NEW YORK STATE
MEDICAID PROGRAM

PHYSICIAN – PROCEDURE CODES

SECTION 2 – MEDICINE, DRUGS and DRUG ADMINISTRATION

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GENERAL RULES AND INFORMATION

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

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

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

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

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

3. **DEFINITIONS OF COMMONLY USED E/M TERMS:** Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting.

NEW AND ESTABLISHED PATIENT: Solely for the purpose of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific code. A new patient is one who has not received any professional services from the practitioner or practitioners working in the same specialty within the same group within the past three years. An established patient is one who has received professional services from the practitioner within the past three years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- marital status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

SYSTEM REVIEW (REVIEW OF SYSTEMS): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular

- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

TIME: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions. The inclusion of time as an explicit factor beginning in 1992 is done to assist practitioners in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

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

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

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

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

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

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

B. **Unit/floor time (hospital observation services, inpatient hospital care, initial and follow-up hospital consultations, nursing facility):** For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the practitioner is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the practitioner establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

In the hospital, pre- and post time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital. This pre- and post visit time is not included in the time component described in these codes. However, the pre- and post work performed during the time spent off the floor or unit was included in calculating the total work of typical services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Problem Focused -- chief complaint; brief history of present illness or problem.
- Expanded Problem Focused -- chief complaint; brief history of present illness; problem pertinent system review.
- Detailed -- chief complaint; extended history of present illness; problem pertinent system review extended to include review of a limited number of additional systems; pertinent past, family and/or social history directly related to the patient's problems.

- Comprehensive -- chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

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

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

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

For the purpose of these definitions, the following body areas are recognized: head, including the face; neck; chest, including breasts and axilla; abdomen; genitalia, groin, buttocks; back and each extremity.

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

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

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

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

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	Straight Forward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

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

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

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

b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; follow-up consultations, other than office; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

c. In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in locum parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

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

The same problem, when seen by physicians in different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptor rather than the examples.

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

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

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

6. **CRITICAL CARE:** Represents extraordinary care by the attending physician in personal attendance in the care of a medical emergency, both directing and personally administering specific corrective measures after initial examination had determined the nature of the ailment. See codes 99291, 99292. **NOTE: Report Required for 99292.**

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

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

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

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

9. **INJECTIONS:** are usually given in conjunction with a medical service. When an injection is the only service performed, a minimal service may be listed in addition to the injection.

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

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

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

    Payment for supplies and materials 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.

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

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

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

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

16. **DVS AUTHORIZATION (#):** Codes followed by # require an authorization via the dispensing validation system (DVS) before services are rendered.

17. **BILLING GUIDELINES:** For additional general billing guidelines see the current CTP manual.

18. **FEES:** The fees are listed in the Physician Medicine Fee Schedule, available at http://www.emedny.org/ProviderManuals/Physician/index.html
    Listed fees are the maximum reimbursable Medicaid fees**.** Fees for the HIV Program and the PPAC Program can be found in the Enhanced Program fee schedule.

MMIS MODIFIERS

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

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

The circumstances under which such further description is required are detailed below along with the appropriate modifiers to be added to the basic code when the particular circumstance applies. Up to four modifiers are allowed on a claim line.

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

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

-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.)

-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral medical procedures and surgical procedures requiring a separate incision that are performed at the same operative session, or bilateral x-ray examinations should be identified by the appropriate procedure code describing the first procedure. To indicate a bilateral procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum State Medical Fee Schedule amount for medicine and surgery services or 160% of the maximum State Medical Fee Schedule amount for radiology services. One claim line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)

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

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

-AJ Clinical Social Worker: To report services of a Certified Social Worker (CSW) under the direct supervision of an employing psychiatrist, modifier –AJ should be added to the appropriate procedure code listed below. (Reimbursement will not exceed the indicated amount.) 90832 ($13.50), 90834 ($27.00), 90846 ($7.20), 90847 ($7.20), 90849 ($7.20), 90853 ($7.20), 90837 ($7.20).

-AQ Physician Providing a Service in an Unlisted Health Professional Shortage Area (HPSA)

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

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

-GT Via interactive audio and video telecommunication systems: Indicates services were performed via telemedicine. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-LT Left Side: (Used to identify procedures performed on the left side of the body). Add modifier –LT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed.) **(Use modifier –50 when both sides done at same operative session.)**

-RT Right Side: (Used to identify procedures performed on the right side.) Add modifier –RT to the usual procedure code number. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount. One claim line should be billed). **(Use modifier –50 when both sides done at same operative session.)**

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

EVALUATION AND MANAGEMENT SERVICES

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

OFFICE OR OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the **practitioner's office or in an outpatient or other ambulatory facility**. A patient is considered an outpatient until inpatient admission to a health care facility occurs. When claiming for Evaluation and Management procedure codes 99201-99205 and 99211-99215 Office or Other Outpatient Services, report the place of service code that represents the location where the service was rendered in claim form field 24B Place of Service. **The maximum reimbursable amount for these codes is dependent on the Place of Service reported.**

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

For Evaluation and Management services rendered in the practitioner's private office, report place of service "11". For services rendered in a Hospital Outpatient setting report place of service "22".

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

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

For observation care, see 99217-99220.

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

NEW PATIENT

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- a problem focused history,
- a problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- a detailed history,
- a detailed examination, and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.

ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

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

Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a problem focused history,
- a problem focused examination, and/or
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:
- an expanded problem focused history,
- an expanded problem focused examination, and/or
- medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:
- a detailed history,
- a detailed examination, and/or
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:
- a comprehensive history,
- a comprehensive examination, and/or
- medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

HOSPITAL OBSERVATION SERVICES

The following codes are used to report evaluation and management services provided to patients designated/admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.

Typical times have not yet been established for this category of services.

OBSERVATION CARE DISCHARGE SERVICES

Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.

99217 Observation care discharge day management (This code is to be utilized by the practitioner to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status". To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services (99234-99236))

INITIAL OBSERVATION CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the encounter(s) by the supervising practitioner with the patient when designated as "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see Inpatient Consultation codes (99251-99255).

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

When "observation status" is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising physician should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting. Evaluation and Management services on the same date provided in sites that are related to initiating "observation status" should NOT be reported separately.

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

99218 Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components:

- a detailed or comprehensive history,
- a detailed or comprehensive examination, and
- medical decision making that is straightforward or of low complexity.

Usually the problem(s) requiring admission to "observation status" are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit.

99219 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the problem(s) requiring admission to "observation status” are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit.

99220 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually, the problem(s) requiring admission to "observation status" are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

SUBSEQUENT OBSERVATION CARE

All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician.

99224 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- problem focused interval history,
- problem focused examination, and/or
- medical decision making that is straightforward or of low complexity.

Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99225 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history,
- an expanded problem focused examination, and/or
- medical decision making of moderate complexity.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99226 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a detailed interval history,
- a detailed examination, and/or
- medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

HOSPITAL INPATIENT SERVICES

The following codes are used to report evaluation and management services provided to **HOSPITAL INPATIENTS**. For Hospital Observation Services, see 99218-99220. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. For services rendered in a hospital outpatient setting, see procedure codes 99201-99215 Office or Other Outpatient Services.

INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting practitioner. For initial inpatient encounters by practitioners other than the admitting practitioner, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

99221 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:
- a detailed or comprehensive history,
- a detailed or comprehensive examination, and
- medical decision making that is straightforward or of low complexity.

Usually, the problem(s) requiring admission are of low severity. Practitioners typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the problem(s) requiring admission are of moderate severity. Practitioners typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually, the problem(s) requiring admission are of high severity. Practitioners typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

SUBSEQUENT HOSPITAL CARE

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (i.e., changes in history, physical condition and response to management) since the last assessment by the practitioner.

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a problem focused interval history,
- a problem focused examination, and/or
- medical decision making that is straightforward or of low complexity.

Usually, the patient is stable, recovering or improving. Practitioners typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history,
- an expanded problem focused examination, and/or
- medical decision making of moderate complexity.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Practitioners typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a detailed interval history,
- a detailed examination, and/or
- medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Practitioners typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

OBSERVATION OR INPATIENT CARE SERVICES (INCLUDING ADMISSION AND DISCHARGE SERVICES)

The following codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. When a patient is admitted to the hospital from observation status on the same date, the physician should report only the initial hospital care code. The initial hospital care code reported by the admitting physician should include the services related to the observation status services he/she provided on the same date of inpatient admission.

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

For patients admitted to observation or inpatient care and discharged on a different date, see codes 99218-99220 and 99217, or 99221-99223 and 99238-99239.

99234 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components:
- a detailed or comprehensive history,
- a detailed or comprehensive examination, and
- medical decision making that is straightforward or of low complexity.

Usually the presenting problem(s) requiring admission are of low severity.

99235 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually the presenting problem(s) requiring admission are of moderate severity.

99236 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually the presenting problem(s) requiring admission are of high severity.

HOSPITAL DISCHARGE SERVICES

The hospital discharge day management codes are to be used to report the total duration of time spent by a practitioner for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the practitioner on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.

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

(These codes are to be utilized by the practitioner to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status. To report services to a patient who is admitted as an inpatient, and discharged on the same date, see codes 99234-99236 for observation or inpatient hospital care including the admission and discharge of the patient on the same date. To report concurrent care services provided by a practitioner(s) other than the attending practitioner, use subsequent hospital care codes (99231-99233) on the day of discharge.)

(For Observation Care Discharge, use 99217)

(For discharge services provided to newborns admitted and discharged on the same date, use 99463)

(For Nursing Facility Care Discharge, see 99315, 99316)

(For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see 99234-99236)

CONSULTATIONS (BY SPECIALISTS)

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

A "consultation" initiated by a patient and/or family is not reported using the consultation codes, but may be reported using the codes for visits, as appropriate.

Any specifically identifiable procedure (i.e., identified with a specific procedure code) performed on or subsequent to the date of the initial consultation should be reported separately.

If subsequent to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used. In the hospital setting, the consulting physician should use the appropriate initial hospital care code for the initial encounter and subsequent hospital care codes (not follow-up consultation codes). In the office setting, the appropriate established patient code should be used.

There are two subcategories of consultations: office and initial inpatient consultation (other than office), See each subcategory for specific reporting instructions.

OFFICE OR OTHER OUTPATIENT CONSULTATION - NEW OR ESTABLISHED PATIENT

The following codes are used to report consultations provided in the **physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency department (see consultation definition, above).** When reporting procedure codes 99241-99245 with a place of service **office**, reimbursement will not exceed 120% of the Maximum State Medical Fee Schedule amount**.** Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant are reported using office visit codes for established patients (99211-99215).

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

Follow-up visits in the consultant's office that are initiated by the physician consultant are reported using office visit codes for established patients (99211-99215). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician or other appropriate source and documented in the medical record, the office consultation codes may be used again.

99241 Office or other outpatient consultation for a new or established patient, which requires these 3 key components:

- a problem focused history,
- a problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office or other outpatient consultation for a new or established patient, which requires these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99243 Office or other outpatient consultation for a new or established patient, which requires these 3 key components:

- a detailed history,
- a detailed examination, and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99244 Office or other outpatient consultation for a new or established patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99245 Office or other outpatient consultation for a new or established patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

INPATIENT CONSULTATIONS - NEW OR ESTABLISHED PATIENT

The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facility, or patients in a partial hospital setting.

99251 Inpatient consultation for a new or established patient, which requires these three key components:
- a problem focused history,
- a problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

99252 Inpatient consultation for a new or established patient, which requires these three key components:
- an expanded problem focused history,
- an expanded problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

99253 Inpatient consultation for a new or established patient, which requires these three key components:
- a detailed history,
- a detailed examination, and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

99254 Inpatient consultation for a new or established patient, which requires these three key components:
- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

99255 Inpatient consultation for a new or established patient, which requires these 3 key components:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

EMERGENCY DEPARTMENT SERVICES - NEW OR ESTABLISHED PATIENT

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

For critical care services provided in the Emergency Department, see critical care notes and 99291-99292.

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

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

99281 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:
- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor.

99282 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:
- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity.

99283 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:
- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate severity.

99284 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:
- a detailed history;
- a detailed examination; and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the practitioner but do not pose an immediate significant threat to life or physiologic function.

99285 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

CRITICAL CARE SERVICES

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

Inpatient critical care services provided to infants 29 days through 71 months of age are reported with pediatric critical care codes 99471-99476. The pediatric critical care codes are reported as long as the infant/young child qualifies for critical care services during the hospital stay through 71 months of age. Inpatient critical care services provided to neonates (28 days of age or less) are reported with the neonatal critical care codes 99468 and 99469. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay through the 28th postnatal day. The reporting of the pediatric and neonatal critical care services is not based on time or the type of unit (eg, pediatric or neonatal critical care unit) and it is not dependent upon the type of provider delivering the care. To report critical care services provided in the outpatient setting (eg, emergency department or office), for neonates and pediatric patients up through 71 months of age, see the critical care codes 99291, 99292. If the same physician provides critical care services for a neonatal or pediatric patient in both the outpatient and inpatient settings on the same day, report only the appropriate neonatal or pediatric critical care code 99468-99472 for all critical care services provided on that day.

Also report 99291-99292 for neonatal or pediatric critical care services provided by the physician providing critical care at one facility but transferring the patient to another facility. Critical care services provided by a second physician of a different specialty not reporting a per day neonatal or pediatric critical care code can be reported with codes 99291-99292. For additional instructions on reporting these services, see the neonatal and pediatric critical care section and codes 99468-99476.

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same physician.

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry, blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data); gastric intubation (43752); temporary transcutaneous pacing (92953), ventilatory management; and vascular access procedures (36000, 36600). Any services performed which are not listed above should be reported separately.

Codes 99291, 99292 should be reported for the physician's attendance during the transport of critically ill or critically injured patients over 24 months of age to or from a facility or hospital. For physician transport services of critically ill or critically injured pediatric patients 24 months of age or less see 99466, 99467.

The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care, whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or lacks capacity to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the management of the patient.

Time spent in activities that occur outside of the unit or off the floor (eg, telephone calls whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient.

Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (eg, participation in administrative meetings or telephone calls to discuss other patients). Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time.

