PHYSICIAN MEDICINE, DRUGS and DRUG ADMINISTRATION PROCEDURE CODES

eMedNY New York State Medicaid Provider Procedure Code Manual

New York State Medicaid
Office of Health Insurance
Department of Health

CONTACTS and LINKS:

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eMedNY Contact Information
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2 GENERAL INFORMATION AND INSTRUCTIONS

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

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

LEVELS OF E/M SERVICES: Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. The Evaluation and Management guidelines in the CPT book should be referenced when selecting the level of E/M codes.

C. 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.

D. 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.

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

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

F. 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.

G. 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.

H. 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.

I. **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.

J. **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.

K. **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.

L. **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.

M. **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.

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

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

P. **FEES**: The fees are listed in the Physician Medicine Fee Schedule, available at http://www.emedny.org/ProviderManuals/Physician/

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.

3 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.)

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.)

4 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.

4.1 OFFICE OR OTHER OUTPATIENT SERVICES

4.1.1 NEW PATIENT

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and /or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

4.1.2 ESTABLISHED PATIENT

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

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires medically appropriate history and/ or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/ or examination and high level of medical decision making. When using time for code selection 40-54 minutes of total time is spent on the date of the encounter.

4.2 HOSPITAL INPATIENT AND OBSERVATION SERVICES

4.2.1 INITIAL HOSPITAL INPATIENT OR OBSERVATION CARE

4.2.1.1 NEW OR ESTABLISHED PATIENT

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

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

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

4.2.2 SUBSEQUENT HOSPITAL INPATIENT OR OBSERVATION CARE

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

met or executed.

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

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

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

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

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

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

4.2.4 HOSPITAL INPATIENT OR HOSPITAL DISCHARGE SERVICES

99238 Hospital discharge day management; 30 minutes or less

99239 more than 30 minutes

4.3 CONSULTATIONS

4.3.1 OFFICE OR OTHER OUTPATIENT CONSULTATIONS

4.3.1.1 NEW OR ESTABLISHED PATIENT

99242 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99243 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low-level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99244 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99245 Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

4.3.2 INPATIENT OR OBSERVATION CONSULTATIONS

4.3.2.1 NEW OR ESTABLISHED PATIENT

99252 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

99253 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low-level of medical decision making.
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99254 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate of medical decision making.
When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

99255 Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.

4.4 EMERGENCY DEPARTMENT SERVICES

4.4.1 NEW OR ESTABLISHED

99281 Emergency department visit for the evaluation and management of a patient that may not r require the presence of a physician or other qualified health care professional

99282 Emergency department visit for the evaluation and management of a patient, which

requires a medically appropriate history and/or examination and straightforward medical decision making

99283 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making

99284 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

99285 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

4.5 CRITICAL CARE SERVICES

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)

4.6 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)).

4.6.1 INITIAL NURSING FACILITY CARE

4.6.1.1 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 medically appropriate history and/or examination and straightforward or low level of medical decision making.
When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

4.6.2 SUBSEQUENT NURSING FACILITY CARE

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low-level of medical decision making.
When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

4.6.3 NURSING FACILITY DISCHARGE SERVICES

99315 Nursing facility discharge day management; 30 minutes or less

99316 more than 30 minutes

4.7 HOME OR RESIDENCE SERVICES

4.7.1 NEW PATIENT

99341 Home or residence visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

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

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

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

4.8 ESTABLISHED PATIENT

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

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

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

99350 Home or residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

4.9 PROLONGED SERVICES

Prolonged service with or without direct patient contact on the date of an evaluation and management service.

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

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

99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)

4.10 PREVENTIVE MEDICINE SERVICES (WELL VISITS)

4.10.1 NEW PATIENT

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

4.10.2 ESTABLISHED PATIENT

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

4.11 COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

4.11.1.1 NEW OR ESTABLISHED PATIENT

4.11.1.1.1 BEHAVIOR CHANGE INTERVENTIONS, INDIVIDUAL

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

4.12 NON-FACE-TO-FACE SERVICES

4.12.1 TELEPHONE SERVICES

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442 11-20 minutes of medical discussion
99443 21-30 minutes of medical discussion

4.12.2 DIGITALLY STORED DATA SERVICES/REMOTE PHYSIOLOGIC MONITORING

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

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

4.13 NEWBORN CARE SERVICES

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

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

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

4.14 DELIVERY/BIRTHING ROOM ATTENDANCE AND RESUSCITATION SERVICES

99464 Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn

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

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

4.15.1 PEDIATRIC CRITICAL CARE PATIENT TRANSPORT

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)

4.15.2 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

4.15.3 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)

5 LABORATORY SERVICES PERFORMED IN A PHYSICIAN'S OFFICE

5.1 GENERAL INFORMATION AND RULES

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.

5.2 URINALYSIS

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

5.3 CHEMISTRY

83655 Lead

5.4 HEMATOLOGY AND COAGULATION

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

5.5 IMMUNOLOGY

86701 Antibody; HIV-1
86703 HIV-1 and HIV-2, single result

5.6 MICROBIOLOGY

87081 Culture, presumptive, pathogenic organisms, screening only (throat only)
87426 Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]).
87428 Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B
87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
87636 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
87651 Streptococcus, group A, amplified probe technique
87806 HIV-1 antigen(s), with HIV1 and HIV-2 antibodies
87811 Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
87880 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 coinsurance payments may be billed for the above listed procedure codes.

6 DRUGS AND DRUG ADMINISTRATION

6.1 GENERAL INFORMATION AND RULES

6.1.1 IMMUNIZATIONS

If a significantly separately identifiable Evaluation and Management service (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.

6.2 IMMUNE GLOBULINS, SERUM OR RECOMNINANT PRODUCTS

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

6.3 IMMUNIZATION ADMINISTRATION FOR VACCINES/TOXOIDS

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

6.4 VACCINES, TOXOIDS

6.4.1 GENERAL INFORMATION AND RULES

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.

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

NCCI editing will allow payment for an office visit (E&M and preventative medicine codes) and a vaccine administration service billed on the same day of service if the office visit meets a higher complexity level of care than a service represented by CPT code 99211. For payment to be made for both services, the office visit must be billed with Modifier-25. Providers must maintain documentation in the medical record to support use of an appropriate modifier.

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 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 (HepA), adult dosage, for intramuscular use
90633 Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636 Hepatitis A and hepatitis B vaccine (HEPA– HEPB), adult dose, for intramuscular use
90647 Haemophilus influenzae type B vaccine (Hib), PRP-OMP conjugate,3 dose schedule, for

	intramuscular use
90648	Haemophilus influenza type B vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use
90649	Human Papillomavirus vaccine, types 6, 11, 16, 18 quadrivalent (4vHPV), 3 dose schedule, for intramuscular use
90650	Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use
90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonvalent (9vHPV), 2 or 3 dose schedule, for intramuscular use
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
90630	Influenza vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, .05 mL dosage, for intramuscular use
90657	Influenza virus vaccine, trivalent (IIV3),split virus,0.25 mL dosage, for intramuscular use
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free,0.5 mL dosage, for intramuscular use
90674	Influenza virus vaccine; quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 ml dosage, for intramuscular use
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine (IIV),split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
90675	Rabies vaccine, for intramuscular use
90676	Rabies vaccine, for intradermal use
90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use
90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use
90682	Influenza virus vaccine, quadrivalent (RIV4),derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular

