# CHAPTER 5221
# DEPARTMENT OF LABOR AND INDUSTRY
# FEES FOR MEDICAL SERVICES

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## 5221.1100 PHYSICIAN SERVICES; MEDICINE.

*[For text of subps 1 and 2, see M R. 1985]*

Subp. 3. **Office services.** The following codes, service descriptions and maximum fees apply to services provided at the physician's office.

| Code | Service | Maximum Fee |
|---|---|---|
| 90010 | New patient - limited service | $ 36.00 |
| 90015 | New patient - intermediate service | 47.00 |
| 90017 | New patient - extended service | 63.00 |
| 90030 | Established patient - minimal service | 15.00 |
| 90040 | Established patient - brief service | 20.00 |
| 90050 | Established patient - limited service | 23.00 |
| 90060 | Established patient - intermediate service | 30.00 |
| 90070 | Established patient - extended service | 47 50 |
| 90080 | Established patient - comprehensive service | 75.00 |

Subp. 4. **Hospital services.** The following codes, service descriptions and maximum fees apply to services provided at a hospital. Initial hospital care shall be categorized under codes 90200 to 90220. Subsequent hospital care shall be categorized under codes 90240 to 90270.

| Code | Service | Maximum Fee |
|---|---|---|
| 90200 | Brief initial hospital care | $55.50 |
| 90215 | Intermediate initial hospital care | 76.00 |
| 90220 | Comprehensive initial hospital care | 112.00 |
| 90240 | Subsequent hospital care - brief service | 25.00 |
| 90250 | Subsequent hospital care - limited service | 33.00 |
| 90270 | Subsequent hospital care - extended service | 61.00 |

Subp. 5. **Emergency department services.** The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department.

## 5221.1100 FEES FOR MEDICAL SERVICES



| Code | Service | Maximum Fee |
|---|---|---|
| 90500 | New patient - minimal service | $25.00 |
| 90505 | New patient - brief service | 30 00 |
| 90510 | New patient - limited service | 39.50 |
| 90515 | New patient - intermediate service | 50.00 |
| 90517 | New patient - extended service | 75.00 |
| 90540 | Established patient - brief service | 32.00 |
| 90550 | Established patient - limited service | 35.00 |
| 90560 | Established patient - intermediate service | 40.00 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

## 5221.1200 CONSULTATIONS.

*[For text of subps 1 and 2, see M.R 1985]*

Subp. 3. **Fees.** The following codes, service descriptions, and maximum fees apply to consultations.

| Code | Service | Maximum Fee |
|---|---|---|
| 90600 | Initial consultation; limited | $ 50.00 |
| 90605 | Intermediate consultation | 66.50 |
| 90610 | Extensive consultation | 81.00 |
| 90620 | Comprehensive consultation | 125.00 |
| 90630 | Complex consultation | 148.00 |
| 90641 | Follow-up consultation, limited visit | 48.00 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

## 5221.1300 PSYCHIATRIC THERAPY.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

| Code | Service | Maximum Fee |
|---|---|---|
| | General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures | |
| 90801 | Psychiatric diagnostic interview examination including history, mental status, or disposition | $106.30 |
| 90843 | Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes | 50 00 |
| 90844 | approximately 45 or 50 minutes | 88 00 |
| 90847 | Family medical psychotherapy (conjoint psychotherapy) | 85.00 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

## 5221.1400 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

| Code | Service | Maximum Fee |
|---|---|---|
| 90906 | Regulation of skin temperature or peripheral blood flow | $ 45.00 |

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.1500 OPHTHALMOLOGICAL SERVICES.**

*[For text of subps 1 and 2, see M R 1985]*

Subp. 3. **Ophthalmological services and fees.** The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92020, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92235, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

General Services

| Code | Service | Maximum Fee |
|---|---|---|
| 92002 | Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient | $ 44.50 |
| 92004 | Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program - new patient, one or more visits | 49.00 |
| 92014 | Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program - established patient, one or more visits | 49.00 |
| 92020 | Gonioscopy with medical diagnostic evaluation (separate procedure) | 28.00 |