Code 99291 is used to report the first 30-74 minutes of critical care on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code.

Code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes.

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

99292 each additional 30 minutes **(Report required)**
(List separately in addition to primary service)
(Use 99292 in conjunction with 99291)

NURSING FACILITY SERVICES

The following codes are used to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs)).

INITIAL NURSING FACILITY CARE - NEW OR ESTABLISHED PATIENT

More than one comprehensive assessment may be necessary during an inpatient confinement.

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a detailed or comprehensive history,
- a detailed or comprehensive examination, and
- medical decision making that is straightforward or of low complexity.

Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes with the patient and/or family or caregiver.

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

SUBSEQUENT NURSING FACILITY CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.

All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician.

99307 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least 2 of these 3 key components:

- a problem focused interval history,
- a problem focused examination,
- straightforward medical decision making.

Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes with the patient and/or family or caregiver.

99308 Subsequent nursing facility care, per day, for the evaluation and management ofa patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of low complexity.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a detailed interval history,
- a detailed examination,
- medical decision making of moderate complexity.

Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- a comprehensive interval history;
- a comprehensive examination;
- medical decision making of high complexity.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes with the patient and/or family or caregiver.

NURSING FACILITY DISCHARGE SERVICES

The nursing facility discharge day management codes are to be used to report the total duration of time spent by a practitioner for the final nursing facility discharge of patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the physician on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

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

DOMICILIARY, REST HOME (e.g., BOARDING HOME), OR CUSTODIAL CARE SERVICES

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component. Typical times have not yet been established for this category of services.

NEW PATIENT

99324 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.

99325 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.

99326 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:

- a detailed history,
- a detailed examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

99327 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

99328 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

ESTABLISHED PATIENT

99334 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a problem focused interval history,
- a problem focused examination, and/or
- medical decision making that is straightforward.

Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99335 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history,
- an expanded problem focused examination, and/or
- medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99336 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a detailed interval history,
- a detailed examination, and/or
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

99337 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a comprehensive interval history,
- a comprehensive examination, and/or
- medical decision making of moderate to high complexity.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

HOME SERVICES

The following codes are used to report evaluation and management services provided in a private residence.

NEW PATIENT

99341 Home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a problem focused history,
- a problem focused examination, and
- straightforward medical decision making.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99342 Home visit for the evaluation and management of a new patient, which requires these 3 key components:

- an expanded problem focused history,
- an expanded problem focused examination, and
- medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99343 Home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a detailed history,
- a detailed examination, and
- medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99344 Home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of moderate complexity.

Usually the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99345 Home visit for the evaluation and management of a new patient, which requires these 3 key components:

- a comprehensive history,
- a comprehensive examination, and
- medical decision making of high complexity.

Usually the patient is unstable or has developed a significant new problem requiring immediate Physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

ESTABLISHED PATIENT

99347 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a problem focused interval history,
- a problem focused examination, and/or
- straightforward medical decision making.

Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99348 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- an expanded problem focused interval history,
- an expanded problem focused examination, and/or
- medical decision making of low complexity.

Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99349 Home visit for the evaluation and management of an established patient, which requires at least 2of these 3 key components:

- a detailed interval history,
- a detailed examination, and/or
- medical decision making of moderate complexity.

Usually the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99350 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- a comprehensive interval history,
- a comprehensive examination, and/or
- medical decision making of moderate to high complexity.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

PROLONGED SERVICES

PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT

- Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting, even if the time spent by the physician on that date is not continuous. This service is reported, for the total duration, in addition to other physician service, including evaluation and management services at any level. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period. **(Report Required)**
- Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service. Either code also may be used to report a total duration of prolonged service of 30-60 minutes on a given date. Either code should be used only once per date, even if the time spent by the physician is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.
- Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

99354 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour **(Report required)**
(List separately in addition to office or other outpatient **Evaluation and Management** service)
(Use 99354 in conjunction with codes 99201-99215, 99241-99245, 99304-99350)

99355 each additional 30 minutes (**Report required)**
(List separately in addition to code for prolonged service)
(Use 99355 in conjunction with code 99354)

99356 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour **(Report required)**
(List separately in addition to code for inpatient evaluation and management service)
(Use 99356 in conjunction with 99218-99220, 99221-99233, 99251-99255, 99304-99310)

99357 each additional 30 minutes **(Report required)**
(List separately in addition to code for prolonged service)
(Use 99357 in conjunction with code 99356)

PREVENTIVE MEDICINE SERVICES (Well Visits)

The following codes are used to report well visit services provided to patients.

NEW PATIENT

99381 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; **infant (age younger than 1 year)**
99382 early childhood (age 1 through 4 years)
99383 late childhood (age 5 through 11 years)
99384 adolescent (age 12 through 17 years)
99385 18-39 years
99386 40-64 years
99387 65 years and older

ESTABLISHED PATIENT

99391 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient;
infant (age younger than 1 year)
99392 early childhood (age 1 through 4 years)
99393 late childhood (age 5 through 11 years)
99394 adolescent (age 12 through 17 years)
99395 18 - 39 years
99396 40 - 64 years
99397 65 years and older

COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

BEHAVIOR CHANGE INTERVENTIONS, INDIVIDUAL

99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407 intensive, greater than 10 minutes

NEWBORN CARE SERVICES

The following codes are used to report the services provided to newborns (birth through the first 28 days) in several different settings. use of the normal newborn codes is limited to the initial care of the newborn in the first days after birth prior to home discharge.

Evaluation and management (e/m) services for the newborn include maternal and/or fetal and newborn history, newborn physical examination(s), ordering of diagnostic tests and treatments, meetings with the family, and documentation in the medical record.

When delivery room resuscitation services (99465) are required, report this in addition to normal newborn services evaluation and management codes.

For E/M services provided to newborns who are other than normal, see codes for hospital inpatient services (99221-99233) and neonatal intensive and critical care services (99466-99469, 99477-99480). When normal newborn services are provided by the same physician on the same date that the newborn later becomes ill and receives additional intensive or critical care services, report the appropriate E/M code with modifier 25 for these services in addition to the normal newborn code.

Procedures (eg, 54150, newborn circumcision) are not included with the normal newborn codes, and when performed, should be reported in addition to the newborn services.

When newborns are seen in follow-up after the date of discharge in the office or outpatient setting, see 99201-99215, 99381, 99391 as appropriate.

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

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

99463 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same day
(For newborn hospital discharge services provided on a date subsequent to the admission date, see 99238, 99239)

DELIVERY/BIRTHING ROOM ATTENDANCE AND RESUSCITATION SERVICES

99465 Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
(99465 may be reported in conjunction with 99460, 99468, 99477)
(Procedures that are performed as a necessary part of the resuscitation [eg, intubation, vascular lines] are reported separately in addition to 99465. In order to report these procedures, they must be performed as a necessary component of the resuscitation and not as a convenience before admission to the neonatal intensive care unit)

INPATIENT NEONATAL INTENSIVE CARE SERVICES AND PEDIATRIC AND NEONATAL CRITICAL CARE SERVICES

PEDIATRIC CRITIACAL CARE PATIENT TRANSPORT

The following codes (99466, 99467) are used to report the physical attendance and direct **face-to-face** care by a physician during the interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or less. For the purpose of reporting codes 99466 and 99467, face-to-face care begins when the physician assumes primary responsibility of the pediatric patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the pediatric patient's care. Only the time the physician spends in direct **face-to-face** contact with the patient during the transport should be reported. Pediatric patient transport services involving less than 30 minutes of face-to-face physician care should not be reported using codes 99466, 99467. Procedure(s) or service(s) performed by other members of the transporting team may not be reported by the supervising physician.

For the definition of the critically ill or critically injured pediatric patient and the list of services included in critical care, see the **Neonatal and Pediatric Critical Care Services** section. Any services performed, which are not listed, may be reported separately.

The direction of emergency care to transporting staff by a physician located in a hospital or other facility by two-way communication is not considered direct face-to-face care and should not be reported with codes 99466, 99467. Physician-directed emergency care through outside voice communication to transporting staff personnel is not reimbursable as a separate procedure.

Emergency department services (99281-99285), initial hospital care (99221-99223), critical care (99291, 99292), initial date neonatal intensive (99477) or critical care (99468) are only reported after the patient has been admitted to the emergency department, the inpatient floor or the critical care unit of the receiving facility. If inpatient critical care services are reported in the referring facility prior to transfer to the receiving hospital, use the critical care codes (99291, 99292).

Code 99466 is used to report the first 30-74 minutes of direct face-to-face time with the transport pediatric patient and should be reported only once on a given date. Code 99467 is used to report each additional 30 minutes provided on a given date. Face-to-face services less than 30 minutes should not be reported with these codes.

99466 Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; first 30-74 minutes of hands on care during transport

99467 each additional 30 minutes
(List separately in addition to primary service)
(Use 99467 in conjunction with 99466)
(Critical care of less than 30 minutes total duration should be reported with the appropriate E/M code)

INPATIENT NEONATAL AND PEDIATRIC CRITICAL CARE

99468 Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less

99469 Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less

99471 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

99472 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age

99475 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

99476 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

INITIAL AND CONTINUING INTENSIVE CARE SERVICES

99477 Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services

99478 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams) (Neonatologist or Pediatric Critical Care Specialist only)

99479 Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams) (Neonatologist or Pediatric Critical Care Specialist only)

99480 Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)

LABORATORY SERVICES PERFORMED IN A PHYSICIAN'S OFFICE

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

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

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

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

81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001 automated, with microscopy
81002 non-automated, without microscopy
81003 automated, without microscopy
81015 Urinalysis; microscopic only
81025 Urine pregnancy test, by visual color comparison methods
83655 Lead
85007 Blood count; blood smear, microscopic examination with manual differential WBC count (includes RBC morphology and platelet estimation)
85013 spun microhematocrit
85018 hemoglobin (Hgb)
85025 complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85041 red blood cell (RBC) automated
85048 leukocyte (WBC), automated
85651 Sedimentation rate, erythrocyte; non-automated
85652 automated
86701 Antibody; HIV-1
87081 Culture, presumptive, pathogenic organisms, screening only (throat only)
87880 Infectious agent detection by immunoassay with direct optical observation; streptococcus, group A (throat only)

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

DRUGS AND DRUG ADMINISTRATION

IMMUNIZATIONS

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

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

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

IMMUNE GLOBULINS

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

90291 Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use **(BR)**
90371 Hepatitis B immune globulin (HBIg), human, for intramuscular use
90375 Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use
90376 Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use
90378 Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
90384 Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
90385 Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
90386 Rho(D) immune globulin (RhIgIV), human, for intravenous use
90389 Tetanus immune globulin (TIg), human, for intramuscular use
90393 Vaccinia immune globulin, human, for intramuscular use **(BR)**
90396 Varicella-zoster immune globulin, human, for intramuscular use
90399 Unlisted immune globulin **(BR)**

IMMUNIZATION ADMINISTRATION for VACCINES/TOXOIDS

90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid) **(Administration for 90660)**
G0008 Administration of influenza virus vaccine
G0009 Administration of pneumococcal vaccine

VACCINES, TOXOIDS

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 Section for further information.

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

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

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

90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586 Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632 Hepatitis A vaccine, adult dosage, for intramuscular use
90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636 Hepatitis A and hepatitis B vaccine (HEPA– HEPB), adult dose, for intramuscular use
90645 Hemophilus influenza B vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646 Hemophilus influenza B vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647 Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648 Hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90649 Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90650 Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
90654 Influenza virus vaccine, split virus, preservative-free, for intradermal use
90655 Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use

90656 Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657 Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
90658 Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660 Influenza virus vaccine, trivalent, live, for intranasal use
90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90669 Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90675 Rabies vaccine, for intramuscular use
90676 Rabies vaccine, for intradermal use
90680 Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90681 Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral 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
90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP – Hib - IPV), for intramuscular use
90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
90702 Diphtheria and tetanus toxoids (DT) absorbed when administered to individuals younger than 7 years, for intramuscular use
90703 Tetanus toxoid absorbed, 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
90710 Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
90712 Poliovirus vaccine, (any type[s]) (OPV), live, for oral use
90713 Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714 Tetanus and diphtheria toxoids (Td) absorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use
90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716 Varicella virus vaccine, live, for subcutaneous use
90717 Yellow fever vaccine, live, for subcutaneous use

90720 Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90725 Cholera vaccine for injectable use
90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90733 Meningococcal polysaccharide vaccine (any group[s]), for subcutaneous use
90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735 Japanese encephalitis virus vaccine, for subcutaneous use
90736 Zoster (shingles) vaccine, live, for subcutaneous injection
90738 Japanese encephalitis virus vaccine, inactivated, for intramuscular 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 Hepatitis B vaccine, adult dose (3 dose schedule), for intramuscular use
90747 dialysis or immunosuppressed patient, dosage (4 dose schedule), for intramuscular use
90748 Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use
90749 Unlisted vaccine/toxoid **(BR)**

DRUGS ADMINISTERED OTHER THAN ORAL METHOD

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

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

Reimbursement for drugs (including vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient.

For all drugs furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice.

