006	Technetium tc-99m glucepatate, per 5 mci	BR
Q3007	Sodium phosphate p32, per mci	BR
Q3008	Indium 111-in pentetreotide, per 3 mci	BR
Q3009	Technetium tc-99m oxidronate, per mci	BR
Q3011	Chromic phosphate p32 suspension, per mci	BR
Q3012	Cyanocobalamin cobalt co57, per 0.5 mci	BR

THERAPEUTIC

79005	Radiopharmaceutical therapy, by oral administration	$30.00
79101	by intravenous administration	$30.00
79200	by intracavitary administration	$45.00
79300	by interstitial radioactive colloid administration	$150.00
79403	radiolabeled monoclonal antibody by intravenous infusion	$30.00
79440	by intra-articular administration	$30.00
79445	by intra-arterial particulate administration	BR
79999	UNLISTED radio-pharmaceutical therapeutic procedure	BR

Therapeutic radiopharmaceuticals;

A9699	Supply of radiopharmaceutical therapeutic imaging agent, not otherwise classified	BR
A9517	I-131 sodium Iodide capsule, per mci	BR
A9523	Yttrium 90 Ibritumomab tiuxetan, per mci	BR
A9530	I-131 sodium solution per mci	BR
A9532	Iodinated I-125, serum albumin, 5 microcuries	BR
A9534	I-131 tositumomab, per mci	BR
A9600	Strontium-89 chloride, per mci	BR
A9605	Samarium sm 153 lexidronamm, 50 mci	BR

POSITRON EMISSION TOMOGRAPHY (PET) SERVICES

Maximum reimbursement amounts are for the complete procedure (professional and technical/administrative components) including the tracer. To receive reimbursement for only the technical/administrative component, see modifier –TC Technical Component.

G0125	PET imaging regional or whole body; single pulmonary nodule;	$1634.00
G0210	PET imaging whole body, full- and partial-ring PET scanners only; diagnosis, lung cancer, non-small cell	$1634.00
G0211	initial staging, lung cancer, non-small cell	$1634.00
G0212	restaging, lung cancer, non-small cell	$1634.00
G0213	diagnosis, colorectal cancer	$1634.00
G0214	initial staging, colorectal cancer	$1634.00
G0215	restaging, colorectal cancer	$1634.00
G0216	diagnosis, melanoma	$1634.00
G0217	initial staging melanoma	$1634.00
G0218	restaging melanoma	$1634.00
G0219	melanoma for non-covered indicators	$1634.00
G0220	diagnosis, lymphoma	$1634.00
G0221	initial staging, lymphoma	$1634.00

G0222	restaging lymphoma	$1634.00
G0223	PET imaging whole body or regional, full- and partial-ring PET scanners only; diagnosis, head and neck cancer, excluding thyroid and CNS cancers	$1634.00
G0224	initial staging head and neck cancer, excluding thyroid and CNS cancers	$1634.00
G0225	restaging head and neck cancer excluding thyroid and CNS cancers	$1634.00
G0226	PET imaging whole body; full- and partial-ring PET scanners only; diagnosis esophageal cancer	$1634.00
G0227	initial staging esophageal cancer	$1634.00
G0228	restaging esophageal cancer	$1634.00
G0229	PET imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures; full- and partial-ring PET scanners only	$1634.00
G0230	PET imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study; full- and partial-ring PET scanners only	$1634.00
G0252	PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (eg, initial staging of axillary lymph nodes)	$1,634.00
G0253	Pet imaging, for breast cancer, full and partial-ring pet scanners only, staging/restaging of local regional recurrence or distant metastases (ie, staging/restaging after or prior to course of treatment).	$1934.00
G0254	evaluation of response to treatment, performed during course of treatment.	$1934.00
G0296	Pet imaging, full and partial ring pet scanner only, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan	$1634.00
G0336	Pet imaging, brain imaging for the differential diagnosis of Alzheimer’s disease with aberrant features vs fronto-temporal dementia.	$1934.00
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress	$1850.00
78492	multiple studies at rest and/or stress	$1850.00

MEDICINE SERVICES

IMMUNIZATION INJECTIONS

Immunization procedures include the supply of material **and administration.**

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

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the estimated acquisition cost of the antigen. Insert actual acquisition cost per dose plus a two dollar ($2.00) administration fee in amount charged field on claim form. For codes listed **BR**, also attach itemized invoice to claim form.