	use
90688	Influenza virus vaccine, quadrivalent (IIV4) split virus, 0.5 mL dosage, for intramuscular use
90694	Influenza virus vaccine, quadrivalent, (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use.
90690	Typhoid vaccine, live, oral
90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine, (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type B, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
90702	Diphtheria and tetanus toxoids absorbed (DT) when administered to individuals younger than 7 years, for intramuscular use
90707	Measles, Mumps and Rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids absorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine (VAR), live, for subcutaneous use
90717	Yellow fever vaccine, live, for subcutaneous use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90644	Meningococcal conjugate vaccine, serogroups C&Y and Haemophilus influenza type b vaccine (Hib-MedCY), 4 dose schedule, when administered to children 6 weeks – 18 months of age, for intramuscular use
90733	Meningococcal polysaccharide vaccine, serogroups A,C,Y,W-135,quadrivalent (MPSV4), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 quadrivalent (MCV4 or MenACWY), for intramuscular use
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B,(MenB-4C) 2 dose schedule, for intramuscular use
90621	Meningococcal recombinant lipoprotein vaccine, Serogroup B,(MenB-FHpb), 2 or 3 dose

schedule, for intramuscular use
90736 Zoster (shingles) vaccine (HZV), live, for subcutaneous injection
90750 Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use
90738 Japanese encephalitis virus vaccine, inactivated, for intramuscular use
90739 Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use
90740 Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
90743 Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use
90744 Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule for intramuscular use
90746 Hepatitis B vaccine (HepB), adult dose,3 dose schedule, for intramuscular use
90759 Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use
90747 Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use
90748 Hepatitis B and Haemophilus influenza type b vaccine (Hib-HepB), for intramuscular use
90749 Unlisted vaccine/toxoid

6.5 DRUGS ADMINISTERED OTHER THAN ORAL METHOD

6.5.1 GENERAL INFORMATION AND RULES

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.

6.5.2 THERAPEUTIC INJECTIONS (MAXIMUM FEE INCLUDES COST OF MATERIALS)

J0121 Omadacycline, 1 mg
J0129 Abatacept, 10 mg
(Administered under direct physician supervision, not for self-administration)
J0131 Acetaminophen, not otherwise specified,10 mg
J0133 Acyclovir, 5 mg
J0134 Acetaminophen (fresenius kabi) not therapeutically equivalent to J0131, 10 mg
J0135 Adalimumab, 20 mg
J0136 Acetaminophen (b braun) not therapeutically equivalent to J0131, 10 mg
J0153 Adenosine, 1 mg
(Not to be used to report any adenosine phosphate compounds, instead use unlisted code)
J0171 Adrenalin, epinephrine, 0.1 mg
J0178 Aflibercept, 1 mg
J0179 Brolucizumab-dbll, 1 mg
J0180 Agalsidase beta, 1 mg
J0185 Aprepitant, 1 mg
J0202 Alemtuzumab, 1 mg
J0205 Alglucerase, per 10 units
J0207 Amifostine, 500 mg
J0208 Sodium thiosulfate, 100 mg
J0210 Methyldopate HCl, up to 250 mg
J0215 Alefacept, 0.5 mg
J0218 Olipudase alfa-rpcp, 1mg
J0219 Avalglucosidase alfa-ngpt, 4 mg
J0220 Alglucosidase alfa, not otherwise specified, 10 mg
J0221 Alglucosidase alfa, (lumizyme), 10 mg
J0222 Patisiran, 0.1 mg
J0223 Givosiran, 0.5 mg
J0224 Lumasiran, 0.5 mg
J0225 Vutrisiran, 1 mg
J0248 Remdesivir, 1 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
J0291	Plazomicin, 5 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
J0401	Aripiprazole, extended release, intramuscular, 1 mg.
J0456	Azithromycin, 500 mg
J0461	Atropine sulfate, 0.01 mg
J0470	Dimercaprol, per 100 mg
J0475	Baclofen, 10 mg
J0485	Belatacept , 1 mg
J0490	Belimumab, 10 mg
J0491	Anifrolumab-fnia, 1 mg
J0500	Dicyclomine HCl, up to 20 mg
J0515	Benztropine mesylate, per 1 mg
J0517	Benralizumab, 1 mg
J0520	Bethanechol chloride, 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
J0565	Bezlotoxumab, 10 mg
J0567	Cerliponase alfa, 1 mg
J0570	Buprenorphine implant, 74.2 mg
J0584	Burosumab-twza, 1mg
J0585	Onabotulinumtoxina A, 1 unit
J0586	Abobotulinumtoxina A, 5 units
J0587	Rimabotulinumtoxin B, 100 units
J0588	Incobotulinumtoxin A, 1 unit
J0593	Lanadelumab-flyo, 1 mg
J0594	Busulfan, 1 mg
J0598	C1 esterase inhibitor (human), cinryze, 10 units
J0599	C1 esterase inhibitor (human), (haegarda), 10 units
J0600	Edetate calcium disodium, up to 1000 mg
J0610	Calcium gluconate (Fresenius Kabi), per 10 ml
J0611	Calcium gluconate (wg critical care), per 10 ml

J0612	Calcium glucon (fresenius), per 10 mg
J0613	Calcium glucon (wg critical)
J0620	Calcium glycerophosphate and calcium lactate, per 10 ml
J0630	Calcitonin salmon, up to 400 units
J0636	Calcitriol, 0.1 mcg
J0637	Caspofungin acetate, 5 mg
J0638	Canakinumab, 1 mg
J0640	Leucovorin calcium, per 50 mg
J0641	Levoleucovorin NOS, 0.5 mg
J0642	Levoleucovorin (khapzory), 0.5 mg
J0689	Cefazolin sodium (baxter), not therapeutically equivalent to J0690, 500 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
J0701	Cefepime hydrochloride (baxter), not therapeutically equivalent to maxipime, 500 mg
J0702	Betamethasone acetate 3 mg and betamethasone sodium phosphate 3mg
J0703	Cefepime hydrochloride (b braun), not therapeutically equivalent to maxipime, 500 mg
J0710	Cephapirin sodium, up to 1 gm
J0712	Ceftaroline fosamil, 10 mg
J0713	Ceftazidime, per 500 mg
J0715	Ceftizoxime sodium, per 500 mg
J0717	Certolizumab pegol, 1 mg (Administered under direct physician supervision, not for self-administration)
J0720	Chloramphenicol sodium succinate, up to 1 gm
J0725	Chorionic gonadotropin, per 1,000 USP units
J0739	Cabotegravir 1 mg
J0740	Cidofovir, 375 mg
J0741	Cabotegravir and rilpivirine, 2mg/3mg
J0743	Cilastatin sodium; imipenem, per 250 mg
J0744	Ciprofloxacin for intravenous infusion, 200 mg
J0745	Codeine phosphate, per 30 mg
J0770	Colistimethate sodium, up to 150 mg
J0775	Collagenase, clostridium histolyticum, 0.01 mg
J0780	Prochlorperazine, up to 10 mg
J0791	Crizanlizumab-tmca, 5mg
J0795	Corticorelin ovine triflutate, 1 mcg
J0834	Cosyntropin 0.25 mg
J0875	Dalbavancin, 5 mg
J0881	Darbepoetin alfa, 1 mcg (Non-ESRD use)
J0885	Epoetin alfa, (Non-ESRD use), 1000 units
J0888	Epoetin beta, 1 mcg (Non-ESRD use)