New York State Medicaid does not intend to pay more than the acquisition cost of the drug dosage, as established by invoice, to the practitioner. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

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

THERAPEUTIC INJECTIONS (Maximum fee includes cost of materials)

J0129 Abatacept, 10 mg
(Administered under direct physician supervision, not for self-administration)

J0131 Acetaminophen, 10 mg
J0133 Acyclovir, 5 mg
J0135 Adalimumab, 20 mg
J0150 Adenosine, for therapeutic use, 6 mg
(Not to be used to report any adenosine phosphate compounds, instead use unlisted code)

J0171 Adrenalin, epinephrine, 0.1 mg
J0178 Aflibercept, 1 mg
J0180 Agalsidase beta, 1 mg
J0205 Alglucerase, per 10 units
J0207 Amifostine, 500 mg
J0210 Methyldopate HCl, up to 250 mg
J0215 Alefacept, 0.5 mg
J0220 Alglucosidase alfa, not otherwise specified, 10 mg
J0221 Alglucosidase alfa, (lumizyme),10 mg
J0256 Alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg
J0257 Alpha 1 proteinase inhibitor (human), (glassia), 10 mg
J0270 Alprostadil, per 1.25 mcg
(Administered under direct physician supervision, not for self-administration)

J0275 Alprostadil urethral suppository
(Administered under direct physician supervision, not for self-administration)

J0278 Amikacin sulfate, 100 mg
J0280 Aminophylline, up to 250 mg
J0285 Amphotericin B, 50 mg
J0287 Amphotericin B lipid complex, 10 mg
J0288 Amphotericin B cholesteryl sulfate complex, 10 mg
J0289 Amphotericin B liposome, 10 mg
J0290 Ampicillin sodium, 500 mg

J0295 Ampicillin sodium/sulbactam sodium, per 1.5 g
J0300 Amobarbital, up to 125 mg
J0348 Anidulafungin, 1 mg
J0360 Hydralazine HCl, up to 20 mg
J0364 Apomorphine hydrochloride, 1 mg
J0380 Metaraminol bitartrate, per 10 mg
J0390 Chloroquine HCl, up to 250 mg
J0400 Aripiprazole, intramuscular, 0.25 mg
J0456 Azithromycin, 500 mg
J0461 Atropine sulfate, 0.01 mg
J0470 Dimercaprol, per 100 mg
J0475 Baclofen, 10 mg
J0485 Belatacept, 1 mg (Nulojix)
J0490 Belimumab, 10 mg **(Report required)**
J0500 Dicyclomine HCl, up to 20 mg
J0515 Benztropine mesylate, per 1 mg
J0520 Bethanechol chloride, Mytonachol or Urecholine, up to 5 mg
J0558 Penicillin G benzathine and penicillin G procaine, 100,000 units
J0561 Penicillin G benzathine, 100,000 units
J0585 OnabotulinumtoxinA, 1 unit
J0586 AbobotulinumtoxinA, 5 units
J0587 RimabotulinumtoxinB, 100 units
J0588 Incobotulinumtoxin A, 1 unit **(Report required)**
J0594 Busulfan, 1 mg
J0598 C1 esterase inhibitor (human), cinryze, 10 units **(Report required)**
J0600 Edetate calcium disodium, up to 1000 mg
J0610 Calcium gluconate, per 10 ml
J0620 Calcium glycerophosphate and calcium lactate, per 10 ml
J0630 Calcitonin salmon, up to 400 units
J0636 Calcitriol, 0.1 mcg
J0637 Caspofungin acetate, 5 mg
J0638 Canakinumab, 1 mg **(Report required)**
J0640 Leucovorin calcium, per 50 mg
J0641 Levoleucovorin calcium, 0.5 mg
J0690 Cefezolin sodium, 500 mg
J0692 Cefepime hydrochloride, 500 mg
J0694 Cefoxitin sodium, 1 gm
J0696 Ceftriaxone sodium, per 250 mg
J0697 Sterile cefuroxime sodium, per 750 mg
J0698 Cefotaxime sodium, per g
J0702 Betamethasone acetate 3 mg and betamethasone sodium phosphate 3mg
J0710 Cephapirin sodium, up to 1 gm
J0712 Ceftaroline fosamil, 10 mg
J0713 Ceftazidime, per 500 mg
J0715 Ceftizoxime sodium, per 500 mg
J0718 Certolizumab pegol, 1 mg

J0720 Chloramphenicol sodium succinate, up to 1 gm
J0725 Chorionic gonadotropin, per 1,000 USP units
J0740 Cidofovir, 375 mg
J0743 Cilastatin sodium; imipenem, per 250 mg
J0744 Ciprofloxacin for intravenous infusion, 200 mg
J0745 Codeine phosphate, per 30 mg
J0760 Colchicine, per 1 mg
J0770 Colistimethate sodium, up to 150 mg
J0775 Collagenase, clostridium histolyticum, 0.01 mg
J0780 Prochlorperazine, up to 10 mg
J0795 Corticorelin ovine triflutate, 1 mcg
J0834 Cosyntropin (Cortrosyn), 0.25 mg
J0881 Darbepoetin alfa, 1 mcg (**Non-ESRD** use)
J0885 Epoetin alfa, (**Non-ESRD** use), 1000 units
J0894 Decitabine, 1 mg
J0895 Deferoxamine mesylate, 500 mg
J0897 Denosumab, 1mg
J0900 Testosterone enanthate and estradiol valerate, up to 1 cc
J0945 Brompheniramine maleate, per 10 mg
J1000 Depo-estradiol cypionate, up to 5 mg
J1020 Methylprednisolone acetate, 20 mg
J1030 Methylprednisolone acetate, 40 mg
J1040 Methylprednisolone acetate, 80 mg
J1050 Medroxyprogesterone acetate, 1 mg
J1060 Testosterone cypionate and estradiol cypionate (Depo-Testadiol), up to 1 ml
J1070 Testosterone cypionate, up to 100 mg
J1080 Testosterone cypionate, 1 cc, 200 mg
J1094 Dexamethasone acetate, 1 mg
J1100 Dexamethasone sodium phosphate, 1 mg
J1110 Dihydroergotamine mesylate, per 1 mg
J1120 Acetazolamide sodium, up to 500 mg
J1160 Digoxin, up to 0.5 mg
J1165 Phenytoin sodium, per 50 mg
J1170 Hydromorphone, up to 4 mg
J1180 Dyphylline, up to 500 mg
J1190 Dexrazoxane HCl, per 250 mg
J1200 Diphenhydramine HCL, up to 50 mg
J1205 Chlorothiazide sodium, per 500 mg
J1212 DMSO, dimethyl sulfoxide, 50%, 50 ml
J1230 Methadone HCl, up to 10 mg
J1240 Dimenhydrinate, up to 50 mg
J1260 Dolasetron mesylate, 10 mg
J1267 Doripenem, 10 mg
J1300 Eculizumab, 10 mg
J1320 Amitriptyline HCl, up to 20 mg

J1330 Ergonovine maleate, up to 0.2 mg
J1335 Ertapenem sodium, 500 mg
J1364 Erythromycin lactobionate, per 500 mg
J1380 Estradiol valerate, up to 10 mg
J1410 Estrogen conjugated, per 25 mg
J1435 Estrone, per 1 mg
J1436 Etidronate disodium, per 300 mg
J1438 Etanercept, 25 mg
(Administered under direct physician supervision, not self administered)
J1440 Filgrastim (G-CSF), 300 mcg
J1441 Filgrastim (G-CSF), 480 mcg
J1450 Fluconazole, 200 mg
J1452 Fomivirsen sodium, intraocular, 1.65 mg
J1453 Fosaprepitant Injection, 1 mg
J1455 Foscarnet sodium, per 1000 mg
J1458 Galsulfase, 1 mg **(Report required)**
J1459 Immune globulin (Privigen), intravenous, non lyophilized (e.g. liquid), 500 mg
J1460 Gamma globulin, intramuscular, 1 cc
J1557 Immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1560 Gamma globulin, intramuscular, over 10 cc
J1561 Immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562 Immune globulin (Vivaglobin), 100 mg
J1566 Immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg **(Report required)**
J1568 Immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1569 Immune globulin, (Gammagard Liquid), non-lyophilized, (e.g. liquid), 500 mg
J1570 Ganciclovir sodium, 500 mg
J1572 Immune globulin, (flebogamma/flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1573 Hepatitis B immune globulin (HepaGam B), intravenous, 0.5 ml
J1580 Garamycin, gentamicin, up to 80 mg
J1590 Gatifloxacin, 10 mg
J1595 Glatiramer acetate, 20 mg
J1599 Immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg **(Report required)**
J1600 Gold sodium thiomalate, up to 50 mg
J1610 Glucagon HCl, per 1 mg
J1620 Gonadorelin HCl, per 100 mcg
J1626 Granisetron HCl, 100 mcg
J1630 Haloperidol, up to 5 mg
J1631 Haloperidol decanoate, per 50 mg
J1642 Heparin sodium, (heparin lock flush), per 10 units
J1644 Heparin sodium, per 1000 units

J1645 Dalteparin sodium, per 2500 IU
J1652 Fondaparinux sodium, 0.5 mg
J1655 Tinzaparin sodium, 1000 IU
J1710 Hydrocortisone sodium phosphate, up to 50 mg
J1720 Hydrocortisone sodium succinate, up to 100 mg
J1725 Hydroxyprogesterone caproate, 1 mg
J1730 Diazoxide, up to 300 mg
J1740 Ibandronate sodium, 1 mg
J1741 Ibuprofen. 100 mg
J1743 Idursulfase, 1 mg **(Report required)**
J1745 Infliximab, 10 mg
J1750 Iron dextran, 50mg
J1756 Iron sucrose, 1 mg
J1786 Imiglucerase, 10 units
J1790 Droperidol, up to 5 mg
J1800 Propranolol HCl, up to 1 mg
J1815 Insulin, per 5 units
J1817 Insulin (i.e., insulin pump) per 50 units
(Administered under direct physician supervision, not for self-administration)
J1826 Interferon beta-1a, 30 mcg
J1830 Interferon beta-1b, 0.25 mg
(Administered under direct physician supervision, not for self-administration)
J1840 Kanamycin sulfate, up to 500 mg
J1850 Kanamycin sulfate, up to 75 mg
J1885 Ketorolac tromethamine, per 15 mg
J1890 Cephalothin sodium, up to 1 gm
J1930 Lanreotide, 1mg
J1931 Laronidase, 0.1 mg
J1940 Furosemide, up to 20 mg
J1950 Leuprolide acetate (for depot suspension), per 3.75 mg
J1955 Levocarnitine, per 1 gm
J1956 Levofloxacin, 250 mg
J1960 Levorphanol tartrate, up to 2 mg
J1980 Hyoscyamine sulfate, up to 0.25 mg
J1990 Chlordiazepoxide HCl, up to 100 mg
J2001 Lidocaine HCl for intravenous infusion, 10 mg
J2010 Lincomycin HCl, up to 300 mg
J2020 Linezolid, 200 mg
J2060 Lorazepam, 2 mg
J2150 Mannitol, 25% in 50 ml
J2175 Meperidine HCl, per 100 mg
J2180 Meperidine and promethazine HCL, up to 50 mg **(Report required)**
J2185 Meropenem, 100 mg
J2210 Methylergonovine maleate, up to 0.2 mg
J2248 Micafungin sodium, 1 mg

J2260 Milrinone lactate, per 5 mg
J2270 Morphine sulfate, up to 10 mg
J2275 Morphine sulfate (preservative-free sterile solution), per 10 mg
J2278 Ziconotide, 1 mcg
J2280 Moxifloxacin, 100 mg
J2320 Nandrolone decanoate, up to 50 mg
J2323 Natalizumab, 1 mg
J2353 Octreotide, depot form for intramuscular injection, 1 mg
J2355 Oprelvekin, 5 mg
J2357 Omalizumab, 5 mg
J2360 Orphenadrine citrate, up to 60 mg
J2370 Phenylephrine HCl, up to 1 ml
J2405 Ondansetron HCl, per 1 mg
J2410 Oxymorphone HCl, up to 1 mg
J2425 Palifermin, 50 mcg
J2430 Pamidronate disodium, per 30 mg
J2440 Papaverine HCl, up to 60 mg
J2460 Oxytetracycline HCl, up to 50 mg
J2469 Palonosetron HCl, 25 mcg
J2503 Pegaptanib sodium, 0.3 mg
J2504 Pegademase bovine, 25 IU
J2505 Pegfilgrastim, 6 mg
J2507 Pegloticase, 1mg
J2510 Penicillin G procaine, aqueous, up to 600,000 units
J2513 Pentastarch, 10% solution, 100 ml
J2515 Pentobarbital sodium, per 50 mg
J2540 Penicillin G potassium, up to 600,000 units
J2543 Piperacillin sodium/tazobactam sodium, 1 gram/0.125 grams (1.125 grams)
J2545 Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg
J2550 Promethazine HCl, up to 50 mg
J2560 Phenobarbital sodium, up to 120 mg
J2562 Plerixafor, 1 mg
J2590 Oxytocin, up to 10 units
J2597 Desmopressin acetate, per 1 mcg
J2650 Prednisolone acetate, up to 1 ml
J2670 Tolazoline HCl, up to 25 mg
J2675 Progesterone, per 50 mg
J2680 Fluphenazine decanoate, up to 25 mg
J2690 Procainamide HCl, up to 1 gm
J2700 Oxacillin sodium, up to 250 mg
J2710 Neostigmine methylsulfate, up to 0.5 mg
J2720 Protamine sulfate, per 10 mg
J2730 Pralidoxime chloride, up to 1 gm
J2760 Phentolamine mesylate, up to 5 mg
J2765 Metoclopramide HCl, up to 10 mg

J2778 Ranibizumab, 0.1 mg **(Report required)**
J2780 Ranitidine HCl, 25 mg
J2783 Rasburicase, 0.5 mg
J2793 Rilonacept, 1 mg
J2794 Risperidone, long acting, 0.5 mg
J2796 Romiplostim, 10 micrograms
J2800 Methocarbamol, up to 10 ml
J2820 Sargramostim (GM-CSF), 50 mcg
J2910 Aurothioglucose, up to 50 mg
J2916 Sodium ferric gluconate complex in sucrose injection, 12.5 mg
J2920 Methylprednisolone sodium succinate, up to 40 mg
J2930 Methylprednisolone sodium succinate, up to 125 mg
J2940 Somatrem, 1 mg
J2941 Somatropin, 1 mg
J2995 Streptokinase, per 250,000 IU
J2997 Alteplase recombinant, 1 mg
J3000 Streptomycin, up to 1 gm
J3030 Sumatriptan succinate, 6 mg
J3070 Pentazocine, 30 mg
J3105 Terbutaline sulfate, up to 1 mg
J3120 Testosterone enanthate, up to 100 mg
J3130 Testosterone enanthate, up to 200 mg
J3140 Testosterone suspension, up to 50 mg
J3150 Testosterone propionate, up to 100 mg
J3230 Chlorpromazine HCl, up to 50 mg
J3240 Thyrotropin alpha, 0.9 mg. provided in 1.1 mg vial
J3243 Tigecycline, 1 mg
J3250 Trimethobenzamide HCl, up to 200 mg
J3260 Tobramycin sulfate, up to 80 mg
J3262 Tocilizumab, 1 mg
J3265 Torsemide, 10 mg/ml
J3280 Thiethylperazine maleate, up to 10 mg
J3285 Treprostinil, 1 mg
J3300 Triamcinolone acetonide, preservative free, 1mg
J3301 Triamcinolone acetonide, not otherwise specified,10 mg
J3302 Triamcinolone diacetate, per 5 mg
J3303 Triamcinolone hexacetonide, per 5 mg
J3305 Trimetrexate glucuronate, per 25 mg
J3310 Perphenazine, up to 5 mg
J3315 Triptorelin pamoate, 3.75 mg
J3320 Spectinomycin dihydrochloride, up to 2 gm
J3357 Ustekinumab, 1 mg **(Report required)**
J3360 Diazepam, up to 5 mg
J3364 Urokinase, 5,000 IU vial
J3370 Vancomycin HCl, 500 mg
J3385 Velaglucerase alfa, 100 units