To meet the reporting requirements of immunization registries, vaccine distribution programs and reporting systems (eg, Vaccine Adverse Event Reporting System) the exact vaccine product administered needs to be reported. 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, hepatitus A, Hib) or the vaccine product is available in more than one chemical formulation, dosage, or route of administration.

Reimbursement for drugs (including vaccines and immune globulins) furnished by provider to their patients is based on the acquisition cost to the provider of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the provider 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 provider. Regardless of whether an invoice must be submitted to Medicaid for payment, the provider is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

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

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

IMMUNE GLOBULINS

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

90281 Immune globulin (Ig), human, for intramuscular use (per 1 ml)
90283 Immune globulin (IgIV), human, for intravenous use (per 500 mg)
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 use (150 IU/ml)
90376 Rabies immune globulin, heat-treated (Rig-HT), human, for intramuscular and/or subcutaneous use
90379 Respiratory syncytial virus immune globulin (RVS-IgIV), human, for intravenous use (per 50 mg)
90384 Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
90385 Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
90386 Rho(D) immune globulin (RhIgIV), human, for intravenous use (per 1500 IU)
90389 Tetanus immune globulin (Tig), human, for intramuscular use (up to 250 units)
90393 Vaccinia immune globulin, human, for intramuscular use
90396 Varicella-zoster immune globulin, human, for intramuscular use (per 62.5 u/ml)
90399 Unlisted immune globulin

VACCINES/TOXOIDS

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

90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586 Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632 Hepatitis A vaccine, adult dosage, for intramuscular use
90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636 Hepatitis A and hepatits B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645 Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646 Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647 Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use

90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90665	Lyme disease vaccine, adult dosage, for intramuscular use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use
90675	Rabies vaccine, for intramuscular use
90676	Rabies vaccine, for intradermal use
90690	Typhoid vaccine, live, oral
90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use
90692	Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (dtap), for use in individuals younger than 7 years, for intramuscular use
90701	Diptheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702	Diptheria and tetanus toxoids (DT) adsorbed for use in individuals younger than seven years, for intramuscular use
90703	Tetanus toxoid adsorbed, for intramuscular use
90704	Mumps virus vaccine, live, for subcutaneous use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90708	Measles and rubella virus vaccine, live, for subcutaneous use
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90716	Varicella virus vaccine, live, for subcutaneous use
90717	Yellow fever vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (td) adsorbed for use in individuals 7 years or older, for intramuscular use
90720	Diptheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721	Diptheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723	Diptheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-Hep B-IPV), for intramuscular use
90725	Cholera vaccine for injectable use

90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use

90733 Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use

90734 Meningococococcal conjugate vaccine, serogroups A, C, Y and W-135 (Tetravalent), for intramuscular use

90735 Japanese encephalitis virus vaccine, for subcutaneous use

90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use

90743 Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use

90744 Hepatitis B vaccine; pediatric/adolescent dosage, (3 dose schedule) for intramuscular use

90746 adult dosage, for intramuscular use

90747 dialysis or immunosuppressed patient, dosage (4 dose schedule), for intramuscular use

90748 Hepatitis B and Hemophilus influenza B vaccine (Hep B –HIB), for intramuscular use

90749 UNLISTED vaccine/toxoid

THERAPEUTIC OR DIAGNOSTIC INFUSTIONS (EXCLUDES CHEMOTHERAPY)

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

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

MISCELLANEOUS DRUGS AND SOLUTIONS

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

Reimbursement for drugs (including vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the provider of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the provider 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 provider. 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.