J0893	Decitabine (sun pharma) not therapeutically equivalent to J0894, 1 mg
J0894	Decitabine, 1 mg
J0895	Deferoxamine mesylate, 500 mg
J0896	Luspatercept-aamt, 0.25 mg
J0897	Denosumab, 1mg
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
J1071	Testosterone cypionate, 1 mg
J1094	Dexamethasone acetate, 1 mg
J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg
J1097	Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml, ophthalmic irrigation solution, 1 ml
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
J1201	Cetirizine hydrochloride, 0.5 mg
J1205	Chlorothiazide sodium, per 500 mg
J1212	DMSO, dimethyl sulfoxide, 50%, 50 ml
J1230	Methadone HCl, up to 10 mg
J1240	Dimenhydrinate, up to 50 mg
J1260	Dolasetron mesylate, 10 mg
J1267	Doripenem, 10 mg
J1300	Eculizumab, 10 mg
J1301	Edaravone, 1 mg
J1302	Sutimlimab-jome, 10 mp
J1303	Ravulizumab-cwvz, 10 mg
J1305	Evinacumab-dgnb, 5mg
J1306	Inclisiran, 1 mg
J1320	Amitriptyline HCl, up to 20 mg
J1322	Elosulfase alfa, 1mg
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
J1426	Casimersen, 10 mg
J1427	Viltolarsen, 10 mg
J1428	Eteplirsen, 10 mg
J1429	Golodirsen, 10 mg
J1435	Estrone, per 1 mg
J1436	Etidronate disodium, per 300 mg
J1437	Ferric derisomaltose, 10 mg
J1438	Etanercept, 25 mg (Administered under direct physician supervision, not self-administered)
J1439	Ferric Carboxymaltose, 1 mg
J1442	Filgrastim (G-CSF), excludes biosimilars,1 microgram
J1447	Tbo-Filgrastim, 1 microgram
J1448	Trilaciclib, 1mg
J1449	Eflapegrastim-xnst, 0.1mg
J1450	Fluconazole, 200 mg
J1452	Fomivirsen sodium, intraocular, 1.65 mg
J1453	Fosaprepitant Injection, 1 mg
J1454	Fosnetupitant 235 mg and palonestron 0.25 mg
J1455	Foscarnet sodium, per 1000 mg
J1456	Fosaprepitant (teva), not therapeutically equivalent to J1453, 1 mg
J1458	Galsulfase, 1 mg
J1459	Immune globulin (Privigen), intravenous, non lyophilized (e.g. liquid), 500 mg
J1460	Gamma globulin, intramuscular, 1 cc
J1551	Immune globulin (cutaquig), 100 mg
J1554	Immune globulin (Asceniv), 500 mg
J1555	Immune globulin (Cuvitru), 100 mg
J1556	Immune globulin (Bivigam), 500 mg
J1557	Immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1558	Immune globulin (xembify), 100 mg
J1560	Gamma globulin, intramuscular, over 10 cc
J1561	Immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562	Immune globulin (Vivaglobin), 100 mg
J1566	Immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg
J1568	Immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1569	Immune globulin, (Gammagard Liquid), non-lyophilized, (e.g. liquid), 500 mg
J1570	Ganciclovir sodium, 500 mg
J1572	Immune globulin, (flebogamma/flebogamma DIF), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1573	Hepatitis B immune globulin (HepaGam B), intravenous, 0.5 ml
J1574	Ganciclovir sodium (exela) not therapeutically equivalent to J1570, 500 mg
J1575	Immune Globulin/Hyaluronidase (HYQVIA), 100 mg
J1580	Garamycin, gentamicin, up to 80 mg
J1595	Glatiramer acetate, 20 mg

J1599	Immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg
J1600	Gold sodium thiomalate, up to 50 mg
J1602	Golimumab, 1mg, for intravenous use
J1610	Glucagon HCl, per 1 mg
J1611	Glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to J1610, per 1 mg
J1620	Gonadorelin HCl, per 100 mcg
J1626	Granisetron HCl, 100 mcg
J1627	Granisetron, extended release, 0.1 mg
J1628	Guselkumab, 1 mg
J1630	Haloperidol, up to 5 mg
J1631	Haloperidol decanoate, per 50 mg
J1642	Heparin sodium, (heparin lock flush), per 10 units
J1643	Heparin sodium (pfizer), not therapeutically equivalent to J1644, per 1000 units
J1644	Heparin sodium, per 1000 units
J1645	Dalteparin sodium, per 2500 IU
J1652	Fondaparinux sodium, 0.5 mg
J1655	Tinzaparin sodium, 1000 IU
J1710	Hydrocortisone sodium phosphate, up to 50 mg
J1720	Hydrocortisone sodium succinate, up to 100 mg
J1726	Hydroxyprogesterone caproate,(makena), 10 mg
J1729	Hydroxyprogesterone caproate, not otherwise specified, 10 mg
J1730	Diazoxide, up to 300 mg
J1738	Meloxicam, 1mg
J1740	Ibandronate sodium, 1 mg
J1741	Ibuprofen, 100 mg
J1743	Idursulfase, 1 mg
J1745	Infliximab, 10 mg
J1746	Ibalizumab-uiyk, 10 mg
J1747	Spesolimab-sbzo, 1 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)
J1823	Inebilizumab-cdon, 1 mg
J1826	Interferon beta-1a, 30 mcg
J1830	Interferon beta-1b, 0.25 mg (Administered under direct physician supervision, not for self-administration)
J1840	Kanamycin sulfate, up to 500 mg
J1850	Kanamycin sulfate, up to 75 mg

J1885	Ketorolac tromethamine, per 15 mg
J1890	Cephalothin sodium, up to 1 gm
J1930	Lanreotide, 1mg
J1931	Laronidase, 0.1 mg
J1932	Lanreotide, (cipla), 1 mg
J1940	Furosemide, up to 20 mg
J1943	Aripiprazole lauroxil (Initio), 1 mg
J1944	Aripiprazole lauroxil, 1 mg
J1950	Leuprolide acetate (for depot suspension), per 3.75 mg
J1951	Leuprolide acetate for depot suspension (fensolvi), per .25 mg
J1952	Leuprolide injectable, camcevi, 1 mg
J1954	Lutrate depot 7.5 mg
J1955	Levocarnitine, per 1 gm
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
J2021	Linezolid (hospira) not therapeutically equivalent to J2020, 200 mg
J2060	Lorazepam, 2 mg
J2150	Mannitol, 25% in 50 ml
J2175	Meperidine HCl, per 100 mg
J2180	Meperidine and promethazine HCL, up to 50 mg
J2182	Mepolizumab, 1 mg
J2184	Meropenem (b. braun) not therapeutically equivalent to J2185, 100 mg
J2185	Meropenem, 100 mg
J2210	Methylergonovine maleate, up to 0.2 mg
J2247	Micafungin sodium (par pharm) not thereapeutically equivalent to J2248, 1 mg
J2248	Micafungin sodium, 1 mg
J2260	Milrinone lactate, per 5 mg
J2270	Morphine sulfate, up to 10 mg
J2272	Morphine sulfate (fresenius kabi) not therapeutically equivalent to J2270, up to 10 mg
J2274	Morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg
J2278	Ziconotide, 1 mcg
J2280	Moxifloxacin, 100 mg
J2281	Moxifloxacin (fresenius kabi) not therapeutically equivalent to J2280, 100 mg
J2310	Naloxone hydrochloride, 1 mg
J2311	Naloxone hydrochloride (zimhi), 1 mg
J2320	Nandrolone decanoate, up to 50 mg
J2323	Natalizumab, 1 mg
J2326	Nusinersen, 0.1 mg