J3396 Verteporfin, 0.1 mg
J3400 Trifluprom azine HCl, up to 20 mg
J3410 Hydroxyzine HCl, up to 25 mg
J3411 Thiamine HCl, 100 mg
J3415 Pyridoxine HCl, 100 mg
J3420 Vitamin B-12 cyanocobalamin, up to 1000 mcg
J3430 Phytonadione, (vitamin K), per 1 mg
J3465 Voriconazole, 10 mg
J3470 Hyaluronidase, up to 150 units
J3475 Magnesium sulfate, per 500 mg
J3480 Potassium chloride, per 2 meq
J3487 Zoledronic acid (Zometa), 1 mg
J3488 Zoledronic acid (Reclast), 1 mg
J3490 Unclassified drugs **(BR)**
J3520 Edetate disodium, per 150 mg
J3590 Unclassified Biologicals **(BR)**

MISCELLANEOUS DRUGS AND SOLUTIONS

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

A4216^ Sterile water, saline and/or dextrose (diluent), 10 ml
A4218^ Sterile saline or water, metered dose dispenser, 10 ml
J7030 Infusion, normal saline solution (or water), 1000 cc
J7040 Infusion, normal saline solution (or water), sterile (500 ml = 1 unit)
J7042 5% dextrose/normal saline (500 ml = 1 unit)
J7050 Infusion, normal saline solution (or water), 250 cc
J7060 5% dextrose/water (500 ml = 1 unit)
J7070 Infusion, D5W, 1000 cc
J7100 Infusion, dextran 40, 500 ml
J7110 Infusion, dextran 75, 500 ml
J7120 Ringers lactate infusion, up to 1000 cc
J7131 Hypertonic saline solution, 1 ml
J7300 Intrauterine copper contraceptive
J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7303 Contraceptive supply, hormone containing vaginal ring, each
J7304 Contraceptive supply, hormone containing patch, each
J7306^ Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307 Etonogestrel (contraceptive) implant system, including implant and supplies
J7308 Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7311 Fluocinolone acetonide, intravitreal implant **(Report required)**
J7312 Dexamethasone, intravitreal implant, 0.1 mg
J7321^ Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose
J7323^ Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7324^ Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7325^ Hyaluronan or derivative, Synvisc or Synvisc-One, intra-articular

J7326 Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7335 Capsaicin 8% patch, per 10 square centimeters
J7501 Azathioprine, parenteral (eg Imuran), 100 mg
J7504 Lymphocyte immune globulin, antithymocyte globulin equine, parenteral, 250 mg
J7527 Everolimus, oral, 0.25 mg **(Report required)**
J7606 Formoterol Fumarate, inhalation solution, non-compounded, administered through DME, unit dose form, 20 mcg
J7611 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1mg
J7612 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME. Unit dose. 0.5 mg
J7620 Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded, administered through DME
J7627 Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg
J7628 Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per mg
J7631 Cromolyn sodium, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7640 Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 mcg
J7644 Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7648 Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7649 Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7658 Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7668 Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 10 mg
J7669 Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7674 Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg
J7682 Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, 300 mg
J8501 Aprepitant, oral, 5 mg
J8540 Dexamethasone, oral, 0.25 mg
J8650 Nabilone, oral, 1 mg
J9226 Histrelin implant (Supprelin LA), 50 mg **(Report required)**

L8603^ Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies **(Report required)**
Q4101^ Apligraf, per square centimeter **(Report required)**
Q4102^ Oasis wound matrix, per square centimeter **(Report required)**
Q4103^ Oasis burn matrix, per square centimeter **(Report required)**
Q4106^ Dermagraft, per square centimeter **(Report required)**
Q4108^ Integra matrix, per square centimeter **(Report required)**
Q4110^ Primatrix, per square centimeter **(Report required)**
Q4111^ GammaGraft, per square centimeter **(Report required)**
S0190 Mifepristone, oral, 200 mg
(When administered for medically necessary non-surgical abortion)
S0191 Misoprostol, oral, 200 mcg
(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) **(Report required)**

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

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported using modifier '25' in addition to 96360-96549. For same day E/M service a different diagnosis is not required.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

a. Use of local anesthesia
b. IV start
c. Access to indwelling IV, subcutaneous catheter or port
d. Flush at conclusion of infusion
e. Standard tubing, syringes, and supplies

When multiple drugs are administered, report the service(s) and the specific materials or drugs for each.

When administering multiple infusions, injections or combinations, only one "initial'' service code should be reported, unless protocol requires that two separate IV sites must be used. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (eg, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code). When these codes are reported by the physician, the "initial'' code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur. When reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered. Intravenous or intra-arterial push is defined as: (a) an injection in which the health care professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or (b) an infusion of 15 minutes or less.

HYDRATION

Codes 96360-96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal saline+30mEq KCL/liter), but are not used to report infusion of drugs or other substances.

Hydration IV infusions typically require direct physician supervision for purposes of consent, safety oversight, or intraservice supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff that administer these do not typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring. These codes are not intended to be reported by the physician in the facility setting.

96360 Intravenous infusion, hydration; initial, 31minutes to 1 hour
(Do not report 96360 if performed as a concurrent infusion service)
(Do not report intravenous infusion for hydration of 30 minutes or less)

96361 each additional hour
(List separately in addition to primary procedure)
(Use 96361 in conjunction with 96360)
(Report 96361 for hydration infusion intervals of greater than 30 minutes beyond 1 hour increments)
(Report 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service [96360, 96365, 96409, 96413] is administered through the same IV access)

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

A therapeutic, prophylactic or diagnosis IV infusion or injection (other than hydration) is for the administration of substances/drugs. When fluids are used to administer the drug(s), the administration of the fluid is considered incidental hydration and is not separately reportable. These services typically require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intra-service supervision of staff. Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and require periodic patient assessment with vital sign monitoring during the infusion. These codes are not intended to be reported by the physician in the facility setting.

(Do not report 96365-96371 with codes for which IV push or infusion is an inherent part of the procedure [eg, administration of contrast material for a diagnostic imaging study])

96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour

96366 each additional hour
(List separately in addition to primary procedure)
(Report 96366 in conjunction with 96365, 96367)
(Report 96366 for additional hour[s] of sequential infusion)
(Report 96366 for infusion intervals of greater than 30 minutes beyond 1 hour increments)

96367 additional sequential infusion of a new drug/substance, up to 1 hour
(List separately in addition to primary procedure)
(Report 96367 in conjunction with 96365, 96409, 96413 to identify the infusion of a new drug/substance provided as a secondary or subsequent service after a different initial service is administered through the same IV access)
(Report 96367 only once per sequential infusion of same infusate mix)

96368 concurrent infusion
(List separately in addition to primary procedure)
(Report 96368 only once per encounter)
(Report 96368 in conjunction with 96365, 96366, 96413, 96415, 96416)

96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)

96370 each additional hour
(List separately in addition to primary procedure)
(Use 96370 in conjunction with 96369)
(Use 96370 for infusion intervals of greater than 30 minutes beyond 1 hour increments)

96371 additional pump set-up with establishment of new subcutaneous infusion site(s)
(List separately in addition to primary procedure)
(Use 96371 in conjunction with 96369)
(Use 96369, 96371 only once per encounter)

96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (Bill on one claim line for multiple injections)

CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG OR HIGHLY COMPLEX BIOLOGIC AGENT ADMINISTRATION

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

Regional (isolation) chemotherapy perfusion should be reported using the codes for arterial infusion (96420-96425). Placement of the intra-arterial catheter should be reported using the appropriate code from the Cardiovascular Surgery section. Placement of arterial and venous cannula(s) for extracorporeal circulation via a membrane oxygenator perfusion pump should be reported using code 38623. Code 36823 includes dose calculation and administration of the chemotherapy agent by injection into the perfusate. Do not report code(s) 96409-96425 in conjunction with code 36823.

Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. The administration of medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics) administered independently or sequentially as supportive management of chemotherapy administration should be separately reported using 96360, 96361, 96365 as appropriate.

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

Intravenous or intra-arterial push is defined as: a) an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or b) an infusion of 15 minutes or less.

96405 Chemotherapy administration, intralesional; up to and including 7 lesions
96406 intralesional, more than 7 lesions
96409 intravenous; push technique, single or initial substance/drug
96413 Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
(Report 96361 to identify hydration if administered as a secondary or subsequent service in association with 96413 through the same IV access)
(Report 96366, 96367, to identify therapeutic, prophylactic, or diagnostic drug infusion or injection, if administered as a secondary or subsequent service in association with 96413 through the same IV access)

96415 each additional hour
(List separately in addition to primary procedure)
(Use 96415 in conjunction with 96413)
(Report 96415 for infusion intervals of greater than 30 minutes beyond 1-hour increments)

96416 initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump

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

96420 Chemotherapy administration, intra-arterial; push technique
96422 infusion technique, up to one hour

96423	infusion technique, each additional hour (List separately in addition to primary procedure) (Use 96423 in conjunction with code 96422) (Report 96423 for infusion intervals of greater than 30 minutes beyond 1-hour increments)
96425	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

OTHER INJECTION AND INFUSION SERVICES

96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96446	Chemotherapy administration into the peritoneal cavity via indwelling port or catheter
96450	Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
96521	Refilling and maintenance of portable pump
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery systemic (eg, intravenous, intra-arterial) (Access of pump port is included in filling of implantable pump) Codes 96521-96523 may be reported when these devices are used for therapeutic drugs other than chemotherapy.
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
96549	Unlisted chemotherapy procedure
J9999	Not otherwise classified, antineoplastic drugs

CHEMOTHERAPY DRUGS

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

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

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

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

J9000 Doxorubicin HCl, 10 mg
J9002 Doxorubicin HCl, liposomal, doxil, 10 mg
J9010 Alemtuzumab, 10 mg
J9015 Aldesleukin, per single use vial
J9017 Arsenic trioxide, 1 mg
J9019 Asparaginase (Erwinaze), 1,000 IU
J9020 Asparaginase, not otherwise specified, 10,000 units
J9025 Azacitidine, 1 mg
J9027 Clofarabine, 1 mg
J9031 BCG live (intravesical), per installation
J9033 Bendamustine injection HCL, 1mg
J9035 Bevacizumab, 10 mg
J9040 Bleomycin sulfate, 15 units
J9041 Bortezomib, 0.1 mg
J9042 Brentuximab vedotin, 1 mg
J9043 Cabazitaxel, 1 mg **(Report required)**
J9045 Carboplatin, 50 mg
J9050 Carmustine, 100 mg
J9055 Cetuximab, 10 mg
J9060 Cisplatin, powder or solution, 10 mg
J9065 Cladribine, per 1 mg
J9070 Cyclophosphamide, 100 mg
J9098 Cytarabine liposome, 10 mg
J9100 Cytarabine, 100 mg
J9120 Dactinomycin, 0.5 mg
J9130 Dacarbazine, 100 mg
J9150 Daunorubicin HCl, 10 mg
J9151 Daunorubicin citrate, liposomal formulation, 10 mg
J9155 Degarelix, 1 mg
J9160 Denileukin diftitox, 300 mcg
J9165 Diethylstilbestrol diphosphate, 250 mg
J9171 Docetaxel, 1 mg
J9175 Elliott's B solution, 1 ml
J9178 Epirubicin HCl, 2 mg
J9179 Eribulin mesylate, 0.1 mg **(Report required)**
J9181 Etoposide, 10 mg
J9185 Fludarabine phosphate, 50 mg
J9190 Fluorouracil, 500 mg
J9200 Floxuridine, 500 mg
J9201 Gemcitabine HCl, 200 mg
J9202 Goserelin acetate implant per 3.6 mg
J9206 Irinotecan, 20 mg
J9207 Ixabepilone, injection, 1mg
J9208 Ifosfamide, 1 g
J9209 Mesna, 200 mg
J9211 Idarubicin HCl, 5 mg

J9212 Interferon alfacon-1, recombinant, 1 mcg
J9213 Interferon, alfa-2a, recombinant, 3 million units
J9214 Interferon, alfa-2b, recombinant, 1 million units
J9215 Interferon, alfa-N3, (human leukocyte derived), 250,000 IU
J9216 Interferon, gamma 1-B, 3 million units
J9217 Leuprolide acetate (for depot suspension), 7.5 mg
J9218 Leuprolide acetate, per 1 mg
J9219^ Leuprolide acetate implant, 65 mg
J9225 Histrelin implant (Vantas), 50 mg **(Report required)**
J9228 Ipilimumab, 1 mg **(Report required)**
J9230 Mechlorethamine HCl (nitrogen mustard), 10 mg
J9245 Melphalan HCl, 50 mg
J9250 Methotrexate sodium, 5 mg
J9260 Methotrexate sodium, 50 mg
J9261 Nelarabine, 50 mg
J9263 Oxaliplatin, 0.5 mg
J9264 Paclitaxel protein-bound particles, 1 mg
J9265 Paclitaxel, 30 mg
J9266 Pegaspargase, per single dose vial
J9268 Pentostatin, per 10 mg
J9270 Plicamycin, 2.5 mg
J9280 Injection, Mitomycin, 5 mg
J9293 Mitoxantrone HCl, per 5 mg
J9300 Gemtuzumab ozogamicin, 5 mg
J9302 Ofatumumab, 10 mg
J9303 Panitumumab, 10 mg
J9305 Pemetrexed, 10 mg
J9307 Pralatrexate, 1 mg
J9310 Rituximab, 100 mg
J9315 Romidepsin, 1 mg
J9320 Streptozocin, 1 g
J9330 Temsirolimus, injection, 1 mg
J9340 Thiotepa, 15 mg
J9351 Topotecan, 0.1 mg
J9355 Trastuzumab, 10 mg
J9357 Valrubicin, intravesical, 200 mg
J9360 Vinblastine sulfate, 1 mg
J9370 Vincristine sulfate, 1 mg
J9390 Vinorelbine tartrate, 10 mg
J9395 Fulvestrant, 25 mg
J9600 Porfimer sodium, 75 mg
J9999 Not otherwise classified, antineoplastic drugs
Q0165 Prochlorperazine maleate, 10 mg, oral
Q0174 Thiethylperazine maleate, 10 mg, oral
Q0177 Hydroxyzine pamoate, 25 mg, oral
Q2017 Teniposide, 50 mg

MEDICINE

PSYCHIATRY

Codes 90785-90899 are for face-to-face services provided by a Psychiatrist.