A4260	Levonorgestrel contraceptive implant system (Norplant System), including implants and supplies	BR
A4647	Supply of paramagnetic contrast material, e.g., gadolinium (per ml)	
J0207	Amifostine, 500 mg	
J0215	Alefacept (Amevive), 0.5 mg	
J0256	Alpha 1-Proteinase Inhibitor-Human, 10 mg	
J0456	Azithromycin, 500 mg	
J0585	Botulinum toxin type A, per 100 units	
J0587	Botulinum toxin type B, per 100 units	
J0640	Leucovorin Calcium, 50 mg	
J0696	Ceftriaxone Sodium, per 250 mg	
J0697	Sterile Cefuroxime Sodium, per 750 mg	
J1055	Medroxyprogesterone Acetate for contraceptive use, 150 mg (J1055 Should not be billed in addition to the all-inclusive clinic rate)	
J1056	Medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (J1056 should not be billed in addition to the all-inclusive clinic rate)	
J1100	Dexamethasone Sodium Phosphate, 1 mg	
J1190	Dexrazoxane Hydrochloride, per 250 mg	
J1260	Dolasetron mesylate, 10 mg	
J1436	Etidronate Disodium, per 300 mg	
J1438	Etanercept, 25 mg (not for self-administration)	
J1440	Filgrastim (G-CSF), 300 mcg	
J1441	Filgrastim (G-CSF), 480 mcg	
J1450	Fluconazole, 200 mg	
J1452	Fomivirsen Sodium, intraocular, 1.65 mg	
J1565	Respiratory syncytial virus immune globulin, intravenous, 50 mg	
J1570	Ganciclovir Sodium, 500 mg	
J1595	Glatiramer acetate, 20 mg	
J1626	Granisetron hydrochloride, 100 mcg	
J1652	Fondaparinux sodium, 0.5 mg	
J1655	Tinzaparin sodium, 1000 IU	
J1745	Infliximab, 10 mg	
J1750	Iron dextran, 50 mg	
J1825	Interferon beta-1a, 33 mcg (not for self-administration)	
J1830	Interferon beta-1b, 0.25 mg (not for self-administration)	
J2353	Octreotide, depot form for intramuscular injection, 1 mg	
J2405	Ondansetron Hydrochloride, per 1 mg	
J2430	Pamidronate disodium, per 30 mg	
J2469	Palonosetron HCL, 25 mcg	

J2505	Pegfilgrastim (Neulasta), 6 mg	
J2545	Pentamidine, Isethionate inhalation solution, per 300 mg (NebuPent)	
J2597	Desmopressin acetate, per 1 mcg	
J2783	Rasburicase, 0.5 mg	
J3240	Thyrotropin alpha, 0.9 mg., provided in 1.1 mg vial	
J3305	Trimetrexate glucoronate, per 25 mg	
J3487	Zoledronic acid (Zometa), 1 mg	
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	
J7130	Hypertonic saline solution, 50 or 100 mEq, 20 cc vial	
J7190	Factor VIII (antihemophilic factor (Human)), per IU	BR
J7191	Factor VIII (antihemophilic factor (Porcine)), per IU	BR
J7192	Factor VIII (antihemophilic factor (recombinant)), per IU	BR
J7193	Factor IX (antihemophilic factor, purified, non-recombinant), per IU	BR
J7194	Factor IX, Complex, per IU	BR
J7195	Factor IX (antihemophilic factor, recombinant), per IU	BR
J7197	Antithrombin III (Human), per IU	BR
J7198	Anti-inhibitor, per IU	BR
J7199	Hemophilia clotting factor, not otherwise classified	BR
J7310	Ganciclovir, 4.5 mg, long-acting implant (not billable in addition to rate)	BR
J7501	Azathioprine parenteral (eg, Imuran), 100 mg	
J7504	Lymphocyte immune globulin, anti-thymyocyte globulin, parenteral, 250 mg	
J8501	Aprepitant, oral, 5 mg	
Q2005	Corticorelin ovine triflutata, per dose	
Q2012	Pegademase bovine, 25 IU	
Q4054	Darbepoetin alfa, 1 mcg (for ESRD on dialysis)	
Q4055	Epoetin alfa, 1000 units (for ESRD on dialysis)	
S0190	Mitepristone, oral, 200 mg (when administered for medically necessary non-surgical abortion)	

S0191	Misoprostol, oral, 200 mg (when administered for medically necessary non-surgical abortion)	
S9435	Medical foods for inborn errors of metabolism (reimbursement limited to Inborn Metabolic Disease Centers or Medical Directors of Inborn Metabolic Disease Centers)	BR
90799	UNLISTED therapeutic or diagnostic injection	BR