Special Services

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|---|---|---|
| 92065 | Orthoptic or pleoptic training, with continuing medical direction and evaluation | $ 29.50 |
| 92083 | Visual field examination with medical diagnostic evaluation; extended examination; quantitative perimetry (e.g. manual static and kinetic perimetry or Goldmann or Tubinger perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41) | 48.00 |
| 92100 | Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day | 22.00 |
| 92140 | Provocative tests for glaucoma, with | |

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| | medical diagnostic evaluation, without tonography | 25.00 |
| | Ophthalmoscopy | |
| 92225 | Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial | $ 25.00 |
| 92235 | Ophthalmoscopy, including medical diagnostic with fluorescein angiography and multiframe photography and medical interpretation | 128.00 |
| | Other Specialized Services | |
| 92265 | Oculoelectromyography, one more extraocular muscles, one or both eyes, with medical diagnostic evaluation | $ 68.50 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.1600 OTORHINOLARYNGOLOGIC SERVICES.**

The codes, service descriptions, and maximum fees in this part apply to otorhinolaryngologic services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, which do not include the following, should be reported as an integrated medical service using the appropriate code from the 90000 series. Component services such as otoscopy, rhinoscopy, or tuning fork test, should not be itemized separately. All of the following services include medical diagnostic evaluation. Technical procedures, which may or may not be performed by the physician personally, are often part of the service, but do not constitute the service itself.

| Code | Service | Maximum Fee |
|---|---|---|
| 92543 | Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording | $ 50.00 |
| 92545 | Oscillating tracking test, with recording | 30.00 |

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.1700 AUDIOLOGIC TESTS.**

The codes, service descriptions, and maximum fees in this part apply to audiologic function tests with medical diagnostic evaluation, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. The tests involve use of calibrated electronic equipment. Other hearing tests such as whispered voice, tuning fork which are usually included in a comprehensive otorhinolaryngologic evaluation or office visit shall not be itemized, but shall be included in the basic office visit or consultation. The following codes refer to testing of both ears.

Basic Audiometry

| Code | Service | Maximum Fee |
|---|---|---|
| 92552 | Pure tone audiometry (threshold); air only | $ 19.00 |
| 92553 | Pure tone audiometry (threshold); | |

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|---|---|---|
| | air and bone | 29.50 |
| 92556 | Speech audiometry; threshold and discrimination | 32.00 |
| 92557 | Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination) | 50.50 |
| | Audiologic Tests | |
| 92563 | Tone decay test | $ 12 00 |
| 92566 | Impedance testing | 18.75 |
| 92567 | Tympanometry | 15.00 |
| 92575 | Sensorineural acuity level test | 8.75 |
| 92581 | Evoked response audiometry | 155.00 |
| 92585 | Brainstem evoked response recording | 165.00 |
| 92591 | Hearing aid examination and selection binaural | 65.00 |
| 92593 | Hearing aid check; binaural | 18.00 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.1800 CARDIOGRAPHY.**

The codes, service descriptions, and maximum fees in this part apply to cardiographic services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

| Code | Service | Maximum Fee |
|---|---|---|
| 93000 | Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads | $ 37.50 |
| 93040 | Rhythm ECG, one to three leads; with interpretation | 20.00 |
| 93041 | Rhythm ECG, tracing only without interpretation and report | 16.50 |
| 93220 | Vectorcardiogram (VCG), with or without ECG; with interpretation and report | 95 00 |
| 93270 | Electrocardiographic monitoring utilizing a system such as magnetic tape for up through 12 hours; includes recording, scanning analysis, interpretation, and report | 171.00 |
| 93274 | Electrocardiographic monitoring utilizing a system such as magnetic tape, 12 through 24 hours; includes recording, scanning analysis, interpretation and report | 190.50 |
| 93276 | Scanning analysis with report | 96.00 |
| 93277 | physician review and interpretation, with report | 90.00 |
| 93308 | Echocardiography, real-time with image documentation (2D), limited | 155.00 |

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.1900 PULMONARY.**

The codes, service descriptions, and maximum fees of this part apply to pulmonary services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. The services include laboratory procedures, interpretation, and physician services, except surgical and anesthesia services.