J2327	Risankizumab-rzaa, intravenous, 1 mg
J2350	Ocrelizumab, 1 mg
J2353	Octreotide, depot form for intramuscular injection, 1 mg
J2355	Oprelvekin, 5 mg
J2356	Tezepelumab-ekko, 1 mg
J2357	Omalizumab, 5 mg
J2358	Olanzapine, long-acting, 1 mg
J2360	Orphenadrine citrate, up to 60 mg
J2370	Phenylephrine HCl, up to 1 ml
J2405	Ondansetron HCl, per 1 mg
J2406	Oritavancin (kimyrsa), 10 mg
J2407	Oritavancin, 10 mg
J2410	Oxymorphone HCl, up to 1 mg
J2425	Palifermin, 50 mcg
J2426	Paliperidone palmitate extended release, 1mg
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
J2502	Pasireotide long acting, 1 mg
J2503	Pegaptanib sodium, 0.3 mg
J2504	Pegademase bovine, 25 IU
J2506	Pegfilgrastim, excludes biosimilar, 0.5 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
J2777	Faricimab-svoa, 0.1 mg
J2778	Ranibizumab, 0.1 mg
J2779	Ranibizumab, via intravitreal implant (susvimo), 0.1 mg
J2780	Ranitidine HCl, 25 mg
J2783	Rasburicase, 0.5 mg
J2786	Reslizumab, 1 mg
J2793	Rilonacept, 1 mg
J2794	Risperidone, (Risperdal consta), 0.5 mg
J2796	Romiplostim, 10 micrograms
J2797	Rolapitant, 0.5 mg
J2798	Risperidone (perseris), 0.5 mg
J2800	Methocarbamol, up to 10 ml
J2820	Sargramostim (GM-CSF), 50 mcg
J2840	Sebelipase alfa, 1 mg
J2860	Siltuximab, 10 mg
J2910	Aurothioglucose, up to 50 mg
J2916	Sodium ferric gluconate complex in sucrose injection, 12.5 mg
J2920	Methylprednisolone sodium succinate, up to 40 mg
J2930	Methylprednisolone sodium succinate, up to 125 mg
J2940	Somatrem, 1 mg
J2941	Somatropin, 1 mg
J2995	Streptokinase, per 250,000 IU
J2997	Alteplase recombinant, 1 mg
J2998	Plasminogen, human-tvmh, 1 mg
J3000	Streptomycin, up to 1 gm
J3030	Sumatriptan succinate, 6 mg
J3031	Fremanezumab-vfrm, 1 mg
J3032	Eptinezumab-jjmr, 1 mg
J3060	Taliglucerace alfa (Elelyso), 10 units
J3070	Pentazocine, 30 mg
J3090	Tedizolid phosphate, 1mg
J3095	Televancin, 10 mg
J3105	Terbutaline sulfate, up to 1 mg
J3111	Romosozumab-aqqg, 1 mg
J3121	Testosterone enanthate, 1 mg
J3145	Testosterone undecanoate, 1mg
J3230	Chlorpromazine HCl, up to 50 mg
J3240	Thyrotropin alpha, 0.9 mg. provided in 1.1 mg vial
J3241	Teprotumumab-trbw, 10 mg
J3243	Tigecycline, 1 mg
J3244	Tigecycline (accord) not therapeutically equivalent to J3243, 1 mg

J3245	Tildrakizumab, 1 mg
J3250	Trimethobenzamide HCl, up to 200 mg
J3260	Tobramycin sulfate, up to 80 mg
J3262	Tocilizumab, 1 mg
J3265	Torsemide, 10 mg/ml
J3280	Thiethylperazine maleate, up to 10 mg
J3285	Treprostinil, 1 mg
J3299	Triamcinolone acetonide (xipere), 1 mg
J3300	Triamcinolone acetonide, preservative free, 1mg
J3301	Triamcinolone acetonide, not otherwise specified, 10 mg
J3302	Triamcinolone diacetate, per 5 mg
J3303	Triamcinolone hexacetonide, per 5 mg
J3304	Triamcinolone acetonide, preservative free, extended-release, 1 mg
J3305	Trimetrexate glucuronate, per 25 mg
J3310	Perphenazine, up to 5 mg
J3315	Triptorelin pamoate, 3.75 mg
J3316	Triptorelin, extended-release, 3.75 mg
J3320	Spectinomycin dihydrochloride, up to 2 gm
J3357	Ustekinumab, for subcutaneous injection, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg
J3360	Diazepam, up to 5 mg
J3364	Urokinase, 5,000 IU vial
J3370	Vancomycin HCl, 500 mg
J3371	Vancomycin hcl (mylan) not therapeutically equivalent to J3370, 500 mg
J3372	Vancomycin hcl (xellia) not therapeutically equivalent to J3370, 500 mg
J3380	Vedolizumab, 1 mg
J3385	Velaglucerase alfa, 100 units
J3396	Verteporfin, 0.1 mg
J3397	Vestronidase alfa-vjbk, 1 mg
J3398	Voretigene neparvovec-rzyl, 1 billion vector genomes
J3399	Onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes
J3400	Triflupromazine 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
J3489	Zoledronic acid, 1 mg
J3490	Unclassified drugs
J3520	Edetate disodium, per 150 mg

J3590 Unclassified Biologicals
J3591 Unclassified Drug or Biological used for ESRD on dialysis

6.5.3 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
J7121 5% Dextrose in lactated ringers infusion, up to 1000 cc
J7131 Hypertonic saline solution, 1 ml\
J7168 Prothrombin complex concentrate (human), kcentra, per i.u. of factor ix activity
J7169 Coagulation Factor xa (recombinant), inactivated-zhzo (andexxa), 10 mg
J7294 Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hour
J7295 Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each
J7296 Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg
J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration
J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
J7300 Intrauterine copper contraceptive
J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7304 Contraceptive supply, hormone containing patch, each
J7306 Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307 Etonogestrel (contraceptive) implant system, including implant and supplies
J7308 Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7311 Fluocinolone acetonide, intravitreal implant (Retisert), 0.01 mg
J7312 Dexamethasone, intravitreal implant, 0.1 mg
J7313 Fluocinolone acetonide, intravitreal implant, (Iluvien) 0.01 mg
J7314 Fluocinolone acetonide, intravitreal implant, (Yutiq) 0.01 mg
J7316 Ocriplasmin (Jetrea), 0.125 mg
J7321^ Hyaluronan or derivative, Hyalgan or Supartz, or visco-3, for intra-articular injection, per dose
J7323^ Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7326^ Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7336 Capsaicin 8% patch, per square centimeter
J7342 Ciprofloxacin otic suspension, 6 mg

J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg
J7351	Bimatoprost, intracameral implant, 1 microgram
J7402	Mometasone furoate sinus implant, (sinuva), 10 micrograms
J7501	Azathioprine, parenteral (eg Imuran), 100 mg
J7504	Lymphocyte immune globulin, antithymocyte globulin equine, parenteral, 250 mg
J7527	Everolimus, oral, 0.25 mg
J7606	Formoterol Fumarate, inhalation solution, non-compounded, administered through DME, unit dose form, 20 mcg
J7611	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1mg
J7612	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME. Unit dose. 0.5 mg
J7620	Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded, administered through DME
J7627	Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg
J7628	Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per mg
J7631	Cromolyn sodium, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7640	Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 mcg
J7644	Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7648	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7649	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per mg
J7658	Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per mg
J7668	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 10 mg
J7669	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7674	Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg
J7682	Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, 300 mg
J7999	Compounded drug, not otherwise classified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8999	Prescription drug, oral, chemotherapeutic, NOS