GASTROENTEROLOGY SERVICES

91000	Esophageal intubation and collection of washings for cytology, including preparation of specimens (separate procedure)	$60.00
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study;	$50.00
91011	with mecholyl or similar stimulant	$50.00
91012	with acid perfusion studies	$50.00
91020	Gastric motility (manometric) studies	$50.00
91030	Esophagus, acid perfusion (Bernstein) test for esophagitis	$60.00
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	$35.00
91038	prolonged (greater than 1 hour, up to 24 hours)	$35.00
91040	Esophageal balloon distension provocation study	BR
91060	Gastric saline load test	$50.00
91065	Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	$25.00
91110	Gastrointesinal track imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report	$800.00
91120	Rectal sensation, tone, and compliance test (ie., response to graded balloon distention)	BR
91122	Anorectal manometry	$50.00

OPHTHALMOLOGICAL DIAGNOSTIC AND TREATMENT SERVICES

GENERAL OPHTHALMOLOGICAL SERVICES

92002	Ophthalmological services, new patient; medical examination and evaluation with initiation of diagnostic and treatment program; intermediate	$16.00
92004	comprehensive (includes refraction)	$20.00

92012	Ophthalmological services, established patient; medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate (includes refraction)	$16.00
92014	comprehensive (includes refraction)	$20.00

SPECIAL OPHTHALMOLOGICAL SERVICES

92020	Gonioscopy (separate procedure)	$8.00
92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	$15.00
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	$8.00
92082	intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	$8.00
92083	extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	$8.00
	(Gross visual field testing (eg, confrontation testing) is a part of general opthalmological services and is not reported separately.)	
92120	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method	$8.00
92130	Tonography with water provocation	$16.00
92135	Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral	$16.00
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	$22.00
92140	Provocative tests for glaucoma, with interpretation and report, without tonography	$8.00

OPHTHALMOSCOPY

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated. It is a non-itemized service and is not reported separately.

92225	Ophthalmoscopy, extended, with retinal drawing, (eg, for retinal detachment, melanoma), with interpretation and report; initial	$15.00
92226	subsequent	$15.00
92230	Fluorescein angioscopy with interpretation and report; (one or both eyes)	BR
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	$50.00
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report	$50.00
92250	Fundus photography with interpretation and report	$16.00
92260	Ophthalmodynamometry	$25.00

MISCELLANEOUS SPECIALIZED SERVICES

92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report	$35.00
92270	Electro-oculography with interpretation and report	$25.00
92275	Electroretinography with interpretation and report	$35.00
92286	Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count	$8.00
92287	with fluorescein angiography	BR

OTORHINOLARYNGOLOGIC SERVICES

92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)	$15.00
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	$35.00
92542	Positional nystagmus test, minimum of 4 positions, with recording	$35.00
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	$35.00
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	$35.00
92545	Oscillating tracking test, with recording	$10.00
92546	Sinusoidal vertical axis rotational testing	$10.00

AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION SERVICES

92551	Screening test, pure tone, air only	$5.00
92552	Pure tone audiometry (threshold); air only	$5.00
92553	air and bone	$10.00
92555	Speech audiometry threshold;	$5.00
92556	with speech recognition	$15.00
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	$25.00
92563	Tone decay test	$5.00
92564	Short increment sensitivity index (SISI)	$10.00
92565	Stenger test, pure tone	$5.00
92567	Tympanometry (impedance testing)	$10.00
92568	Acoustic reflex testing	$10.00
92569	Acoustic reflex decay test	$5.00
92571	Filtered speech test	$25.00
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	$90.00
92586	limited	$25.00
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	$50.00
92588	comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	$69.00

CARDIOVASCULAR SERVICES

CARDIOGRAPHY

93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	$15.00
93005	tracing only, without interpretation and report	$7.50
93012	Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24 hour attended monitoring, per 30 day period of time; tracing only	$18.00
93014	**(complete procedure)** includes physician review with interpretation and report	$60.00
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician interpretation and report	$60.00
93017	tracing only, without interpretation and report	$30.00