| Code | Service | Maximum Fee |
|---|---|---|
| 94640 | Nonpressurized inhalation treatment for acute airway obstruction | $18.75 |
| 94664 | Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes, initial demonstration and/or evaluation | 17.10 |
| 94667 | Manipulation of chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial demonstration and/or evaluation | 18.00 |
| | Allergy and Clinical Immunology | |
| 95120 | Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen | $7.00 |
| 95125 | Multiple antigens (specify number of injections) | 9.00 |

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.2000 NEUROLOGY AND NEUROMUSCULAR.**

The codes, service descriptions, and maximum fees of this part apply to neurology and neuromuscular services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy Services performed as part of and included in the definition of an office visit, hospital visit, or consultation shall not be listed separately, but shall be submitted under the appropriate code.

| Code | Service | Maximum Fee |
|---|---|---|
| 95860 | Electromyography; one extremity and related paraspinal areas | $145.00 |
| 95861 | two extremities and related paraspinal areas | 225.00 |
| 95863 | three extremities and related paraspinal areas | 138.60 |
| 95864 | four extremities and related paraspinal areas | 191.50 |
| 95935 | "H" reflex, by electrodiagnostic testing | 36.25 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.2100 PHYSICAL MEDICINE.**

The following codes, service descriptions and maximum fees apply to physical medicine services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Physical medicine office visits as listed under "modalities"

and "procedures" shall be submitted under the appropriate code from this paragraph. Modalities and procedures require supervision by the physician, and constant attendance by the physician or therapist.

| Code | Service | Maximum Fee |
|---|---|---|
| | Modalities | |
| 97010 | Physical medicine treatment to one area; hot or cold packs | $15.00 |
| 97012 | Traction, mechanical | 14.00 |
| 97014 | Electrical stimulation (unattended) | 13 00 |
| 97020 | Microwave | 18.00 |
| 97022 | Whirlpool | 14.00 |
| 97026 | Infrared | 11 00 |
| 97028 | Ultraviolet | 19.50 |
| 97039 | Unlisted modality (specify) | 30.00 |
| | Procedures | |
| 97110 | Physical medicine treatment to one area, initial 30 minutes, each visit, therapeutic exercises | $22.00 |
| 97120 | Iontophoresis | 20.00 |
| 97124 | Massage | 15.50 |
| 97126 | Contrast baths | 14.50 |
| 97128 | Ultrasound | 15.00 |
| 97145 | Physical medicine treatment to one area, each additional 15 minutes | 10.00 |
| 97260 | Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area | 21 00 |
| 97540 | Activities of daily living (ADL) and diversional activities; initial 30 minutes, each visit | 29.70 |
| 97541 | Each additional 15 minutes | 12 50 |

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.2200 CRITICAL CARE SERVICES.**

Critical care services (codes 99162 to 99173) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

| Code | Service | Maximum Fee |
|---|---|---|
| 99058 | Office services provided on an emergency basis | $31.00 |

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| 99075 | Medical testimony | Reasonableness of charges reviewable by commissioner |
| 99080 | Special reports like insurance forms, or the review of medical data to clarify a patient's status more than the information conveyed in the usual medical communications or on standard reporting forms required by the commissioner | Reasonableness of charges reviewable by commissioner |
| | Prolonged Services | |
| 99156 | Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 50 minutes | $100.00 |
| | Critical Care | |
| 99162 | Critical care, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each 30 minutes beyond first hour | $ 60.50 |
| 99171 | Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness | 55.00 |
| 99172 | Critical care, subsequent follow-up visit; limited examination, evaluation, or treatment for same or new illness | 42.00 |
| 99173 | intermediate examination, evaluation, or treatment, same or new illness | 75.00 |

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.2250 PHYSICIAN SERVICES — SURGERY.**

*[For text of subps 1 and 2, see M R 1985]*

Subp. 3. **Integumentary system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system. Excision of benign lesions (codes 11400 to 11442) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions Treatment of burns (codes 16000 to 16020) refer to local treatment of the burned surface only. Simple repair (codes 12001 to 12013) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require

closure with adhesive strips only shall be listed according to the appropriate office visit. Intermediate repair (codes 12034 to 12051) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure. Complex repair (codes 13151 to 13152) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions. The instructions in items A to C also apply to coding of repair services (codes 12001 to 13152):

*[For text of subp 3, items A and B, see M.R 1985]*

C Involvement of nerves, blood vessels, and tendons shall be reported under the appropriate system for repair of these structures. The repair of the associated wound shall be included in the primary procedure, unless it qualifies as a complex wound, in which case modifier number 50 applies. Simple ligation of vessels in an open wound is considered as part of any wound closure. Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required.