Hospital care by the attending physician in treating a psychiatric inpatient or partial hospitalization may be initial or subsequent in nature (see 99221-99233) and may include exchanges with nursing and ancillary personnel. Hospital care services involve a variety of responsibilities unique to the medical management of inpatients, such as physician hospital orders, interpretation of laboratory or other medical diagnostic studies and observations. Some patients receive hospital evaluation and management services only and others receive evaluation and management services and other procedures. If other procedures such as electroconvulsive therapy are rendered, by the physician, in addition to hospital evaluation and management services, these should be listed separately (ie, hospital care service plus electroconvulsive therapy).

Other evaluation and management services, such as office medical services or other patient encounters, may be described as listed in the section on Evaluation and Management, if appropriate. The Evaluation and Management services should not be reported separately, when reporting codes 90833, 90836, 90838.

(When billing for procedure codes 90832 through 90837, 96101, 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 (eg, analysis of tests, reviewing records, etc.) is included in the maximum reimbursable amount for the face-to-face encounter.) More information on the definition of time, specifically the definition of face-to-face contact time can be found under General Information and Rules in the Medicine Section.

INTERACTIVE COMPLETITY

90785 Interactive complexity
(List separately in addition to primary procedure)
(Use 90785 in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837) psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99201- 99251, 99304 – 99337, 99341 – 99350), and group psychotherapy (90853))

(Do not report 90785 in conjunctions with 90839, 90840, or in conjunction with E/M services when no psychotherapy service is also reported)

90791 Psychiatric diagnostic examination

90792 Psychiatric diagnostic examination with medical services
(Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)

(Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444)

PSYCHOPHERAPY

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy; and Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy.

Interactive psychotherapy is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Some patients receive psychotherapy only and other receive psychotherapy and medical evaluation and management services. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (eg, evaluation of co-morbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.

In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy (interactive using non-verbal techniques versus insight oriented, behavior modifying and/or supportive using verbal techniques), the place of service (office versus inpatient), the face-to-face time spent with the patient during psychotherapy, and whether evaluation and management services are furnished on the same date of service as psychotherapy.

To report medical evaluation and management services furnished on a day when psychotherapy is not provided, select the appropriate code from the **Evaluation and Management Services Guidelines.**

OFFICE INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE PSYCHOTHERAPY

90832 Psychotherapy, 30 minutes with patient and/or family member

90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service
(List separately in addition to primary procedure)
(Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)

90834 Psychotherapy, 45 minutes with patient and/or family member

90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service
(List separately in addition to primary procedure)
(Use 90836 in conjunction with 99201-99255, 99304-99337, 99341-99350)

90837 Psychotherapy, 60 minutes with patient and/or family member

90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service
(List separately in addition to primary procedure)
(Use 90838 in conjunction with 99201-99255, 99304-99337, 99341-99350)

(Use the appropriate prolonged services code (99354-99357) for the psychotherapy services 68 minutes or longer)

(Use 90875 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

OTHER PSYCHOTHERAPY

90839 Psychotherapy for crisis; first 60 minutes

90840 Psychotherapy for crisis; each additional 30 minutes
(List separately in addition to primary service)
(Use 90840 in conjunction with 90839)

(Do not report 90839, 90840, in conjunction with 90791,90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90875-90899)

90846 Family psychotherapy (without the patient present)

90847 Family psychotherapy (conjoint psychotherapy) (with patient present) (1 1/2 hours, per person; maximum 8 persons per group)

90849 Multiple family group psychotherapy (1 1/2 hours, per person; maximum 8 persons per group)

90853 Group psychotherapy (other than of a multiple-family group) (1 1/2 hours, per person; maximum 8 persons per group)

OTHER PSYCHIATRIC SERVICES OR PROCEDURES

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

(Use 90863 in conjunction with 90832, 90834, 90837)

(For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report evaluation and management codes, use the appropriate evaluation and management codes 99201-99255, 99281-99285, 99304-99337, 99341-99359 and the appropriate psychotherapy with the evaluation and management service 90833, 90836, 90838)

90870 Electroconvulsive therapy (includes necessary monitoring)

90899 Unlisted psychiatric service or procedure

PSYCHIATRIC SOCIAL WORKER VISITS

For dates of service on or after July 1, 2002, report services provided by a Certified Social Worker (CSW) under the direct supervision of an employing psychiatrist, using the following procedure codes and maximum reimbursable amounts: 90832 ($13.50), 90834 ($27.00), 90846 ($7.20), 90847 ($7.20), 90849 ($7.20), 90853 ($7.20), 90837 ($7.20). See modifier – AJ. (For services provided prior to July 1, 2002, continue to use procedure codes W0092-W0095.)

DIALYSIS

(Professional dialysis fees for procedures 90935-90947 are intended for the attending physician's personal services related to the dialysis procedures performed)

See SURGERY Section for corresponding surgical procedures.

Codes 90967-90970 are reported when outpatient ESRD related services are not performed consecutively during an entire full month.

Evaluation and management services unrelated to ESRD services that cannot be performed during the dialysis session may be reported separately.

For ESRD related services and dialysis procedure(s) performed during a period of hospitalization: Separately report appropriate Hospital Evaluation and Management Services code(s) for the hospitalized period if service(s) is unrelated to ESRD services. Report 90945 or 90947 for each inpatient dialysis procedure.

HEMODIALYSIS

Codes 90935, 90937 are reported to describe the hemodialysis procedure with all evaluation and management services related to the patient's renal disease on the day of the hemodialysis procedure. These codes are used for inpatient ESRD and non-ESRD procedures or for outpatient non-ESRD dialysis services. Code 90935 is reported if only one evaluation of the patient is required related to the hemodialysis procedure. Code 90937 is reported when patient re-evaluation(s) is required during a hemodialysis procedure. Use the modifier -25 with Evaluation and Management codes for separately identifiable services unrelated to the dialysis procedure or renal failure which cannot be rendered during the dialysis session.

90935	Hemodialysis procedure with single evaluation by a physician or other qualified health care professional
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription

MISCELLANEOUS DIALYSIS PROCEDURE

Codes 90945, 90947 describe dialysis procedures other than hemodialysis (eg, peritoneal dialysis, hemofiltration or continuous renal replacement therapies), and all evaluation and management services related to the patient's renal disease on the day of the procedure. Code 90945 is reported if only one evaluation of the patient is required related to that procedure. Code 90947 is reported when patient re-evaluation(s) is required during a procedure.

Utilize modifier -25 with Evaluation and Management codes for separately identifiable services unrelated to the procedure or renal failure which cannot be rendered during the dialysis session.

90945	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional
90947	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluation by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription

END-STAGE RENAL DISEASE SERVICES

Codes 90951-90962 are reported ONCE per month to distinguish age-specific services related to the patient's end-stage renal disease (ESRD) performed in an outpatient setting with three levels of service based on the number of face-to-face visits. ESRD-related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management during the dialysis provided during a full month. These codes are not used if hospitalization occurred during the month. In the circumstances where the patient has had a complete assessment visit during the month and services are provided over a period of less than a month, 90951-90962 may be used according to the number of visits performed.

Codes 90963-90966 are reported once per month for a full month of service to distinguish age-specific services for end-stage renal disease (ESRD) services for home dialysis patients.

For ESRD and non-ESRD dialysis services performed in an inpatient setting, and for non-ESRD dialysis services performed in an outpatient setting, see 90935-90937 and 90945-90947.

Evaluation and management services unrelated to ESRD services that cannot be performed during the dialysis session may be reported separately.

Codes 90967-90970 are reported to distinguish age-specific services for end-stage renal disease (ESRD) services for less than a full month of service, per day, for services provided under the following circumstances: home dialysis patients less than a full month, transient patients, partial month where there was one or more face-to-face visits without the complete assessment, the patient was hospitalized before a complete assessment was furnished, dialysis was stopped due to recovery or death, or the patient received a kidney transplant. For reporting purposes, each month is considered 30 days.

Codes 90967-90970 are used to report ESRD related services on a per day basis, one claim line is used prorating the number of days within the month X the fee listed, the total number of days should be entered in the "Days or Units" field. The codes can be used preceding and/or following the period of hospitalization. The date of service should be the last date within the month that services were provided.

EXAMPLE: A four year old receiving continuous peritoneal dialysis has sixteen days of daily outpatient care, preceding or following a period of hospitalization. Report code on one line indicating 16 in the days/units field.

90951 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional

90952 with 2-3 face-to-face visits by a physician or other qualified health care professional per month

90953 with 1 face-to-face visit by a physician or other qualified health care professional per month

90954 End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month

90955 with 2-3 face-to-face visits by a physician or other qualified health care professional per month

90956 with 1 face-to-face visit by a physician or other qualified health care professional per month

90957 End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month

90958 with 2-3 face-to-face visits by a physician or other qualified health care professional per month

90959 with 1 face-to-face visit by a physician or other qualified health care professional per month

90960 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month

90961 with 2-3 face-to-face visits by a physician or other qualified health care professional per month

90962 with 1 face-to-face visit by a physician or other qualified health care professional per month

(Codes 90951-90962 are reported one time, once a month)

90963 End stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

90964 End stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

90965 End stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

90966 End stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older

(Codes 90963-90966 are reported one time, once a month)

90967 End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968 for patients 2-11 years of age
90969 for patients 12-19 years of age
90970 for patients 20 years of age and older
(Codes 90967-90970 are reported on one line, prorating the number of days within the month X the fee listed. The total number of days should be entered in the "Days or Units" field. The date of service will be the last date within the month that services were provided)

OTHER DIAYLSIS PROCEDURES

90999 Unlisted dialysis procedure, inpatient or outpatient

GASTROENTEROLOGY

91010 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;
91013 with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to primary procedure) (Use 91013 in conjunction with 91010) (Do not report 91013 more than once per session)

91020 Gastric motility (manometric) studies
91022 Duodenal motility (manometric) study
91030 Esophagus, acid perfusion (Bernstein) test for esophagitis
91034 Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91035 Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation
(91034, 91035 are for patients with esophageal reflux who have already undergone endoscopy and manometry/motility studies, or for those patients who are unable to undergo conventional tests or in whom conventional tests have proven inconclusive. These test are not covered for screening for Barrett's Esophagus)

91037 Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation
91038 prolonged (greater than 1 hour, up to 24 hours)
91040 Esophageal balloon distension provocation study **(Report required)**
91065 Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance; bacterial overgrowth, or oro-cecal gastrointestinal transit)
91110 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report **(Report required)**
(Visualization of the colon is not reported separately)

91111 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report
(Do not report 91111 in conjunction with 91110)

91112 Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report
(Do not report 91112 in conjunction with 91020, 91022, 91117)

91117 Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report
(Do not report 91117 in conjunction with 91120, 91122)

91120 Rectal sensation, tone, and compliance test (ie, response to graded balloon distention) **(Report required)**

91122 Anorectal manometry
(Do not report 91220, 91122 in conjunction with 91117)

91299 Unlisted diagnostic gastroenterology procedure

OPHTHALMOLOGY

OPHTHALMOLOGICAL DIAGNOSTIC AND TREATMENT SERVICES

REPORTING

See MEDICINE General Information and Rules and special ophthalmology notations below.

To report Evaluation and Management services, wherever performed, use descriptors from the Evaluation and Management Services for Specialists in Ophthalmology listing (99201 et seq).

To report hospital and emergency department medical services, use the descriptors from the Evaluation and Management Services for Specialists in Ophthalmology listing (99221 et seq) unless specific ophthalmological descriptors (92002 et seq) are more appropriate.

DEFINITIONS:

INTERMEDIATE OPHTHALMOLOGICAL SERVICES describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis for ophthalmoscopy. Intermediate services in a new patient do not usually include determination of the refractive state but do so in an established patient (92012) who is under continuing active treatment (eg, review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (eg, iritis) not requiring comprehensive ophthalmological services or review of interval history, external examination, ophthalmoscopy, biomicroscopy and tonometry in established patient with known cataract not requiring comprehensive ophthalmological services)

COMPREHENSIVE OPHTHALMOLOGICAL SERVICES describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and includes determination of the refractive state, unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and treatment programs.

Intermediate and comprehensive ophthalmological services constitute integrated services in which medical decision making cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry, or motor evaluation is not applicable.

(eg, the comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient)

“Initiation of diagnostic and treatment program” includes the prescription of medication, lenses and other therapy and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.

SPECIAL OPHTHALMOLOGICAL SERVICES describes services in which a special evaluation of part of the visual system is made, which goes beyond the services usually included under general ophthalmological services, or in which special treatment is given. Special ophthalmological services may be reported in addition to the general ophthalmological services or evaluation and management services. (eg, fluorescein angioscopy or quantitative visual field examination should be separately reported)

Prescription of lenses may be deferred to a subsequent visit, but in any circumstance is not reported separately. (“Prescription of lenses” does not include anatomical facial measurements for or writing of laboratory specifications for spectacles; for spectacle services, see 92340 et seq).

DETERMINATION OF THE REFRACTIVE STATE: is the quantitative procedure that yields the refractive data necessary to determine the best visual acuity with lenses and to prescribe lenses. It is not a separate medical procedure, or service entity, but is an integral part of the general ophthalmological services, carried out with reference to other diagnostic procedures. The evaluation of the need for and the prescription of lenses is never based on the refractive state alone. Determination of the refractive state is not reported separately.