93024	Ergonovine provocation test	BR
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	$78.00
93040	Rhythm ECG, one to three leads; with interpretation and report	$5.00
93224	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation	$60.00
93225	recording (includes hook-up, recording, and disconnection)	$18.00
93230	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation	$60.00
93231	recording (includes hook-up, recording, and disconnection)	$18.00
93235	Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; includes monitoring and real time data analysis with report, physician review and interpretation	$60.00
93236	monitoring and real-time data analysis with report	$18.00
93268	Patient demand single or multiple event recording with presymptom memory loop, 24 hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation **(complete procedure)**	$60.00
93270	recording (includes hook-up, recording, and disconnection)	$9.00
93271	monitoring, receipt of transmissions, and analysis	$9.00
93278	Signal-averaged electrocardiography (SAECG), with or without ECG	$60.00

ECHOCARDIOGRAPHY

For procedure codes 93303-93350, See Radiology Section General Instructions and General Information and Rules. When more than one of these procedures are performed during the same visit, reimbursement shall be limited to the greater fee plus 60% of the lesser fee(s).

(Echocardiography includes obtaining ultrasonic signals from the heart and great arteries, with two-dimensional image and/or Doppler ultrasonic signal documentation, interpretation and report. When technical component is performed separately, use Modifier –TC.)

93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	$90.00
93304	follow-up or limited study	$60.00
93307	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete	$90.00
93308	follow-up or limited study	$60.00
93312	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-Mode recording); including probe placement, image acquisition, interpretation and report	$105.00
93314	image acquisition, interpretation and report only	$84.00
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	$105.00
93317	image acquisition, interpretation and report only	$84.00
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	$100.00
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	$87.00
93321	follow-up or limited study (Use 93320, 93321 separately in addition to codes for echocardiographic imaging 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350)	$60.00
93350	Echocardiography, transthoracic, real-time with image documentation (2D, with or without M-mode recording), during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report (The appropriate stress test code from the 93015-93017 series should be reported in addition to 93350 to capture the exercise stress portion of the study.)	$120.00

MISCELLANEOUS VASCULAR STUDIES

93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	$25.00
93562	subsequent measurement of cardiac output	$12.50
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	$100.00
93701	Bioimpedance, thoracic, electrical	$10.00
93720	Plethysmography, total body; with interpretation and report	$25.00
93721	tracing only, without interpretation and report	$15.00
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	$131.00
93727	Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)	$20.00
93731	Electronic analysis of dual-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming	$20.00
93732	with reprogramming	$20.00
93733	Electronic analysis of dual chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis	$15.00
93734	Electronic analysis of single-chamber pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without reprogramming	$20.00
93735	with reprogramming	$20.00
93736	Electronic analysis of single chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form , and/or testing of sensory function of pacemaker), telephonic analysis	$15.00
93740	Temperature gradient studies	BR

93741	Electronic analysis of pacing cardioverter-defibrillator (inlcudes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, or wearable cardioverter-defibrillator system, without reprogramming	$20.00
93742	single chamber, with reprogramming	$20.00
93743	dual chamber, without reprogramming	$20.00
93744	dual chamber, with reprogramming	$20.00
93770	Determination of venous pressure	$5.00
93784	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis; interpretation and report	$60.00
93786	recording only	$18.00

NON-INVASIVE VASCULAR DIAGNOSTIC STUDIES

For procedure codes 93875-93990, see Radiology Section General Instructions and General Information and Rules.

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided. The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported.

Duplex scan: An ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

CEREBROVASCULAR ARTERIAL STUDIES

93875	Non-invasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)	$40.00
93880	Duplex scan of extracranial arteries; complete bilateral study	$108.00
93882	unilateral or limited study	$93.00

93886	Transcranial Doppler study of the intracranial arteries; complete study	$108.00
93888	limited study	$93.00
93890	vasoreactivity study	$68.00
93892	emboli detection without intravenous microbubble injection	$73.00
93893	emboli detection with intravenous microbubble injection	$71.00

EXTREMITY ARTERIAL STUDIES (INCLUDING DIGITS)

93922	Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)	$72.00
93923	Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)	$72.00
93924	Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study	$72.00
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	$108.00
93926	unilateral or limited study	$93.00
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	$108.00
93931	unilateral or limited study	$93.00

EXTREMITY VENOUS STUDIES (INCLUDING DIGITS)