J8501	Aprepitant, oral, 5 mg
J8540	Dexamethasone, oral, 0.25 mg
J8650	Nabilone, oral, 1 mg
J9046	Bortezomib, (dr. reddy's), not therapeutically equivalent to J9041, 0.1 mg
J9048	Bortezomib (fresenius kabi), not therapeutically equivalent to J9041, 0.1 mg
J9049	Bortezomib (hospira), not therapeutically equivalent to J9041, 0.1 mg
J9196	Gemcitabine hcl (accord)
J9294	Pemetrexed, hospira 10mg
J9296	Pemetrexed (accord) 10mg
J9297	Pemetrexed (sandoz) 10mg
J9393	Fulvestrant (teva) not therapeutically equivalent to J9395, 25 mg
J9394	Fulvestrant (fresenius kabi) not therapeutically equivalent to J9395, 25 mg
L8603^	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies
Q0138	Ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)
Q4101^	Apligraf, per square centimeter
Q4102^	Oasis wound matrix, per square centimeter
Q4103^	Oasis burn matrix, per square centimeter
Q4106^	Dermagraft, per square centimeter
Q4108^	Integra matrix, per square centimeter
Q4110^	Primatrix, per square centimeter
Q4111^	GammaGraft, per square centimeter
Q4121^	Theraskin, per square centimeter
Q5101	Filgrastim-sndz, biosimilar, (zarxio), 1 microgram
Q5103	Infliximab-dyyb, biosimilar,(inflectra), 10 mg
Q5104	Infliximab-abda, biosimilar, (renflexis), 10 mg
Q5108	Pegfilgrastim-jmdb, biosimilar, 0.5 mg
Q5111	Pegfilgrastim-cbqv, biosimilar, 0.5 mg
Q9991	Buprenorphine extended-release, less than or equal to 100 mg
Q9992	Buprenorphine extended-release, greater than 100 mg
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)

6.6 HYDRATION, THERAPEUTIC, PROPHYLACTIC, DIAGNOSTIC INJECTIONS AND INFUSIONS, AND CHEMOTHERAPY AND OTHER HIGHLY COMPLEX DRUG OR HIGHLY COMPLEX BIOLOGIC AGENT ADMINISTRATION

6.6.1 HYDRATION

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

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

96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366 each additional hour
96367 additional sequential infusion of a new drug/substance, up to 1 hour
96368 concurrent infusion
96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
96370 each additional hour
96371 additional pump set-up with establishment of new subcutaneous infusion site(s)
96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (Bill on one claim line for multiple injections)

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

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

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

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

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

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

6.6.3.3 OTHER INJECTION AND INFUSION SERVICES

96440 Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96446 Chemotherapy administration into the peritoneal cavity via indwelling port or catheter
96450 Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
96521 Refilling and maintenance of portable pump
96522 Refilling and maintenance of implantable pump or reservoir for drug delivery systemic
96542 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
96549 Unlisted chemotherapy procedure
J9999 Not otherwise classified, antineoplastic drugs

7 CHEMOTHERAPY DRUGS

7.1 GENERAL INFORMATION AND RULES

(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
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
J9021 Asparaginase, recombinant, (rylaze), 0.1 mg
J9022 Atezolizumab, 10 mg
J9023 Avelumab, 10 mg
J9025 Azacitidine, 1 mg
J9027 Clofarabine, 1 mg
J9030 BCG live (intravesical) instillation, 1 mg
J9032 Belinostat, 10 mg
J9033 Bendamustine injection HCL (Treanda), 1mg
J9034 Bendamustine injection HCL (Bendeka), 1mg

J9035	Bevacizumab, 10 mg
J9036	Bendamustine HCL, 1 mg
J9037	Belantamab mafodontin-blmf, 0.5 mg
J9039	Blinatumomab, 1 microgram
J9040	Bleomycin sulfate, 15 units
J9041	Bortezomib, 0.1 mg
J9042	Brentuximab vedotin, 1 mg
J9043	Cabazitaxel, 1 mg
J9045	Carboplatin, 50 mg
J9047	Carfilzomib (Kyprolis), 1 mg
J9050	Carmustine, 100 mg
J9055	Cetuximab, 10 mg
J9057	Copanlisib, 1 mg
J9060	Cisplatin, powder or solution, 10 mg
J9061	Amivantamab-vmjw, 2 mg
J9065	Cladribine, per 1 mg
J9070	Cyclophosphamide, 100 mg
J9071	Cyclophosphamide, (auromedics), 5 mg
J9098	Cytarabine liposome, 10 mg
J9100	Cytarabine, 100 mg
J9118	Calaspargase pegol-mknl, 10 units
J9119	Cemiplimab-rwlc, 1 mg
J9120	Dactinomycin, 0.5 mg
J9130	Dacarbazine, 100 mg
J9144	Daratumumab, 10 mg and hyaluronidase-fihj
J9145	Daratumumab, 10 mg
J9150	Daunorubicin HCl, 10 mg
J9151	Daunorubicin citrate, liposomal formulation, 10 mg
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
J9155	Degarelix, 1 mg
J9160	Denileukin diftitox, 300 mcg
J9165	Diethylstilbestrol diphosphate, 250 mg
J9171	Docetaxel, 1 mg
J9173	Durvalumab, 10 mg
J9175	Elliott's B solution, 1 ml
J9176	Elotuzumab, 1 mg
J9177	Enfortumab vedotin-ejfv 0.25mg
J9178	Epirubicin HCl, 2 mg
J9179	Eribulin mesylate, 0.1 mg
J9181	Etoposide, 10 mg
J9185	Fludarabine phosphate, 50 mg
J9190	Fluorouracil, 500 mg
J9198	Gemcitabine hydrochloride, (infugem), 100 mg
J9200	Floxuridine, 500 mg

J9201	Gemcitabine HCl, NOS, 200 mg
J9202	Goserelin acetate implant per 3.6 mg
J9203	Gemtuzumab ozogamicin, 0.1 mg
J9204	Mogamulizumab-kpkc, 1 mg
J9205	Irinotecan liposome, 1 mg
J9206	Irinotecan, 20 mg
J9207	Ixabepilone, injection, 1mg
J9208	Ifosfamide, 1 g
J9209	Mesna, 200 mg
J9210	Emapalumab-lxsg, 1 mg
J9211	Idarubicin HCl, 5 mg
J9212	Interferon alfacon-1, recombinant, 1 mcg
J9213	Interferon, alfa-2a, recombinant, 3 million units
J9214	Interferon, alfa-2b, recombinant, 1 million units
J9215	Interferon, alfa-N3, (human leukocyte derived), 250,000 IU
J9216	Interferon, gamma 1-B, 3 million units
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219^	Leuprolide acetate implant, 65 mg
J9223	Lurbinectedin, 0.1 mg
J9225	Histrelin implant (Vantas), 50 mg
J9226	Histrelin implant (Supprelin LA), 50 mg
J9227	Isatuximab-irfc, 10 mg
J9228	Ipilimumab, 1 mg
J9229	Inotuzumab ozogamicin, 0.1 mg
J9230	Mechlorethamine HCl (nitrogen mustard), 10 mg
J9245	Melphalan HCl, 50 mg
J9246	Melphalan (evomela), 1 mg
J9250	Methotrexate sodium, 5 mg
J9260	Methotrexate sodium, 50 mg
J9261	Nelarabine, 50 mg
J9262	Omacetaxine mepesuccinate (Synibro), 0.01 mg
J9263	Oxaliplatin, 0.5 mg
J9264	Paclitaxel protein-bound particles, 1 mg
J9266	Pegaspargase, per single dose vial
J9267	Paclitaxel, 1 mg
J9268	Pentostatin, per 10 mg
J9269	Tagraxofusp-erzs, 10 mcg
J9270	Plicamycin, 2.5 mg
J9271	Pembrolizumab, 1 mg
J9272	Dostarlimab-gxly, 10 mg
J9273	Tisotumab vedotin-tftv, 1 mg
J9274	Tebentafusp-tebn, 1 mcg
J9280	Injection, Mitomycin, 5 mg