Incision

| Code | Service | Maximum Fee |
|---|---|---|
| 10000* | Incision and drainage of infected or nonmfected sebaceous cyst; one lesion | $ 45.00 |
| 10003* | Incision and drainage of infected or noninfected epithelial inclusion cyst with complete removal of sac and treatment of cavity | 55.00 |
| 10020* | Incision and drainage of furuncle | 35.00 |
| 10060* | Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple | 45.50 |
| 10080 | Incision and drainage of piloridial cyst; simple | 49.00 |
| 10100* | Incision and drainage of onychia or paronychia single or simple | 36.00 |
| 10120* | Incision and removal of foreign body, subcutaneous tissues, simple | 46.00 |
| 10160* | Puncture aspiration of abscess, hematoma, bulla, or cyst | 39.20 |

Paring or Curettement

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| 11051 | Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); two to four lesions | $35.00 |

Biopsy

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| 11100 | Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion | $56.45 |

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| | Excision — Benign Lesions | |
| 11400 | Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter | $ 59 00 |
| 11401 | lesion diameter 0.5 to 1.0 centimeter | 69.00 |
| 11402 | lesion diameter 1.0 to 2.0 centimeters | 83.00 |
| 11403 | lesion diameter 2.0 to 3 0 centimeters | 100.00 |
| 11420 | Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter | 67.00 |
| 11421 | lesion diameter 0.5 to 1.0 centimeter | 80.00 |
| 11422 | lesion diameter 1.0 to 2.0 centimeters | 100 00 |
| 11440 | Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter | 75.40 |
| 11442 | lesion diameter 1.0 to 2.0 centimeters | 119.00 |
| | Excision - Malignant Lesions | |
| 11600 | Excision, malignant lesion, trunk, arms, or legs, lesion diameter up to 0.5 centimeters | $100.00 |
| 11601 | Lesion diameter 0.5 to 1.0 centimeters | 145.00 |
| 11621 | Lesion, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 to 1.0 centimeters | 195.00 |
| | Nails | |
| 11730* | Avulsion of nail plate, partial or complete, simple, single | $55.00 |
| 11740 | Evacuation of subungual hematoma | 30.00 |
| | Miscellaneous | |
| 11900 | Injection, intralesional, up to and including seven lesions | $27 90 |
| 11901 | more than seven lesions | 42.50 |
| | Repair — Simple | |
| 12001* | Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet, up to 2 5 centimeters | $ 46.50 |
| 12002* | 2.5 to 7.5 centimeters | 70.00 |
| 12004* | 7 5 to 12.5 centimeters | 100.00 |
| 12011* | Simple repair of superficial wounds | |

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| | of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters | 70.00 |
| 12013* | 2.5 to 5.0 centimeters | 85.00 |
| 12014 | 5.0 to 7.5 centimeters | 92.00 |
| | Repair — Intermediate | |
| 12034 | Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; 7 5 to 12.5 centimeters | $137.00 |
| 12041* | Layer closure of wounds of neck, hands, feet, or external genitalia, up to 2.5 centimeters | 79.50 |
| 12042 | 2.5 to 7.5 centimeters | 120.00 |
| 12051* | Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters | 100.00 |
| | Repair — Complex | |
| 13151 | Repair, complex, eyelids, nose, ears, or lips, 1.0 to 2.5 centimeters | $390.00 |
| 13152 | 2.5 to 7.5 centimeters | 585.00 |
| | Adjacent Tissue Transfer or Rearrangement | |
| 14060 | Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters | $780.00 |
| | Free Skin Grafts | |
| 15100 | Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters, or each one percent of body area of infants and children | 535 00 |
| | Burns, Local Treatment | |
| 16000 | Initial treatment, first degree burn, when no more than local treatment is required | $ 38.50 |
| 16020* | Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small | 35.00 |
| 16025* | without anesthesia, medium, for example, whole face or whole extremity | 55.00 |
| | Destruction | |
| 17000* | Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion | $ 38.00 |