93965	Non-invasive physiologic studies of extremity veins, complete bilateral study, (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)	$108.00
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	$108.00
93971	unilateral or limited study	$93.00

VISCERAL AND PENILE VASCULAR STUDIES

93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	$67.50
93976	limited study	$58.00
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	$67.50
93979	unilateral or limited study	$58.00
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	$58.00
93981	follow-up or limited study	$42.00

EXTREMITY ARTERIAL-VENOUS STUDIES

93990	Duplex scan of hemodialysis access(including arterial inflow, body of access and venous outflow)	$42.00

PULMONARY SERVICES

Codes 94010-94770 include laboratory procedure(s), interpretation and physician's services (except surgical and anesthesia services), unless otherwise stated.

94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	$15.00
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation	$15.00
94015	recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	$7.50
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	$25.00
94070	Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg., antigen(s), cold air, methacholine)	$25.00
94150	Vital capacity, total (separate procedure)	$3.00
94200	Maximum breathing capacity, maximal voluntary ventilation	$10.00
94240	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	$15.00
94250	Expired gas collection, quantitative, single procedure (separate procedure)	$25.00
94260	Thoracic gas volume	$15.00

94350	Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time	$27.50
94360	Determination of resistance to airflow, oscillatory or plethysmographic methods	$15.00
94370	Determination of airway closing volume, single breath tests	$15.00
94375	Respiratory flow volume loop	$15.00
94620	Pulmonary stress testing, simple (eg, prolonged exercise test for bronchospasm with pre- and post-spirometry)	BR
94621	complex (including measurements of CO2 production, O2	$18.00
94640	Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)	$3.00
94642	Aerosol inhalation of pentamidine for pneumocystis pneumonia treatment or prophylaxis	$3.00
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device (Report 94664 one time only per day of service)	$3.00
94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	$25.00
94681	including C02 output, percentage oxygen extracted	$25.00
94690	rest, indirect (separate procedure)	$7.50
94720	Carbon monoxide diffusing capacity (eg, single breath, steady state)	$30.00
94725	Membrane diffusion capacity	$15.00
94750	Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)	$15.00
94770	Carbon dioxide, expired gas determination by infrared analyzer	$5.00

ALLERGY AND CLINICAL IMMUNOLOGY SERVICES

ALLERGY SENSITIVITY TESTS: the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the same number of sensitivity tests. Maximum fees include observation and interpretation of the tests by an allergist.

ALLERGY TESTING

95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests (Note: Must bill with paper claim. Report total number of tests in the description field on the claim form. Calculate total amount due as follows: $0.50 for each test up to 60 tests and $0.25 for each test over 60 tests).	$.50
95010	Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests	$.50
95015	Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests	$.75
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests	$.75
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	$.75
95060	Ophthalmic mucous membrane tests	$2.00
95065	Direct nasal mucous membrane test	$2.00

ALLERGEN IMMUNOTHERAPY

95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; (to be administered by or under the supervision of another physician) single or multiple antigens, multiple dose vial(s), (specify number of **VIALS)**	$5.00

SENSITIVITY TESTING

86485	Skin test; candida	$5.00
86490	coccidioidomycosis	$5.00
86510	histoplasmosis	$5.00
86580	tuberculosis, intradermal	$5.00
86585	tuberculosis, tine test	$1.88
86586	Unlisted antigen, each	$5.00

NEUROLOGY AND NEUROMUSCULAR SERVICES

ROUTINE ELECTROENCEPHALOGRAPHY (EEG)

EEG codes 95812-95822 include hyperventilation and/or photic stimulation when appropriate. Routine EEG codes 95816-95822 include 20-40 minutes of recording. Extended EEG codes 95812-95813 include reporting times longer than 40 minutes.