J9281	Mitomycin pyelocalyceal instillation, 1 mg
J9285	Olaratumab, 10 mg
J9293	Mitoxantrone HCl, per 5 mg
J9295	Necitumumab, 1 mg
J9298	Nivolumab and relatlimab-rmbw, 3 mg/1 mg
J9299	Nivolumab, 1 mg
J9301	Obinutuzumab, 1 mg
J9302	Ofatumumab, 10 mg
J9303	Panitumumab, 10 mg
J9304	Pemetrexed (pemfexy), 10 mg
J9305	Pemetrexed, 10 mg
J9306	Pertuzumab (Perjeta), 1 mg
J9307	Pralatrexate, 1 mg
J9308	Ramucirumab, 5 mg
J9309	Polatuzumab vedotin-piiq, 1 mg
J9311	Rituximab 10 mg and hyaluronidase
J9312	Rituximab, 10 mg
J9313	Moxetumomab pasudotox-tdfk, 0,01 mg
J9314	Pemetrexed (teva) 10mg
J9316	Pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg
J9317	Sacituzumab govitecan-hziy, 2.5 mg
J9318	Romidepsin, non-lyophilized, 0.1 mg
J9319	Romidepsin, lyophilized, 0.1 mg
J9320	Streptozocin, 1 g
J9325	Talimogene laherparepvec, per 1 million plaque forming units
J9330	Temsirolimus, injection, 1 mg
J9331	Sirolimus protein-bound particles, 1 mg
J9332	Efgartigimod alfa-fcab, 2mg
J9340	Thiotepa, 15 mg
J9348	Naxitamab-gqgk, 1 mg
J9349	Tafasitamab-CXIX, 2 mg
J9351	Topotecan, 0.1 mg
J9352	Trabectedin, 0.1 mg
J9353	Margetuximab-cmkb, 5 mg
J9354	Ado-trastuzumab emtansine (Kadcyla), 1 mg
J9355	Trastuzumab, excludes biosimilar, 10 mg
J9356	Trastuzumab, 10 mg and hyaluronidase-oysk
J9357	Valrubicin, intravesical, 200 mg
J9358	Fam-trastuzumab deruxtecan-nxki,1mg
J9359	Loncastuximab tesirine-lpyl, 0.075 mg
J9360	Vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg
J9371	Vincristine sulfate liposome (Marqibo), 1 mg
J9390	Vinorelbine tartrate, 10 mg

J9395 Fulvestrant, 25 mg
J9400 Ziv-aflibercept (Zaltrap), 1 mg
J9600 Porfimer sodium, 75 mg
J9999 Not otherwise classified, antineoplastic drugs
Q0174 Thiethylperazine maleate, 10 mg, oral
Q0177 Hydroxyzine pamoate, 25 mg, oral
Q2017 Teniposide, 50 mg
Q2043 Sipuleucel-T,minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF,including leukapheresis and all other preparatory procedures, per infusion
Q2050 Doxorubicin hydrochloride liposomal, 10 mg
Q5106 Epoetin alfa-epbx; 1000 units
Q5107 Bevacizumab-awwb; 10 mg
Q5112 Trastuzumab-dttb; 10 mg
Q5113 Trastuzumab-pkrb; 10 mg
Q5114 Trastuzumab-dkst; 10 mg
Q5115 Rituximab-abbs, 10 mg
Q5116 Trastuzumab-qyyp; 10 mg
Q5117 Trastuzumab-anns; 10 mg
Q5118 Bevacizumab-bvzr; 10 mg
Q5119 Rituximab-pvvr; 10 mg
Q5120 Pegfilgrastim-bmez; 0.5 mg
Q5121 Infliximab-axxq; 10 mg
Q5121 Infliximab-axxq, biosimilar, (avsola), 10 mg
Q5123 Rituximab-arrx, biosimilar, (riabni), 10 mg
Q5125 Filgrastim-ayow, biosimilar, (releuko), 1 microgram
Q5126 Bevacizumab-maly, biosimilar, (alymsys), 10 mg
Q5127 Stimufend, 0.5 mg
Q5128 Cimerli, 0.1 mg
Q5129 Vegzelma, 10 mg
Q5130 Fylnetra, 0.5 mg

8 PSYCHIATRY SERVICES

8.1 GENERAL INFORMATION AND RULES

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

When billing for procedure codes 90832 through 90837, 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.

8.2 INTERACTIVE COMPLETITY

90785 Interactive complexity
90791 Psychiatric diagnostic examination
90792 Psychiatric diagnostic examination with medical services

8.3 PSYCHIATRIC DIAGNOSTIC PROCEDURES

8.3.1.1 PSYCHOTHERAPY

90832 Psychotherapy, 30 minutes with patient
90833 Psychotherapy, 30 minutes with patient when performed with an evaluation and management service
90834 Psychotherapy, 45 minutes with patient
90836 Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90837 Psychotherapy, 60 minutes with patient
90838 Psychotherapy, 60 minutes with patient when performed with an evaluation and management service

8.3.1.2 OTHER PSYCHOTHERAPY

90846 Family psychotherapy (without the patient present) 50 minutes
90847 Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849 Multiple family group psychotherapy
(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)

8.3.1.3 OTHER PSYCHIATRIC SERVICES OR PROCEDURES

90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services
90870 Electroconvulsive therapy (includes necessary monitoring)
90899 Unlisted psychiatric service or procedure

9 DIALYSIS SERVICES

9.1 GENERAL INFORMATION AND RULES

(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.

9.1.1 HEMODIALYSIS

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

9.1.2 MISCELLANEOUS DIALYSIS PROCEDURE

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

9.1.3 END-STAGE RENAL DISEASE SERVICES

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)

9.1.4 OTHER DIAYLSIS PROCEDURES

90999 Unlisted dialysis procedure, inpatient or outpatient

10 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)
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 tests 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

91065 Breath hydrogen or methane 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

91111 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report

91112 Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

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

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

91122 Anorectal manometry

10.1.1 OTHER PROCEDURES

91200 Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report

91299 Unlisted diagnostic gastroenterology procedure

11 OPHTHALMOLOGY

11.1 GENERAL INFORMATION AND RULES

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.

11.1.1 GENERAL OPHTHALMOLOGICAL SERVICES

11.1.1.1 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)

11.1.1.2 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)

11.1.2 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

92060 Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)

92065 Orthoptic training; performed by a physician or other qualified health care professional

92071 Fitting of contact lens for treatment of ocular surface disease

92072 Fitting of contact lens for management of keratoconus, initial fitting

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)

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

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

11.1.2.1 OPHTHALMOSCOPY

92201 Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral

retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral

92202 with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral

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

92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

92240 Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

92242 Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging)
performed at the same patient encounter with interpretation and report, unilateral or bilateral

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)

11.1.2.2 OTHER SPECIALIZED SERVICES

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

92273 Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld (ERG)

92274 multifocal (mfERG)

92286 Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis

92287 with fluorescein angiography

11.1.3 CONTACT LENS SERVICES

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. A description of the ocular pathology or medical necessity which provides justification for the recipient's need for contact lenses;
B. The best corrected vision both with and without eyeglasses;
C. The best corrected vision both with and without contact lenses;
D. The refractive error; and
E. 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)

11.1.4 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

11.1.5 SPECTACLE SERVICES (INCLUDING PROSTHESIS FOR APHAKIA)

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)

11.2 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.