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| 17100* | Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia, one lesion | 35.00 |
| 17200* | Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions | 40.00 |
| 17340* | Cryotherapy ($CO_2$ slush, liquid $N_2$) | 24.00 |

Subp. 4. **Musculoskeletal system.** The following codes, service descriptions and maximum fees apply to surgical procedures of the musculoskeletal system Rereduction of a fracture or dislocation performed by the primary physician may be identified by the addition of the modifer number 76 to the usual procedure number to indicate "repeat procedure by same physician."

Excision — General

| Code | Service | Maximum Fee |
|---|---|---|
| 20205 | Biopsy, muscle; deep | $210.00 |
| | Introduction or Removal — General | |
| 20501* | Injection of sinus tract, diagnostic (sinogram) (separate procedure) | $ 47.00 |
| 20550* | Injection, tendon sheath, ligament, or trigger points | 39.00 |
| 20600* | Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes | 40.00 |
| 20605* | intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa | 47.10 |
| 20610* | major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa | 49.00 |
| 20680 | Removal of implant, deep, for example, buried wire, pin, screw, metal band, nail, rod, or plate | 287.80 |
| | Introduction or Removal | |
| 21116 | Injection procedure for temporomandibular arthrotomography | $74.00 |
| | Head — Fracture or Dislocation | |
| 21310 | Treatment of closed or open nasal fracture without manipulation | $40.00 |
| 21320 | Manipulative treatment, nasal bone fracture, with stabilization | 260.00 |
| | Neck (Soft Tissues) and Thorax — Fracture or Dislocation | |
| 22555 | Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft) | $2,047.00 |

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| | Shoulders — Fracture or Dislocation | |
| 23420 | Repair of complete shoulder cuff avulsion, chronic (includes acromionectomy) | $1,330.00 |
| 23450 | Capsulorrhaphy for recurrent dislocation, anterior, Putti-Platt procedure or Magnuson type operation | 1,150.00 |
| 23550 | Open treatment of closed or open acromioclavicular dislocation, acute or chronic | 816.00 |
| 23650 | Treatment of closed shoulder dislocation, with manipulation; without anesthesia | 100.00 |
| 23655 | requiring anesthesia | 150.00 |
| | Shoulder — Manipulation | |
| 23700* | Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded) | $158.00 |
| | Humerus (Upper Arm) and Elbow — Fracture or Dislocation | |
| 24105 | Excision, olecranon bursa | $326.00 |
| | Forearm and Wrist — Incision and Excision | |
| 25111 | Excision of ganglion, wrist (dorsal or volar); primary | $337 00 |
| | Forearm and Wrist — Fracture or Dislocation | |
| 25505 | Treatment of closed radial shaft fracture; with manipulation | $285.00 |
| 25565 | Treatment of closed radial and ulnar shaft fractures, with manipulation | 364.00 |
| 25605 | Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation | 278.50 |
| 25610 | Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletalfixation or percutaneous pinning | 398.00 |
| 25611 | with external skeletal fixation or percutaneous pinning | 517.00 |
| | Hand and Fingers — Incision, Excision, Repair, Revision, or Reconstruction | |
| 26055 | Tendon sheath incision for trigger finger | $335.00 |
| 26160 | Excision of lesion of tendon sheath or capsule | 195.00 |
| 26418 | Extensor tendon repair, dorsum of finger, single, primary, or secondary, without free graft, each tendon | 294.00 |

Hands and Fingers — Fractures or Dislocations

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|---|---|---|
| 26600 | Treatment of closed metacarpal fracture, single, without manipulation, each bone | $105.50 |
| 26605 | with manipulation, each bone | 170.00 |
| 26725 | Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each | 120 00 |
| 26750 | Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each | 45.00 |
| 26770 | Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia | 50.00 |

Hand and Fingers — Amputation

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|---|---|---|
| 26951 | Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure | $ 250.00 |
| 27130 | Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple | 2,818.00 |
| 27236 | Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement | 1,522.50 |
| 27244 | Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation | 1,418.00 |