95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	$35.00
95813	greater than one hour	$35.00
95816	Electroencephalogram (EEG); including recording awake and drowsy	$35.00
95819	including recording awake and asleep	$35.00
95822	recording in coma or sleep only	$35.00
95827	all night recording	$13.50
95830	Insertion by physician of sphenoidal electrodes for electroencephalographic (EEG) recording (includes tracing, interpretation and report)	$40.00

MUSCLE AND RANGE OF MOTION TESTING

95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	$7.50
95832	hand, with or without comparison with normal side	$7.50
95833	total evaluation of body, excluding hands	$20.00
95834	total evaluation of body, including hands	$20.00
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	$2.50
95852	hand, with or without comparison with normal side	$2.50
95857	Tensilon test for myasthenia gravis;	$10.00
95858	with electromyographic recording	$45.00
95860	Needle electromyography; one extremity with or without related paraspinal areas	$35.00
95861	two extremities with or without related paraspinal areas	$70.00
95863	three extremities with or without related paraspinal areas	$105.00
95864	four extremities with or without related paraspinal areas	$140.00
95867	cranial nerve supplied muscle(s); unilateral	$30.00
95868	bilateral	$60.00
95869	thoracic paraspinal muscles (excluding T1 or T2)	$30.00
95870	limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters (To report a complete study of the extremities, see 95860-95864) (For needle electromyography of cranial supplied muscles, see 95867, 95868)	$30.00
95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied	$30.00

95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	$7.50

NERVE CONDUCTION STUDIES

95900	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	$15.00
95903	motor, with F-wave study	$15.00
95904	sensory	$15.00
	(Report 95900, 95903 and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded)	
95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval Valsalva ratio, and 30:15 ratio	$15.00
95922	vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt	$15.00
95923	sudomotor, including one or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	$15.00
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	$30.00
95926	in lower limbs	$30.00
95927	in the trunk or head	$30.00
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	$50.00
95929	lower limbs	$52.00
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	$90.00
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	$35.00
95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle	$15.00
95936	record muscle other than gastrocnemius/soleus muscle	$15.00
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method	$35.00
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours	$42.00

95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation, (eg, for presurgical localization), each 24 hours	$62.50
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG; electroencephalographic (EEG) recording and interpretation, each 24 hours	$42.00
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry; electroencephalographic (EEG) recording and interpretation, each 24 hours	$42.00
95990	Refilling and maintenance on implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural)or brain (intraventricular)	$15.00

CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS (e.g., NEURO-COGNITIVE, MENTAL STATUS, SPEECH TESTING)

(When billing for procedure codes 96105 thru 96117, the total time billed to New York State Medicaid should reflect the face-to-face contact time with the patient. Reimbursement for all work performed before and after the face-to-face encounter (e.g., analysis of tests, reviewing records, etc.) is included in the maximum reimbursable amount for the face-to-face encounter.)

96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	$150.00
96111	Developmental testing; extended (includes assessment of motor language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report	$150.00
96115	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour	$150.00
96117	Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour	$150.00

CHEMOTHERAPY ADMINISTRATION SERVICES

Intravenous chemotherapy injections are administered by a physician, a nurse practitioner or by a qualified assistant under supervision of the physician or nurse practitioner.

96405	Chemotherapy administration, intralesional; up to and including 7 lesions	$10.00
96406	more than 7 lesions	$15.00
96408	Chemotherapy administration, intravenous; push technique	$15.00
96410	infusion technique, up to one hour	$35.00
96412	infusion technique, one to 8 hours, each additional hour (Use 96412 in conjunction with code 96410)	$5.00
96414	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	$35.00
96420	Chemotherapy administration, intra-arterial; push technique	$15.00
96422	infusion technique, up to one hour	$35.00
96423	infusion technique, one to 8 hours, each additional hour (Use 96423 in conjunction with code 96422)	$5.00
96425	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	$35.00
96520	Refilling and maintenance of portable pump	$15.00
96530	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial) (Access of pump port is included in filling of implantable pump)	$15.00
96545	Provision of chemotherapy agent (not otherwise listed) (For radioactive isotope therapy, see 79000-79999)	BR
96549	UNLISTED chemotherapy procedure	BR

CHEMOTHERAPY DRUGS

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

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

Reimbursement for drugs furnished by providers to their patients is based on the acquisition cost to the provider of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the provider 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 provider. Regardless of whether an invoice must be submitted to Medicaid for payment, the provider is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