11.3 OTHER PROCEDURES

92499 Unlisted ophthalmological service or procedure

12 SPECIAL OTORHINOLARYNGOLOGIC SERVICES

92502 Otolaryngologic examination under general anesthesia
92511 Nasopharyngoscopy with endoscope (separate procedure)

92521 Evaluation of speech fluency (eg, stuttering, cluttering)
92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523 with evaluation of speech sound production with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524 Behavioral and qualitative analysis of voice and resonance

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

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

12.1.2 AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION

92550 Tympanometry and reflex threshold measurements
92551 Screening test, pure tone, air only
92552 Pure tone audiometry(threshold); air only
92553 air and bone
92555 Speech audiometry threshold
92556 with speech recognition
92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92563 Tone decay test
92565 Stenger test, pure tone
92567 Tympanometry (impedance testing)
92568 Acoustic reflex testing; threshold
92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
92571 Filtered speech test
92650 Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis

92651 for hearing status determination, broadband stimuli, with interpretation and report
92652 for threshold estimation at multiple frequencies, with interpretation and report
92653 neurodiagnostic, with interpretation and report
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

12.1.3 EVALUATIVE AND THERAPEUTIC SERVICES

92601 Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602 subsequent reprogramming
92603 Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604 subsequent reprogramming
92597 Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
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
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 endoscopic evaluation of swallowing by cine or video recording
92613 interpretation and report only
92614 Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording
92615 interpretation and report only
92616 Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording
92617 interpretation and report only

12.1.4 SPECIAL DIAGNOSIS PROCEDURES

92640# Diagnostic analysis with programming of auditory brainstem implant, per hour

12.1.5 OTHER PROCEDURES

92700 Unlisted otorhinolaryngological service or procedure

13 CARDIOVASCULAR

13.1 THERAPEUTIC SERVICES AND PROCEDURES

13.1.1.1 OTHER THERAPEUTIC SERVICES AND PROCEDURES

92950 Cardiopulmonary resuscitation (eg, in cardiac arrest)

(each 15 minute unit of time)
92953 Temporary transcutaneous pacing
92960 Cardioversion, elective, electrical conversion of arrhythmia; external (each 15 minute unit of time)
92961 internal (separate procedure)
92970 Cardioassist-method of circulatory assist; internal
92971 external
92986 Percutaneous balloon valvuloplasty; aortic valve
92987 mitral valve
92990 pulmonary valve
92997 Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
92998 each additional vessel (List separately in addition to primary procedure)

13.1.1.2 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
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
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
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
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
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
92973 Percutaneous transluminal coronary thrombectomy mechanical
92974 Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy
92975 Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography
92977 by intravenous infusion
92978 Endoluminal imaging of (coronary vessel or graft) using intravascular ultrasound (IVUS) or

optical coherence tomography (OCT) 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

13.2 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

93025 Microvolt T-wave alternans for assessment of ventricular arrhythmias

93040 Rhythm ECG, one to three leads; with interpretation and report

93050 Arterial pressure waveform analysis for assessment of central arterial waveform pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive

13.3 CARDIOVASCULAR MONITORING SYSTEM

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

93244 External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation

93248 External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation

93228 External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with EGC triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional.

93229 technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed 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

13.4 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 or leadless pacemaker system in one cardiac chamber

93280 dual lead pacemaker system

93281 multiple lead pacemaker system

93282 single lead transvenous implantable defibrillator system

93283 dual lead transvenous implantable defibrillator system

93284 multiple lead transvenous implantable defibrillator system

93260 implantable subcutaneous lead defibrillator system

93285 subcutaneous cardiac rhythm monitor system

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, or leadless pacemaker system

93287 single, dual, or multiple lead implantable implantable defibrillator system

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, or leadless pacemaker system

93289 single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements

93261 implantable subcutaneous lead defibrillator system

93290 implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors

93291 subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis

93292 wearable defibrillator system

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

93294 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional

93295 single, dual, or multiple lead implantable defibrillator system with analysis, review(s) and report(s) by a physician or other qualified health care professional

93297 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic 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

93298 subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional

13.5 ECHOCARDIOGRAPHY

For procedure codes 93303-93355, 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

93319 3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)

93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete

93321 follow-up or limited study

93325 Doppler echocardiography color flow velocity mapping

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

93351 including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

93355 Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D

13.6 CARDIAC CATHETERIZATION

93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed

93452 Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed

93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation when performed

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

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

93464 Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after

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

93505 Endomyocardial biopsy

93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization

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

93565 for selective left ventricular or left atrial angiography

93566 for selective right ventricular or right atrial angiography

93567 for supravalvular aortography

93568 for nonselective pulmonary arterial angiography

93569 for selective pulmonary arterial angiography, unilateral

93573 for selective pulmonary arterial angiography, bilateral

93574 for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization

93575 for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel

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

93572 each additional vessel

13.6.1.1 REPAIR OF STRUCTURAL HEART DEFECT

93580 Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

93581 Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

93582 Percutaneous transcatheter closure of patent ductus arteriosus

93583 Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed

13.6.1.2 TRANSCATHETER CLOSURE OF PARAVALVULAR LEAK

93590 Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve

93591 initial occlusion device, aortic valve

93592 each additional occlusion device

13.6.1.3 CARDIAC CATHETERIZATION FOR CONGENTAL HEART DEFECTS

93593 Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections
93594 abnormal native connections
93595 Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal or abnormal native connections
93596 Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections
93597 abnormal native connections
93598 Cardiac output measurement(s) thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects

13.7 INTRACARDIAC ELECTROPHYSIOLOGICAL PROCEDURES/STUDIES

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
93610 Intra-atrial pacing
93612 Intraventricular pacing
93613 Intracardiac electrophysiologic 3-dimensional mapping
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
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
93621 with left atrial pacing and recordings from coronary sinus or left atrium
93622 with left ventricular pacing and recordings
93623 Programmed stimulation and pacing after intravenous drug infusion
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 transvenous 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)

93644 Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming of 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 with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording , left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed ; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry

93654 with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed

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

93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed

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

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

13.8 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 reporting of problems or events

93750 Interrogation of ventricular assist device (VAD), in person, with physician or 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 report

93784 Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; including recording, scanning analysis, interpretation and report

93790 review with interpretation and report

13.9 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

14 NONINVASIVE VASCULAR DIAGNOSTIC STUDIES

14.1 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

14.2 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

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

14.3 EXTREMITY VENOUS STUDIES (INCLUDING DIGITS)

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

93971 unilateral or limited study

14.4 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

14.5 EXTREMITY ARTERIAL VENOUS STUDIES

93985 Duplex scan of arterial flow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study

93986 complete unilateral study

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

14.6 OTHER NONINVASIVE VASCULAR DIAGNOSTIC STUDIES

93998 Unlisted noninvasive vascular diagnostic study

15 PULMONARY

15.1 PULMONARY DIAGNOSTIC TESTING, REHABILITATION, AND THERAPIES

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age

94012 Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age

94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV] in an infant or child through 2 years of age

94014 Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and 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

94375 Respiratory flow volume loop

94610 Intrapulmonary surfactant administration by a physician or other qualified health care professional through endotracheal tube

94617 Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)

94619 without electrocardiographic recordings.

94618 Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed

94621 Cardiopulmonary exercise testing including measurements of minute ventilation, CO2 production, O2 uptake and electrocardiographic recordings

94625 Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)

94626 with continuous oximetry monitoring (per session)

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
94645 each additional hour
94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
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
94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes
94728 Airway resistance by impulse oscillometry
94729 Diffusing capacity (eg, carbon monoxide, membrane)
94772 Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant (includes interpretation and report)
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

16 ALLERGY AND CLINICAL IMMUNOLOGY

16.1 ALLERGY TESTING

95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of 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

16.2 SENSITIVITY TESTING

(Maximum fees include reading of test)
86485 Skin test, candida
86486 unlisted antigen, each

86490 coccidioidomycosis
86510 histoplasmosis
86580 tuberculosis, intradermal

16.3 ALLERGEN IMMUNOTHERAPY

Codes 95115-95180 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.