Medical diagnostic evaluation by the physician is an integral part of all Ophthalmological services. Technical procedures (which may or may not be performed by the physician personally) are often part of the service, but should not be mistaken to constitute the service itself.

Intermediate and comprehensive ophthalmological services constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, determination of refractive state, tonometry, motor evaluation, etc. is not applicable.

PRESCRIBING OF POLYCARBONATE LENS(ES): The prescriber must maintain documentation in the recipient's clinical file of the recipient's systemic ailments and ocular pathology which relate to the medical need for one or more polycarbonate lens(es).

GENERAL OPHTHALMOLOGICAL SERVICES

The designation of new or established patient does not preclude the use of a specific level of service. For Evaluation and Management services see 99201et seq.

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s).

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

92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient (with/without refraction)
92004 comprehensive, new patient (with/without refraction)

ESTABLISHED PATIENT: An established patient is one who has received professional services from the physician within the past three years and whose medical and administrative records are available to the physician.

92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient (with/without refraction)
92014 comprehensive, established patient (with/without refraction)

SPECIAL OPHTHALMOLOGICAL SERVICES

92018 Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
92019 limited
92020 Gonioscopy (separate procedure)
92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report
(Do not report 92025 in conjunction with 65710-65755)
(92025 is not used for manual keratoscopy, which is part of a single system evaluation and management or ophthalmological service)
92060 Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)

92065 Orthoptic and/or pleoptic training, with continuing medical direction and evaluation (LT, RT modifiers valid)

92071 Fitting of contact lens for treatment of ocular surface
(Do not report 92071 in conjunction with 92072)

92072 Fitting of contact lens for management of keratoconus, initial fitting
(Do not report 92072 in conjunction with 92071)

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)

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)

92083 extended examination, (eg, Goldmann visual fields with a least 3 isopters plotted and static determination within the central 30 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)

(Gross visual field testing (eg, confrontation testing) is a part of general ophthalmological services and is not reported separately)

92100 Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)

92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral

92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

92134 retina

(Do not report 92133 and 92134 at the same patient encounter)
(For scanning computerized ophthalmic diagnostic imaging of the optic nerve and retina, see 92133, 92134)

92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation (one or both eyes) (LT, RT modifiers valid)

92140 Provocative tests for glaucoma, with interpretation and report, without tonography (one or both eyes) (LT, RT modifiers valid)

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 (LT, RT modifiers valid)

92226 subsequent (LT, RT modifiers valid)

92230 Fluorescein angioscopy with interpretation and report (LT, RT modifiers valid) **(Report required)**

92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report (LT, RT modifiers valid)
92240 Indocyanine-green angiography (includes multiframe imaging) with interpretation and report (LT, RT modifiers valid)
92250 Fundus photography with interpretation and report (one or both eyes) (LT, RT modifiers valid)
92260 Ophthalmodynamometry (one or both eyes) (LT, RT modifiers valid)

OTHER SPECIALIZED SERVICES

Color vision testing with pseudoisochromatic plates is not reported separately. It is included in the appropriate general or ophthalmologic service.

92265 Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report (LT, RT modifiers valid)
92270 Electro-oculography with interpretation and report
92275 Electroretinography with interpretation and report
92286 Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis
92287 with fluorescein angiography **(Report required)**

CONTACT LENS SERVICES

The prescription of contact lens includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is not a part of the general ophthalmological services. The fitting of contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.

Contact lenses may be supplied for the treatment of ocular pathology. A written recommendation or prescription by an ophthalmologist or optometrist is always required for contact lenses. The ophthalmologist or optometrist may also fit and dispense contact lenses.

The prescriber must maintain the following documentation in the recipient's clinical file:

- A description of the ocular pathology or medical necessity which provides justification for the recipient's need for contact lenses;
- The best corrected vision both with and without eyeglasses;
- The best corrected vision both with and without contact lenses;
- The refractive error; and
- The date of the last complete eye exam.

92310 Prescription of optical and physical characteristics of and fitting of contact lens, (includes materials) with medical supervision of adaptation (for ocular pathology) ; corneal lens, both eyes, except for aphakia
(Reimbursement for one eye is limited to $150.00)
(Reimbursement for both eyes requires BR)

92311 corneal lens for aphakia, one eye (LT or RT modifier valid)
92312 corneal lens for aphakia, both eyes
92313 corneoscleral lens (one or both eyes) (LT, RT modifiers valid)
92326 Replacement of contact lens (one or both eyes) (LT, RT modifiers valid)

OCULAR PROSTHETICS, ARTIFICIAL EYE SERVICES

V2623 Prosthetic eye, plastic, custom (Includes fitting and supply of ocular prosthesis and clinical supervision of adaptation)
V2624 Polishing/resurfacing of ocular prosthesis
V2625 Enlargement of ocular prosthesis
V2626 Reduction of ocular prosthesis
V2627 Scleral cover shell
(When prescribed as an artificial support to a shrunken and sightless eye or as barrier in treatment of severe dry eye)
(Includes supply of shell, fitting and clinical supervision of adaptation)

SPECTACLE SERVICES (INCLUDING PROSTHESIS FOR APHAKIA)

Prescription of spectacles, when required, is an integral part of general ophthalmological services and is not reported separately. It includes specification of lens type (monofocal, bifocal, other), lens power, axis prism, absorptive factor, impact resistance and other factors.

Fitting of spectacles is a separate service; when provided by the physician, it is reported as indicated by 92340-92358.

Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography. Presence of physician is not required.

Supply of materials is a separate service component; it is not part of the service of fitting spectacles.

92340 Fitting of spectacles, except for aphakia; monofocal
92341 bifocal
92342 multifocal, other than bifocal
92352 Fitting of spectacle prosthesis for aphakia; monofocal
92353 multifocal
92354 Fitting of spectacle mounted low vision aid; single element system
92355 telescopic or other compound lens system
92358 Prosthesis service for aphakia, temporary (disposable or loan, including materials) (one or both eyes)

SUPPLY OF MATERIALS

Supply of contact lenses and prosthetics is included in codes 92310-V2627.

99070 Supply of spectacles, except prosthesis for aphakia and low vision aids
Supply of low vision aids (A low vision aid is any lens or device used to aid or improve visual function in a person whose vision cannot be normalized by conventional spectacle correction, includes reading additions up to 4 D.)
Supply of permanent prosthesis for aphakia; spectacles. **(Report required)**

OTHER PROCEDURES

92499 Unlisted ophthalmological service or procedure

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, are reported as an integrated medical service, using appropriate descriptors from the 99201 series. Itemization of component procedures, (eg, otoscopy, rhinoscopy, tuning fork test) does not apply.

Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit. These services are reported separately, using codes 92502-92700.

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

92502	Otolaryngologic examination under general anesthesia
92506#	Evaluation of speech, language, voice, communication, and/ or auditory processing
92511	Nasopharyngoscopy with endoscope (separate procedure)

VESTIBULAR FUNCTION TESTS, WITH RECORDING (EG, ENG, PENG), AND MEDICAL DIAGNOSTIC EVALUATION

92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording (Do not report 92540 in conjunction with 92541, 92542, 92544, or 92545)
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Sinusoidal vertical axis rotational testing

AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION

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

92550	Tympanometry and reflex threshold measurements (Do not report 92550 in conjunction with 92567, 92568)
92551	Screening test, pure tone, air only
92552	Pure tone audiometry(threshold); air only
92553	air and bone

92555 Speech audiometry threshold
92556 with speech recognition
92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92563 Tone decay test
92564 Short increment sensitivity index (SISI)
92565 Stenger test, pure tone
92567 Tympanometry (impedance testing)
92568 Acoustic reflex testing; threshold
92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
(Do not report 92570 in conjunction with 92567, 92568)
92571 Filtered speech test
92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586 limited
92587 Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
92588 comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
92597# Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech

EVALUATIVE AND THERAPEUTIC SERVICES

Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator. Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

92601 Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602 subsequent reprogramming
(Do not report 92602 in addition to 92601)
92603 Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604 subsequent reprogramming
(Do not report 92604 in addition to 92603)
92607# Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608# each additional 30 minutes
(List separately in addition to primary procedure)
(Use 92608 in conjunction with 92607)

92609# Therapeutic services for the use of speech-generating device, including programming and modification
92610# Evaluation of oral and pharyngeal swallowing function
92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording
92612 Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording
92613 interpretation and report only
92614 Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording
92615 interpretation and report only
92616 Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording
(For codes 92612, 92614, 92616, if flexible fiberoptic or endoscopic evaluation of swallowing is performed without cine or video recording, use 92700)

92617 interpretation and report only

SPECIAL DIAGNOSIS PROCEDURES

92640# Diagnostic analysis with programming of auditory brainstem implant, per hour
92700 Unlisted otorhinolaryngological service or procedure

CARDIOVASCULAR

CORONARY THERAPEUTIC SERVICES AND PROCEDURES

92920 Percutaneous transluminal coronary angioplasty; single major coronary artery or branch
92921 each additional branch of a major coronary artery
(List separately in addition to primary procedure)
(Use 92921 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943)

92924 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch
92925 each additional branch of a major coronary artery
(List separately in addition to primary procedure)
(Use 92925 in conjunction with 92924, 92928,92933, 92937, 92941, 92943)

92928 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
92929 each additional branch of a major coronary artery
(List separately in addition to primary procedure)
(Use 92925 in conjunction with 92924, 92928, 92933, 92937, 92941, 92943)

92933 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch
92934 each additional branch of a major coronary artery
(List separately in addition to primary procedure)
(Use 92934 in conjunction with 92933, 92937, 93941, 92943)

92937 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel

92938 each additional branch subtended by the bypass graft (List separately in addition to primary procedure) (Use 92938 in conjunction with 92937)

92941 Percutaneous transluminal revascularization of acute total/ subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel

92943 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

92944 each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to primary procedure) (Use 92944 in conjunction with 92944, 92928, 92933, 92937, 92941, 92943)

OTHER THEAPEUTIC SERVICES AND PROCEDURES

92950 Cardiopulmonary resuscitation (eg, in cardiac arrest) (each 15 minute unit of time) (See also critical care services, 99291, 99292)

92953 Temporary transcutaneous pacing

92960 Cardioversion, elective, electrical conversion of arrhythmia; external (each 15 minute unit of time)

92961 internal (separate procedure) (Do not report 92961 in addition to codes 93282, 93283, 93289, 93292, 93295, 93662, 93618-93624, 93631, 93640-93642, 93650-93657)

92970 Cardioassist-method of circulatory assist; internal

92971 external

92973 Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to primary procedure) (Use 92973 in conjunction with codes 92928, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461) (Do not report 92973 for aspiration thrombectomy)

92974 Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to primary procedure) (Use 92974 in conjunction with codes 92928, 92920)

92975 Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography

92977 by intravenous infusion

92978 Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel
(List separately in addition to primary procedure)

92979 each additional vessel
(List separately in addition to primary procedure)
(Use 92979 in conjunction with code 92978)

(Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement))

92986 Percutaneous balloon valvuloplasty; aortic valve
92987 mitral valve
92990 pulmonary valve
92992 Atrial septectomy or septostomy; transvenous method, balloon, (eg, Rashkind type) (includes cardiac catheterization)
92993 blade method (Park septostomy) (includes cardiac catheterization)

92997 Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
92998 each additional vessel
(List separately in addition to primary procedure)
(Use 92998 in conjunction with 92997)

CARDIOGRAPHY

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93010 interpretation and report only
93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report
93016 supervision only without interpretation and report
93018 interpretation and report only
93024 Ergonovine provocation test **(Report required)**
93025 Microvolt T-wave alternans for assessment of ventricular arrhythmias
93040 Rhythm ECG, one to three leads; with interpretation and report
93224 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional
93227 review and interpretation by a physician or other qualified health care professional
93268 External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional
93272 review and interpretation by a physician or other qualified health care professional

93278 Signal-averaged electrocardiography (SAECG), with or without ECG
(For interpretation and report only, see modifier -26)

CARDIOVASCULAR DEVICE MONITORING-IMPLANTABLE AND WEARABLE DEVICES

93279 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system
(Do not report 93279 in conjunction with 93286, 93288)

93280 dual lead pacemaker system
(Do not report 93280 in conjunction with 93286, 93288)

93281 multiple lead pacemaker system
(Do not report 93281 in conjunction with 93286, 93288)

93282 single lead implantable cardioverter-defibrillator system
(Do not report 93282 in conjunction with 93287, 93289)

93283 dual lead implantable cardioverter-defibrillator system
(Do not report 93283 in conjunction with 93287, 93289)

93284 multiple lead implantable cardioverter-defibrillator system
(Do not report 93284 in conjunction with 93287, 93289)

93285 implantable loop recorder system
(Do not report 93285 in conjunction with 33282, 93279, 93284, 93291)

93286 Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system
(Report 93286 once before and once after surgery, procedure, or test, when device evaluation and programming is performed before and after surgery, procedure, or test)
(Do not report 93286 in conjunction with 93279-93281, 93288)

93287 single, dual, or multiple lead implantable cardioverter-defibrillator system
(Report 93287 once before and once after surgery, procedure, or test, when device evaluation and programming is performed before and after surgery, procedure, or test)
(Do not report 93287 in conjunction with 93282-93284, 93289)

93288 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system
(Do not report 93288 in conjunction with 93279-93281, 93286, 93294)

93289 single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements
(Do not report 93289 in conjunction with 93282-93284, 93287, 93295)

93290 implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors
(Do not report 93290 in conjunction with 93297, 93299)

93291 implantable loop recorder system, including heart rhythm derived data analysis
(Do not report 93291 in conjunction with 33282, 93288-93290, 93298)

93292 wearable defibrillator system
(Do not report 93923 in conjunction with 93294)

93293 Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days
(Do not report 93293 in conjunction with 93294)
(Report 93293 only once per 90 days)

93294 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
(Do not report 93294 in conjunction with 93288, 93293)
(Report 93294 only once per 90 days)

93295 single, dual, or multiple lead implantable cardioverter-defibrillator system with analysis, review(s) and report(s) by a physician or other qualified health care professional
(Do not report 93295 in conjunction with 93289)
(Report 93295 only once per 90 days)

93297 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified
(Do not report 93297 in conjunction with 93290, 93298)
(Report 93297 only once per 30 days)

93298 implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional
(Do not report 93298 in conjunction with 93291, 93297)
(Report 93298 only once per 30 days)

ECHOCARDIOGRAPHY

For procedure codes 93303-93350, See Radiology Section General Instructions and General Information and Rules. When more than one radiology procedure is performed during the same patient encounter, reimbursement shall be limited to the greater fee plus 60% of the lesser fees. (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 interpretation is performed separately, use modifier -26.)