J0128 Abarelix, 10 mg
J9000 (Adriamycin) Doxorubicin HCL, 10 mg
J9001 Doxorubicin hydrochloride, all lipid formulations, 10 mg
J9010 Alemtuzumab, 10 mg
J9015 Aldesleukin, per single use vial
J9017 Arsenic trioxide, 1 mg (Trisenox)
J9020 Asparaginase (Elspar) 10,000 Units
J9031 BCG live (Intravesical), per installation
J9035 Bevacizumab, 10 mg
J9040 (Lenoxane) Bleomycin Sulfate, 15 units
J9041 Bortezomib, 0.1 mg
J9045 Carboplatin, 50 mg
J9050 Carmustine, 100 mg
J9055 Cetuximab, 10 mg
J9060 Cisplatin (Platinol), powder or solution, per 10 mg
J9062 Cisplatin, (Platinol), 50 mg
J9065 Cladribine, per 1 mg
J9070 Cyclophosphamide (Cytoxan, Neosar) 100 mg
J9080 Cyclophosphamide (Cytoxan, Neosar) 200 mg
J9090 Cyclophosphamide (Cytoxan, Neosar) 500 mg
J9091 Cyclophosphamide (Cytoxan, Neosar) 1.0 gram
J9092 Cyclophosphamide (Cytoxan, Neosar) 2.0 gram
J9093 Cyclophosphamide, Lyophilized (Cytoxan) 100 mg
J9094 Cyclophosphamide, Lyophilized (Cytoxan) 200 mg
J9095 Cyclophosphamide, Lyophilized (Cytoxan) 500 mg

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

J9266	Pegaspargase, per single dose vial	
J9268	Pentostatin, per 10 mg	
J9270	Plicamycin 2.5 mg	
J9280	Mitomycin, 5 mg	
J9290	Mitomycin, 20 mg	
J9291	Mitomycin, 40 mg	
J9293	Mitoxantrone Hydrochloride, per 5 mg	
J9300	Gemtuzumab ozogamicin, 5 mg	
J9305	Pemetrexed, 10 mg	
J9310	Rituximab, 100 mg	
J9320	Streptozocin, 1 gm	
J9340	Thiotepa 15 mg	
J9350	Topotecan, 4 mg	
J9355	Trastuzumab, 10 mg	
J9357	Valrubicin, intravesical, 200 mg	
J9360	Vinblastine Sulfate, 1 mg	
J9370	Vincristine Sulfate, 1 mg	
J9375	Vincristine Sulfate, 2 mg	
J9380	Vincristine Sulfate, 5 mg	
J9390	Vinorelbine Tartrate, per 10 mg	
J9395	Fulvestrant, 25 mg	
J9600	Porfimer Sodium, 75 mg	
J9999	Not otherwise classified, antineoplastic drugs	BR
Q2017	Teniposide, 50 mg	
96545	Provision of chemotherapy agent (not listed above)	BR

MISCELLANEOUS ORDERED AMBULATORY SERVICES

36430	Transfusion, blood or blood components	$8.00
36511	Therapeutic apheresis; for white blood cells	$150.00
36512	for red blood cells	$150.00
36513	for platelets	$150.00
36514	for plasma pheresis	$150.00
36515	with extracorporeal immunoadsorption and plasma reinfusion	$150.00
36516	with extracorporeal selective adsorption or selective filtration and plasma reinfusion	$150.00
36522	Photopheresis, extracorporeal (for technical component see Modifier –TC)	$150.00
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic donor lymphocyte infusions	$8.00

54240	Penile plethysmography	$25.00
59020	Fetal contraction stress test	$20.00
59025	Fetal non-stress test	$15.00
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma (99170 should not be billed in addition to the all-inclusive clinic rate or emergency room rate)	$27.00
99195	Phlebotomy, therapeutic (separate procedure)	$10.00

REHABILITATION SERVICES

SPEECH LANGUAGE PATHOLOGY SERVICES

(Codes 92506 and 92507 are limited to Speech Language Pathology Services)

92506	Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status	$15.00
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual, (each half hour)	$4.70

PHYSICAL THERAPY SERVICES/OCCUPATIONAL THERAPY SERVICES

97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes (up to a maximum of 2 hours)	$2.35

USE OF THE OPERATING ROOM

For information regarding the application process required for the Hospital-Based Ambulatory Surgery Program, please contact the hospital services representative in the appropriate OHSM Area Office for consultation. Current addresses and telephone numbers for the OHSM Area Offices are provided in the Inquiry Section of the manual.