95115 Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117 2 or more injections
95144 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
95145 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95146 2 single stinging insect venoms
95147 3 single stinging insect venoms
95148 4 single stinging insect venoms
95149 5 single 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)
95170 whole body extract of biting insect of other arthropod (specify number of doses)
95180 Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)

17 ENDOCRINOLOGY

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

18 NEUROLOGY AND NEUROMUSCULAR PROCEDURES

18.1 SLEEP TESTING

18.1.1 GENERAL INFORMATION AND RULES

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
95782 younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783 younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

18.2 ROUTINE ELECTROENCEPHALOGRAPHY (EEG)
95812-95813 include reporting times longer than 40 minutes.

95812 Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813 61-119 minutes
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
95830 Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording

18.2.1 ELECTROCORTICOGRAPHY

95829 Electrocorticogram at surgery (separate procedure)

18.3 RANGE OF MOTION TESTING

95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
95852 hand, with or without comparison with normal side
95857 Cholinesterase inhibitor challenge test for myasthenia gravis

18.4 ELECTROMYOGRAPHY

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
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
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
95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study

18.5 ISCHEMIC MUSCLE TESTING AND GUIDANCE FOR CHEMODENERVATION

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

18.6 NERVE CONDUCTION TESTS

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
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

18.7 INTRAOPERATIVE NEUROPHYSIOLOGY

95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes

18.8 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

18.9 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
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
95927 in the trunk or head
95928 Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929 lower limbs
95939 Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs
95930 Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report
95933 Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95937 Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

18.10 SPECIAL EEG TESTS

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 professional
95965 Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)
95966 for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)
95967 for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)

18.10.1.1 LONG-TERM EEG SETUP

95700 Electroencephalogram (EEG), continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels

18.10.1.2 MONITORING

95705 Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored
95706 with intermittent monitoring and maintenance
95707 with continuous, real-time monitoring and maintenance
95708 Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored
95709 with intermittent monitoring and maintenance
95710 with continuous, real-time monitoring and maintenance
95711 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored
95712 with intermittent monitoring and maintenance
95713 with continuous, real-time monitoring and maintenance
95714 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored
95715 with intermittent monitoring and maintenance
95716 with continuous, real-time monitoring and maintenance
95717 Electroencephalogram (EEG), continuous recording, physician or other qualified health care
professional review of recorded events, analysis of spike and seizure detection, interpretation
and report, 2-12 hours of EEG recording; without video
95718 with video (VEEG)
95719 Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each

increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video

95720 with video (VEEG)

95721 Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video

95722 greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)

95723 greater than 60 hours, up to 84 hours of EEG recording, without video

95724 greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)

95725 greater than 84 hours of EEG recording, without video

95726 greater than 84 hours of EEG recording, with video (VEEG)

18.11 NEUROSTIMULATORS, ANALYSIS-PROGRAMMING

95970 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming

95971 with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

95972 with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

95976 with simple cranial nerve neurostimulator pulse generator/transmitter programming by a physician or other qualified health care professional

95977 with complex cranial nerve neurostimulator pulse generator/transmitter programming by a physician or other qualified health care professional

95983 with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to face time with physician or other qualified health care professional

95984 with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to face time with physician or other qualified health care professional

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

18.12 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

18.13 MOTION ANALYSIS

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

18.14 FUNCTIONAL BRAIN MAPPING

96020 Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report

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

19.1.1 ASSESSMENT OF APHASIA AND COGNITIVE PERFORMANCE TESTING

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

19.1.2 DEVELOPMENTAL/BEHAVIORAL SCREENING TESTING

96110 Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

96112 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

96113 each additional 30 minutes (List separately in addition to code for primary procedure)

19.1.3 PSYCHOLOGICA/NEUROPSYCHOLOGICAL

19.1.3.1 NEUROBEHAVIORAL STATUS EXAMINATION

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]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour

96121 each additional hour (List separately in addition to code for primary procedure)

19.1.3.2 TESTING EVALUATION SERVICES

96130 Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

96131 each additional hour (List separately in addition to code for primary procedure)

96132 Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

96133 each additional hour

19.1.3.3 TEST ADMINISTRATION AND SCORING

96136 Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

96137 each additional 30 minutes

96138 Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes

96139 each additional 30 minutes

20 PHOTODYNAMIC THERAPY

96570 Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s), first 30 minutes

96571 each additional 15 minutes

96573 Photodynamic therapy by external application of light to destroy premalignant lesions of the
skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day

96574 Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day

21 SPECIAL DERMATOLOGICAL PROCEDURES

Dermatologic services are typically consultative, and any of the levels of consultation (99242-99255) 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

22 OSTEOPATHIC MANIPULATIVE TREATMENT

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

23 SPECIAL SERVICES

23.1 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)
99091 Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to to the physician or other qualified healthcare professional, qualified by education,

	training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
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)
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth.
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth.
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth.
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth.
G0426	Initial inpatient telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth.
G0427	Initial inpatient telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth.
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy. Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation
G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
G8431	Screening for clinical depression is documented as being positive and a follow-up plan is documented
G8510	Screening for clinical depression is documented as being negative, a follow-up plan is not required
H0049	Alcohol and/or drug screening
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
Q3014	Telehealth originating site facility fee
S0013	Esketamine, nasal spray, 1 mg
S0189	Testosterone pellet, 75 mg
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)
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session. (The initial lactation counseling session should be a minimum of 45 minutes. Follow up

session (s) should be a minimum of 30 minutes. Three sessions within 12-month period immediately following delivery.)

S9446 Patient education, not otherwise classified, non-physician provider, group, per session. (Up to a maximum of eight participants in a group session. 60 minute minimum session length. One prenatal and one postpartum class per recipient per pregnancy.)
New York State Medicaid will provide reimbursement for separate and distinct breastfeeding services provided by International Board Certified Lactation Consultants (IBCLCs) credentialed by the International Board of Lactation Consultant Examiners (IBLCE).
Modifier "AF" (specialty physician), along with the appropriate "S" code, must be reported on a claim when the physician is the provider of service. For additional information on eligible provider types and coverage/billing guidelines see: http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-03.htm#fee

T1013 Sign language or oral interpretive services, per 15 minutes

T2022 Case Management, per month (Physician Specialty: 333 billing for Collaborative Care *ONLY*.)

23.2 OTHER SPECIAL SERVICES

99116 Anesthesia complicated by utilization of total body hypothermia

24 MODERATE (CONSCIOUS) SEDATION

99151 Moderate sedation services provided by the same physician or other qualified healthcare 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: initial 15 minutes of intraservice time, patient younger than 5 years of age

99152 initial 15 minutes of intraservice time, patient age, 5 years or older

99153 each additional 15 minutes of intraservice time

99155 Moderate sedation services provided by a physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing
the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age

99156 initial 15 minutes of intraservice time, patient age 5 years or older

99157 each additional 15 minutes of intraservice time

25 OTHER SERVICES AND PROCEDURES

99170 Anogenital examination magnified, in childhood for suspected trauma, including image recording when performed.

99183 Physician or other qualified health care professional attendance and supervision of

	hyperbaric oxygen therapy, per session
99184	Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling
99188	Application of topical fluoride varnish by a physician or other qualified health care professional
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