Femur (Thigh Region) and Knee Joint — Excision

| | | |
|---|---|---|
| 27332 | Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy), medial or lateral | $942.00 |

Femur (Thigh Region) and Knee Joint — Introduction or Removal

| | | |
|---|---|---|
| 27370 | Injection procedure for knee arthrography | $ 53.50 |
| 27373 | Arthroscopy, knee, diagnostic (separate procedure) | 368.00 |
| 27374 | Arthroscopy, knee, surgical; debridement with cartilage shaving or drilling or resection of reactive synovium | 1,207.50 |
| 27376 | with synovial biopsy | 648.00 |
| 27377 | with removal of loose body | 1,097.00 |
| 27378 | with partial meniscectomy | 1,295.00 |
| 27379 | with plica resection or shelf resection | 1,056.00 |

Femur (Thigh Region) and Knee Joint — Repair, Revision, or Reconstruction

| | | |
|---|---|---|
| 27425 | Lateral retinacular release (any method) | $1,006.00 |

| | | |
|---|---|---|
| 27442 | Arthroplasty, knee, femoral condyles or tibial plateaus | 2,900.00 |
| 27444 | Arthroplasty, knee, total, fascial | 2,900.00 |
| 27447 | Arthroplasty, knee condyle and plateau, medial and lateral compartments with or without patella resurfacing (total knee replacement) | 2,724.00 |

Leg (Tibula and Fibula) and Ankle Joint — Fractures or Dislocations

| | | |
|---|---|---|
| 27760 | Treatment of closed distal tibial fracture (Medial Malleolus); without manipulation | $165.00 |
| 27802 | Treatment of closed tibia and fibula fractures, shafts, with manipulation | 451.50 |
| 27814 | Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation | 822.20 |
| 27822 | Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus, only | 977.00 |
| 27880 | Amputation leg, through tibia and fibula | 780.00 |

Foot — Fracture or Dislocation

| | | |
|---|---|---|
| 28090 | Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion) foot | $250.00 |
| 28290 | Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure) | 310 00 |
| 28292 | Keller, McBride or Mayo type procedure | 600.00 |
| 28296 | with metatarsal osteotomy (Mitchell or Lapidus type procedure) | 724.00 |
| 28490 | Treatment of closed fracture great toe, phalanx, or phalanges, without manipulation | 52.00 |
| 28510 | Treatment of closed fracture, phalanx or phalanges, other than great toe, without manipulation, each | 41.00 |

Subp. 5. **Casts and strapping.** The following codes, service descriptions, and maximum fees apply to procedures associated with the application of casts and strapping The services include the application and removal of the first cast or traction device only. Subsequent replacement of cast or traction device requires an additional listing. Codes for cast removal shall be employed only for casts applied by another physician.

Body and Upper Extremity Casts

| Code | Service | Maximum Fee |
|---|---|---|
| 29035 | Application of body cast, shoulder to hips | $167.00 |
| 29065 | shoulder to hand (long arm) | 74.00 |

| | | |
|---|---|---|
| 29075 | elbow to finger (short arm) | 61.80 |
| 29085 | hand and lower forearm (gauntlet) | 61.10 |
| | Splints | |
| 29105 | Application of long arm splint (shoulder to hand) | $ 44.00 |
| 29125 | Application of short arm splint (forearm to hand); static | 36.00 |
| 29130 | Application of finger splint, static | 23.00 |
| | Strapping — Any Age | |
| 29200 | Strapping; thorax | $ 20.00 |
| 29260 | elbow or wrist | 20.00 |
| 29345 | Application of long leg cast (thigh to toes) | 95.00 |
| 29355 | walker or ambulatory type | 116.00 |
| 29358 | Application of long leg cast brace | 295.00 |
| 29365 | Application of cylinder cast (thigh to ankle) | 90.00 |
| 29405 | Application of short leg cast (below knee to toes) | 75.00 |
| 29425 | walking or ambulatory type | 84.00 |
| 29435 | Application of patellar tendon bearing (PTB) cast | 107.00 |
| 29440 | Adding walker to previously applied cast | 31.00 |
| 29450 | Application of clubfoot cast with molding or manipulation, long or short leg; unilateral | 48.00 |
| 29455 | bilateral | 79.00 |
| | Splints | |
| 29505 | Application of long leg splint (thigh to ankle or toes) | $ 54.00 |
| | Strapping — Any Age | |
| 29580 | Unna boot | $30.00 |
| | Removal or Repair | |
| 29700 | Removal or bivalving, gauntlet, boot, or body cast | $ 30.00 |
| 29705 | Removal or bivalving; full arm or full leg cast | 30.00 |
| 29720 | Repair of spica, body cast, or jacket | 17.00 |

Subp. 6. **Respiratory system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the respiratory system.