93303 Transthoracic echocardiography for congenital cardiac anomalies; complete
93304 follow-up or limited study
93306 Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography
93307 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
93308 follow-up or limited study
93312 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93313 placement of transesophageal probe only
93314 image acquisition, interpretation and report only
93315 Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93316 placement of transesophageal probe only
93317 image acquisition, interpretation and report only
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
93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete
(List separately in addition to codes for echocardiographic imaging)

93321 follow-up or limited study
(List separately in addition to codes for echocardiographic imaging)
(Use 93320, 93321 separately in conjunction with 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, 93351)

93325 Doppler echocardiography color flow velocity mapping
(List separately in addition to codes for echocardiography)
(Use 93325 in conjunction with 76825-76828, 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, 93351)

93350 Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
(The appropriate stress testing code(s) from the 93015-93018 series should he reported in addition to 93350 to capture the exercise stress portion of the study)

93351 including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional
(Do not report 93351 in conjunction with 93015-93018, 93350)

CARDIAC CATHETERIZATION

Cardiac catheterization is a diagnostic medical procedure which includes introduction, positioning and repositioning, when necessary, of catheter(s), within the vascular system, recording of intracardiac and/or intravascular pressure(s), and final evaluation and report of procedure. There are two code families for cardiac catheterization: one for congenital heart disease and one for all other conditions. Anomalous coronary arteries, patent foramen vale, mitral valve prolapse, and bicuspid aortic valve are to be reported with 93451-93464, 93566-93568.

93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed
(Do not report 93451 in conjunction with 93453, 93456, 93457, 93460, 93461)

93452 Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
(Do not report 93452 in conjunction with 93453, 93458-93461)

93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation when performed
(Do not report 93453 in conjunction with 93451, 93452, 93456-93461)

93454 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;

93455 with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography

93456 with right heart catheterization

93457 with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization

93458 with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

93459 with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

93460 with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

93461 with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

93462 Left heart catheterization by transseptal puncture through intact septum or by transapical puncture
(List separately in addition to primary procedure)
(Use 93462 in conjunction with 93452, 93453, 93458-93461, 93653, 93657)

93463 Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent), including assessing hemodynamic measurements before, during, after, and repeat pharmacologic agent administration, when performed
(List separately in addition to primary procedure)
(Use 93463 in conjunction with 93451-93453, 93456-93461, 93530-93533)
(Report 93463 only once per catheterization procedure)
(Do not report 93463 for pharmacologic agent administration in conjunction with coronary interventional procedure codes 92975, 92977, 92928, 92920, 92924)

93464 Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after
(List separately in addition to primary procedure)
(Use 93464 in conjunction with 93451-93453, 93456-93461, 93530-93533)
(Report 93464 only once per catheterization procedure)

93503 Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes

93505 Endomyocardial biopsy

93530 Right heart catheterization, for congenital cardiac anomalies

93531 Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies

93532 Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies

93533 Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies

INJECTION PROCEDURES

All injection codes include radiological supervision, interpretation, and report. Cardiac catheterization codes (93452-93461), other than those for congenital heart disease, include contrast injection(s) for imaging typically performed during these procedures (see cardiac catheterization above). Do not report 93563-93565 in conjunction with 93452-93461.

When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital cardiac anomalies (93530-93533), see 93563-93568. Injection procedure codes 93563-93568 include imaging supervision, interpretation, and report.
Injection procedures 93563-93568 represent separate identifiable services and may be coded in conjunction with one another when appropriate. The technical details of angiography, supervision of filming and processing, interpretation, and report are included.

93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

93562 subsequent measurement of cardiac output

(Do not report 93561, 93562 in conjunction with 93451-93462)

93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization
(List separately in addition to primary procedure)

93564 for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed
(List separately in addition to primary procedure)

93465 for selective left ventricular or left atrial angiography
(List separately in addition to primary procedure)

(Do not report 93563-93565 in conjunction with 93452-93461)
(Use 93563-93565 in conjunction with 93530-93533)

93566 for selective right ventricular or right atrial angiography
(List separately in addition to primary procedure)

93567 for supravalvular aortography
(List separately in addition to primary procedure)

93568 for pulmonary angiography
(List separately in addition to primary procedure)

(Use 93566-93568 in conjunction with 93530-93533, 93451-93461)

93571 Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel
(List separately in addition to primary procedure)

93572 each additional vessel
(List separately in addition to primary procedure)

(Intravascular distal coronary blood flow velocity measurements include all Doppler transducer manipulations and repositioning within the specific vessel being examined, during coronary angioplasty or therapeutic intervention [eg, angioplasty])

REPAIR OF SEPTAL DEFECT

93580 Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant
(Percutaneous transcatheter closure of atrial septal defect includes a right heart catheterization procedure. Code 93580 includes injection of contrast for atrial and ventricular angiograms. Code 93533 should not be reported separately in addition to code 93580)

93581 Percutaneous transcatheter closure of a congenital ventricular septal defect with implant
(Percutaneous transcatheter closure of ventricular septal defect includes a right heart catheterization procedure. Code 93581 includes injection of contrast for atrial and ventricular angiograms. Code 93533 should not be reported separately in addition to code 93581)

INTRACARDIAC ELECTROPHYSIOLOGICAL PROCEDURES/STUDIES

Intracardiac electrophysiologic studies (EPS) are an invasive diagnostic medical procedure which include the insertion and repositioning of electrode catheters, recording of electrograms before and during pacing or programmed stimulation of multiple locations in the heart, analysis of recorded information, and report of the procedure.

Electrophysiologic studies are most often performed with two or more electrode catheters. In many circumstances, patients with arrhythmias are evaluated and treated at the same encounter. In this situation, a diagnostic *electrophysiologic study* is performed, induced tachycardia(s) are *mapped,* and on the basis of the diagnostic and mapping information, the tissue is *ablated*. Electrophysiologic study(s), mapping, and ablation represent distinctly different procedures, requiring individual reporting whether performed on the same or subsequent dates.

DEFINITIONS:

ARRHYTHMIA INDUCTION: In most electrophysiologic studies, an attempt is made to induce arrhythmia(s) from single or multiple sites within the heart. Arrhythmia induction is achieved by performing pacing at different rates, programmed stimulation (introduction of critically timed electrical impulses), and other techniques. Because arrhythmia induction occurs via the same catheter(s) inserted for the electrophysiologic study(s), catheter insertion and temporary pacemaker codes are not additionally reported. Codes 93600-93603, 93610-93612 and 93618 are used to describe unusual situations where there may be recording, pacing or an attempt at arrhythmia induction from only one site in the heart.
Code 93619 describes only evaluation of the sinus node, atrioventricular node and His-Purkinje conduction system, without arrhythmia induction. Codes 93620-93624 and 93640-93642 all include recording, pacing and attempted arrhythmia induction from one or more site(s) in the heart.

MAPPING: Mapping is a distinct procedure performed in addition to a diagnostic electrophysiologic procedure and should be separately reported using code 93609. When a tachycardia is induced, the site of tachycardia origination or its electrical path through the heart is often defined by mapping. Mapping creates a multidimensional depiction of a tachycardia by recording multiple electrograms obtained sequentially or simultaneously from multiple catheter sites in the heart. Depending upon the technique, certain types of mapping catheters may be repositioned from point-to-point within the heart, allowing sequential recording from the various sites to construct maps. Other types of mapping catheters allow mapping without a point-to-point technique by the allowing simultaneous recording from many electrodes on the same catheter and computer-assisted three dimensional reconstruction of the tachycardia activation sequence.

ABLATION: Once the part of the heart involved in the tachycardia is localized, the tachycardia may be treated by ablation (the delivery of a radiofrequency energy to the area to selectively destroy cardiac tissue). Ablation procedures (93653-93657) may be performed: independently on a date subsequent to a diagnostic electrophysiologic study and mapping; or, at the time a diagnostic electrophysiologic study, tachycardia(s) induction and mapping is performed. When an electrophysiologic study, mapping, and ablation are performed on the same date, each procedure should be separately reported. In reporting catheter ablation, code 93653 and/or 93657 should be reported once to describe ablation of cardiac arrhythmias, regardless of the number of arrhythmias ablated.

93600 Bundle of His recording
93602 Intra-atrial recording
93603 Right ventricular recording
93609 Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia
(List separately in addition to primary procedure)
(Use 93609 in conjunction with codes 93620, 93653, 93657)
(Do not report 93609 in addition to 93613)

93610 Intra-atrial pacing
93612 Intraventricular pacing
(Do not report 93612 in conjunction with codes 93620-93622)

93613 Intracardiac electrophysiologic 3-dimensional mapping
(List separately in addition to primary procedure)
(Use 93613 in conjunction with codes 93620, 93653, 93657)
(Do not report 93613 in addition to 93609)

93615 Esophageal recording of atrial electrogram with or without ventricular electrogram(s);
93616 with pacing
93618 Induction of arrhythmia by electrical pacing

93619 Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, HIS bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia
(Do not report 93619 in conjunction with 93600, 93602, 93610, 93612, 93618, or 93620-93622)

93620 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, HIS bundle recording
(Do not report 93620 in conjunction with 93600, 93602, 93610 93612, 93618 or 93619)

93621 with left atrial pacing and recordings from coronary sinus or left atrium
(List separately in addition to primary procedure)
(Use 93621 in conjunction with code 93620)

93622 with left ventricular pacing and recordings
(List separately in addition to primary procedure)
(Use 93622 in conjunction with codes 93620)

93623 Programmed stimulation and pacing after intravenous drug infusion
(List separately in addition to primary procedure)
(Use this code with 93620, 93621, 93622)

93624 Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia

93631 Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction

93640 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;

93641 with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator

93642 Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)

93650 Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement

93653 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter
(Do not report 93653 in conjunction with 93600-93603, 93610, 93612, 93618-93620, 93642, 93654)

93654 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter
(Do not report 93654 in conjunction with 93279-93284, 93286-93289, 93600-93603, 93609, 93610, 93612, 93613, 93618-93620, 93622, 93642, 93653)

93655 Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia
(List separately in addition to primary procedure)
(Use 93655 in conjunction with 93653, 93654, 93656)

93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, his bundle
(Do not report 93656 in conjunction with 92379-93284, 93286-93289, 93462, 93600, 93602, 93603, 93610, 93612, 93618, 93619, 93620, 93621, 93653, 93654)

93657 Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation
(List separately in addition to primary procedure)
(Use 93657 in conjunction with 93656)

93660 Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention

93662 Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation
(List separately in addition to primary procedure)
(Use 93662 in conjunction with 93621, 93622, 93653, or 93657, as appropriate)
(Do not report 92961 in addition to code 93662)

NONINVASIVE PHYSIOLOGIC STUDIES AND PROCEDURES

93701 Bioimpedance, thoracic; electrical

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)

93745 Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ecg, transmission of data to data repository, patient instruction in wearing system and patient
(Do not report 93745 in conjunction with 93282, 93292)

93750 Interrogation of ventricular assist device (vad), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and
(Do not report 93750 in conjunction with 33975, 33976, 33797, 33981-33983)

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

93790 review with interpretation and report

OTHER PROCEDURES

93797 Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ecg monitoring (per session)

93798 with continuous ECG monitoring (per session)

93799 Unlisted cardiovascular service or procedure

NONINVASIVE VASCULAR DIAGNOSTIC STUDIES

For procedure codes 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 (eg, 93880, 93882): Describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries or veins with the production of real time images integrating B-mode two-dimensional vascular structure with spectral and/or color flow Doppler mapping or imaging.

Non-invasive physiologic studies are performed using equipment separate and distinct from the duplex scanner. Codes 93922, 93923 and 93924, 93965 describe the evaluation of non-imaging physiologic recordings of pressures, Doppler analysis of bi-directional blood flow, plethysmography, and/or oxygen tension measurements appropriate for the anatomic area studied.

CEREBROVASCULAR ARTERIAL STUDIES

93880 Duplex scan of extracranial arteries; complete bilateral study

93882 unilateral or limited study

93886 Transcranial Doppler study of the intracranial arteries; complete study

93888 limited study

93890 Transcranial Doppler study of the intracranial arteries; vasoreactivity study

93892 emboli detection without intravenous microbubble injection

93893 emboli detection with intravenous microbubble injection

EXTREMITY ARTERIAL STUDIES (INCLUDING DIGITS)

93922 Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/ brachial indices at distal posterior tibial and anterior tibial/ dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/ brachial indices at distal posterior tibial and anterior tibial/ dorsalis pedis arteries with transcutaneous oxygen tension measurements at 1-2 levels)

93923 Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

93924 Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study
(Do not report 93924 in conjunction with 93922, 93923)

93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study

93926 unilateral or limited study

93930 Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study

93931 unilateral or limited study

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)

93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

93971 unilateral or limited study

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
93976 limited study
93978 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979 unilateral or limited study
93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981 unilateral or limited study
93982 Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report

EXTREMITY ARTERIAL-VENOUS STUDIES

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

OTHER NONINVASIVE VASCULAR DIAGNOSTIC STUDIES

93998 Unlisted noninvasive vascular diagnostic study **(BR)**

PULMONARY

Codes 94010-94799 include laboratory procedure(s), interpretation and physician's services (except surgical and anesthesia services as listed in their sections), unless otherwise stated.

If a separate identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported in addition to 94010-94799.

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
94012 Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age
94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV] in an infant or child through 2 years of age
94014 Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional
94016 review and interpretation only by a physician or other qualified health care professional
94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

94070 Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg antigen(s), cold air, methacholine)
94200 Maximum breathing capacity, maximal voluntary ventilation
94250 Expired gas collection, quantitative, single procedure (separate procedure)
94375 Respiratory flow volume loop
94610 Intrapulmonary surfactant administration by a physician or other qualified health care professional through endotracheal tube
94620 Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)
94621 complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)
94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)
94642 Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment for prophylaxis
94644 Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour
(For services of less than 1 hour, use 94640)
94645 each additional hour
(List separately in addition to primary procedure)
(Use 94645 in conjunction with 94644)

94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
(94664 can be reported one time only per day of service)

94680 Oxygen uptake, expired gas analysis; rest and exercise, direct, simple
94681 including C02 output, percentage oxygen extracted
94690 rest, indirect (separate procedure)
94726 Plethysmography for determination of lung volumes and, when performed, airway resistance
(Do not report 94726 in conjunction with 94727, 94728)

94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes
(Do not report 94727 in conjunction with 94726)

94728 Airway resistance by impulse oscillometry
(Do not report 94728 in conjunction with 94010, 94060, 94070, 94375, 94726)

94729 Diffusing capacity (eg, carbon monoxide, membrane)
(List separately in addition to primary procedure)
(Report 94729 in conjunction with 94010, 94060, 94070, 94375, 94726-94728)

94750 Pulmonary compliance study (plethysmography, volume and pressure measurements)

94770 Carbon dioxide, expired gas determination by infrared analyzer **(Report required)**
94772 Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant (includes interpretation and report)
(Separate procedure codes for electromyograms, EEG, ECG, and recordings of respiration are excluded when 94772 is reported)
94777 Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; review, interpretation and preparation of report only by a physician or other qualified health care professional
94799 Unlisted pulmonary service or procedure

ALLERGY AND CLINICAL IMMUNOLOGY

DEFINITIONS:

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 or the same number of sensitivity tests. Maximum fees include observation and interpretation of the tests by a physician. In routine office practice, any of the following items may be billed in addition to the appropriate visit codes.

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

For professional services for allergen immunotherapy not including provision of allergenic extracts, see appropriate Evaluation and Management code.

ALLERGY TESTING

95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
(**Note**: Must bill with paper claim when billing for more than 60 tests. Report total number of tests in Field 24E on the claims form. Calculate total amount due as follows: full fee listed in Fee Schedule for each test up to 60 tests and 50% of the fee listed for each test over 60 tests).
95017 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and Intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests
95018 Allergy testing, any combination of percutaneous (scratch, puncture, prick) and Intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests
95024 Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests

95028 Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95044 Patch or application test(s) (up to 10 tests) (Specify number of tests)
95060 Ophthalmic mucous membrane tests
95065 Direct nasal mucous membrane test

SENSITIVITY TESTING

(Maximum fees include reading of test)

86485 Skin test, candida
86486 unlisted antigen, each
86490 coccidioidomycosis
86510 histoplasmosis
86580 tuberculosis, intradermal

ALLERGEN IMMUNOTHERAPY

Codes 95120-95180 include the professional services necessary for allergen immunotherapy. Office Evaluation and Management codes may be used in addition to allergen immunotherapy if, and only if, other identifiable services are provided at that time.

95120 Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single injection
95125 two or more injections (specify number of injections)
95130 single stinging insect venom
95131 two stinging insect venoms
95132 three stinging insect venoms
95133 four stinging insect venoms
95134 five stinging insect venoms
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 **DOSES)**

95180 Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)

NEUROLOGY AND NEUROMUSCULAR PROCEDURES

Neurologic services are typically consultative, and any of the levels of consultation (99241-99255) may be appropriate. In addition, services and skills outlined under Evaluation and Management levels of service appropriate to neurologic illnesses should be coded similarly.

All services listed below (95805-95829) include recording, interpretation by a physician and report. For interpretation only, use modifier -26.

SLEEP TESTING

Orders for sleep testing are limited to physician specialists in pulmonology, otolaryngology and neurology. Documentation to support the medical necessity of sleep testing must be maintained in the ordering physician's clinical file. Sleep studies and polysomnography refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation and report.

The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP). Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which is defined to include a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG).

Additional parameters of sleep include: 1) ECG; 2) airflow; 3) ventilation and respiratory effort; 4) gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; 5) extremity muscle activity, motor activity-movement; 6) extended EEG monitoring; 7) penile tumescence; 8) gastroesophageal reflux; 9) continuous blood pressure monitoring; 10) snoring; 11) body positions; etc.

For a study to be reported as polysomnography, sleep must be recorded and staged.

95805 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95807 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate and oxygen saturation, attended by a technologist
95808 Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810 age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811 age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

ROUTINE ELECTROENCEPHALOGRAPHY (EEG)

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

95812 Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813 greater than one hour
95816 Electroencephalogram (EEG); including recording awake and drowsy
95819 including recording awake and asleep
95822 recording in coma or sleep only
95824 cerebral death evaluation only
95829 Electrocorticogram at surgery (separate procedure)

95830 Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording

MUSCLE AND RANGE OF MOTION TESTING

95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95832 hand with or without comparison with normal side
95833 total evaluation of body, excluding hands
95834 total evaluation of body, including hands
95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine) **(Report required)**
95852 hand, with or without comparison with normal side **(Report required)**
95857 Cholinesterase inhibitor challenge test for myasthenia gravis

ELECTROMYOGRAPHY AND NERVE CONDUCTION TESTS

Needle electromyographic procedures include the interpretation of electrical waveforms measured by equipment that produces both visible and audible components of electrical signals recorded from the muscle(s) studied by the needle electrode.

95860 Needle electromyography; one extremity with or without related paraspinal areas
95861 two extremities with or without related paraspinal areas
95863 three extremities with or without related paraspinal areas
95864 four extremities with or without related paraspinal areas
95865 larynx
(Do not report modifier 50 in conjunction with 95865)
95866 hemidiaphragm
95867 cranial nerve supplied muscle(s), unilateral
95868 cranial nerve supplied muscle(s), bilateral
95869 thoracic paraspinal muscles (excluding T1 or T12)
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
95872 Needle electromyography, using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied
95875 Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)
95885 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to primary procedure)
95886 complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels
(List separately in addition to primary procedure)
95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study
(List separately in addition to primary procedure)

95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report
(Report 95905 only once per limb studied)
(Do no report 95905 in conjunction with 95907-95913)

95907 Nerve conduction studies; 1-2 studies
95908 3-4 studies
95909 5-6 studies
95910 7-8 studies
95911 9-10 studies
95912 11-12 studies
95913 13 or more studies

INTRAOPERATIVE NEUROPHYSIOLOGY

AUTONOMIC FUNCTION TESTS

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
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
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
95924 combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt
(Do not report 95924 in conjunction with 95921 or 95922)
95943 Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head up postural change.
(Do not report 95943 in conjunction with 93040, 95921, 95922, 95924)

EVOKED POTENTIALS AND REFLEX TESTS

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
95926 in lower limbs
95927 in the trunk or head
95928 Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929 lower limbs
95930 Visual evoked potential (VEP) testing central nervous system, checkerboard or flash
95933 Orbicularis oculi (blink) reflex, by electrodiagnostic testing

95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes
(List separately in addition to primary procedure)
(Use 95940 in conjunction with the study preformed)

95937 Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

95938 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs

95939 Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs

SPECIAL EEG TESTS

95950 Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours

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

95954 Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)

95955 Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)

95958 Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring

95961 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional

95962 each additional hour of attendance by a physician or other qualified health care care professional
(List separately in addition to primary procedure)
(Use 95962 in conjunction with code 95961)

NEUROSTIMULATORS, ANALYSIS-PROGRAMMING

A simple neurostimulator pulse generator/transmitter (95970, 95971) is one capable of affecting three or fewer of the following: pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time (stimulation parameters changing in time periods of minutes including dose lockout times), more than one clinical feature (eg, rigidity, dyskinesia, tremor). A complex neurostimulator pulse generator/transmitter (95970, 95972-95975) is one capable of affecting more than three of the above.

Code 95970 describes subsequent electronic analysis of a previously-implanted simple or complex brain, spinal cord, or peripheral neurostimulator pulse generator system, without reprogramming. Code 95971 describes intraoperative or subsequent electronic analysis of an implanted simple brain, spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator system, with programming.

Codes 95972 and 95973 describe intraoperative (at initial insertion/revision) or subsequent electronic analysis of an implanted complex brain, spinal cord or peripheral (except cranial nerve) neurostimulator pulse generator system, with programming. Codes 95974 and 95975 describe intraoperative (at initial insertion/revision) or subsequent electronic analysis of an implanted complex cranial nerve neurostimulator pulse generator system, with programming.

Code 95980 describes intraoperative electronic analysis of an implanted gastric neurostimulator pulse generator system, with programming; code 95981 describes subsequent analysis of the device; code 95982 describes subsequent analysis and reprogramming. For electronic analysis and reprogramming of gastric neurostimulator, lesser curvature, see 95980-95982.

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95972 complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

95973 complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour
(List separately in addition to primary procedure)
(Use 95973 in conjunction with code 95972)

95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour
(List separately in addition to primary procedure)
(Use 95975 in conjunction with code 95974)

95980 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming
95981 subsequent, without reprogramming
95982 subsequent, with reprogramming

OTHER PROCEDURES

95991 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional
95999 Unlisted neurological or neuromuscular diagnostic procedure

MOTION ANALYSIS

Codes describe services performed as part of a major therapeutic or diagnosis decision making process. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics and dynamic electromyography).

96002 Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
96003 Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle
(Do not report 96002, 96003 in conjunction with 95860-95864, 95869-95872)

FUNCTIONAL BRAIN MAPPING

96020 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional **(Report required)**
(Do not report 96020 in conjunction with 96101, 96116-96118)
(Evaluation and Management services codes should not be reported on the same day as 96020)

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

The following codes are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. (When billing for procedure codes 96101 through 96118, 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 (eg, analysis of tests, reviewing records, etc.) is included in the maximum reimbursable amount for the face-to-face encounter.) More information on **time** can be found under General Information and Rules, Rule #3.

96101 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

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

96111 Developmental testing; (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

96118 Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

PHOTODYNAMIC THERAPY

96567 Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session

96570 Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s), first 30 minutes
(List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)

96571 each additional 15 minutes
(List separately in addition to code for endoscopy or bronchoscopy procedures of lung and esophagus)
(96570, 96571 are to be used in addition to bronchoscopy, endoscopy codes)
(Use 96570, 96571 in conjunction with codes 31641, 43228 as appropriate)

SPECIAL DERMATOLOGICAL PROCEDURES

Dermatologic services are typically consultative, and any of the levels of consultation (99241-99255) may be appropriate. In addition, services and skills outlined under Evaluation and Management levels of service appropriate to dermatologic illnesses should be coded similarly.

96910 Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B (For diagnosis of Cutaneous T-Cell Lymphoma)
96920 Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm
96921 250 sq cm to 500 sq cm
96922 over 500 sq cm
96999 Unlisted special dermatological service or procedure

OSTEOPATHIC MANIPULATIVE TREATMENT

Osteopathic manipulative treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

Body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

98925 Osteopathic manipulative treatment (OMT); one to two body regions involved
98926 three to four body regions involved
98927 five to six body regions involved
98928 seven to eight body regions involved
98929 nine to ten body regions involved

SPECIAL SERVICES

MISCELLANEOUS SERVICES

96040 Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
97542# Wheelchair management (eg, assessment, fitting, training), each 15 minutes (up to a maximum of 2 hours)
98960 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961 2-4 patients
98962 5-8 patients
99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99070 Supplies and materials, provided by the physician over and above those usually included with the office visit or other services rendered
(List drugs, trays, supplies, or materials provided)

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
G0109 group session (2 or more), per 30 minutes

G0372 Physician service required to establish and document the need for a power mobility device
(Use in addition to primary Evaluation and Management code)

H0049 Alcohol and/or drug screening
H0050 Alcohol and/or drug services, brief intervention, per 15 minutes
S2083 Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline (included in an E/M visit after the 90 day post operative period, if no E/M visit billed code can be billed separately)
T1013 Sign language or oral interpretive services, per 15 minutes

OTHER SPECIAL SERVICES

99116 Anesthesia complicated by utilization of total body hypothermia
(List separately in addition to primary procedure)

For D.O.S. prior to 7/1/01, see modifier -AF for anesthesia complicated by total body hypothermia and/or pump oxygenator. See Anesthesia Section General Information and Rules.

MODERATE (C0NSCIOUS) SEDATION

Moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

When providing moderate sedation the following services are included and NOT reported separately:

- Assessment of the patient (not included in intraservice time);
- Establishment of IV access and fluids to maintain patency when performed;
- Administration of agent(s);
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure; and
- Recovery (not included in intraservice time)

Intraservice time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance and ends at the conclusion of personal contact by the physician providing the sedation.

Do not report 99143-99145 in conjunction with codes that include moderate (conscious) sedation.

Do not report 99148-99150 in conjunction with codes that include moderate (conscious) sedation when performed in a nonfacility setting.

When a second physician other than the healthcare professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting (eg, hospital, outpatient/ambulatory surgery center, skilled nursing facility) for the procedures that include moderate conscious sedation, the second physician reports 99148-99150. However, for the circumstance in which these services are performed by the second physician in the nonfacility setting (eg, physician office, freestanding imaging center) codes 99148-99150 are NOT reported.

99143 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; under 5 years of age, first 30 minutes intra-service time (**15 minutes = 1 unit**)

99144 age 5 or older, first 30 minutes intra-service time

99145 each additional 15 minutes intra-service time
(List separately in addition to primary service)
(Use 99145 in conjunction with 99143, 99144)

99148 Moderate sedation services, provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time.
(15 minutes = 1 unit)

99149 age 5 years or older, first 30 minutes intra-service time

99150 each additional 15 minutes intra-service time
(List separately in addition to primary service)
(Use 99150 in conjunction with 99148, 99149)

OTHER SERVICES AND PROCEDURES

99170 Anogenital examination with colposcopic magnification in childhood for suspected trauma

99183 Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session

99190 Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour

99191 45 minutes

99192 30 minutes

99195 Phlebotomy, therapeutic (separate procedure)

99199 Unlisted special service, procedure