Nose — Repair

| Code | Service | Maximum Fee |
|---|---|---|
| 30420 | Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, or elevation of nasal tip, including major septal repair | $1,825.00 |

| | | |
|---|---|---|
| 30520 | Septoplasty with or without cartilage implant (separate procedure) | 810.00 |

Other Procedures

| | | |
|---|---|---|
| 30901 | Control nasal hemorrhage, anterior, simple (cauterization), unilateral | $41.00 |
| 30903 | Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral | 67.00 |

Subp. 7. **Cardiovascular system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the cardiovascular system. Injection procedures include necessary local anesthesia, introduction of needles or catheter, injection of contrast medium with or without automatic power injection, or necessary pre- and postinjection care specifically related to the injection procedure. Catheters, drugs, and contrast media are not included in the listed service for the injection procedures.

Vascular Injection Procedures — Venous

| Code | Service | Maximum Fee |
|---|---|---|
| 36471 | Venipuncture; multiple veins, same leg | $26.00 |

Vascular Injection Procedures — Arterial

| | | |
|---|---|---|
| 36620 | Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous | $120.00 |

Subp. 8. **Digestive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the digestive system.

Abdomen, Peritoneum, and Omentum — Repair, Hernioplasty, Herniorrhaphy, Herniotomy

| Code | Service | Maximum Fee |
|---|---|---|
| 49505 | Repair inguinal hernia, age 5 or over; unilateral | $ 630.00 |
| 49506 | bilateral | 1,050.00 |
| 49515 | with excision of hydrocele or spermatocele | 720.00 |
| 49520 | recurrent | 750.00 |
| 49560 | Repair ventral (incisional) hernia (separate procedure) | 689.00 |
| 49565 | Recurrent | 907.00 |
| 49581 | Repair umbilical hernia; age 5 or over | 527.00 |

Subp. 9. **Nervous system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the nervous system.

Spine and Spinal Cord — Puncture for Injection, Drainage, or Aspiration

| Code | Service | Maximum Fee |
|---|---|---|
| 62270* | Spinal puncture lumbar diagnostic | $ 75.00 |
| 62273* | Injection lumbar epidural, of blood or clot patch | 176.00 |
| 62274* | Injection of anesthetic substance, | |

| | | |
|---|---|---|
| | diagnostic or therapeutic; subarachnoid or subdural simple | 89.00 |
| 62278* | epidural or caudal single | 125.00 |
| 62284* | Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa | 130.00 |
| 62289 | Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal | 184.00 |
| 62292 | Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar | 1,595.00 |

Spine and Spinal Cord — Laminectomy or Laminotomy, for Exploration or Decompression

| | | |
|---|---|---|
| 63005 | Laminectomy for decompression of spinal cord and/or cavda equina, one or two segments; lumbar, except for spondylolisthesis | $1,750.00 |
| 63030 | Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root; one interspace, lumbar, unilateral | 1,755.00 |
| 63042 | Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or re-exploration; lumbar | 2,255.00 |

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System — Exploration, Neurolysis, or Nerve Decompression (Neuroplasty)

| | | |
|---|---|---|
| 64718 | Neurolysis or transposition; ulnar nerve at elbow | $875.00 |
| 64721 | median nerve at carpal tunnel | 640.00 |

Eye and Ocular Adnexa — Removal of Ocular Foreign Body

| | | |
|---|---|---|
| 65205* | Removal foreign body, external eye; conjunctival superficial | $36.00 |
| 65210* | conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating | 44.00 |
| 65220* | corneal, without slit lamp | 43.50 |
| 65222* | corneal, with slit lamp | 55.00 |

Subp. 10. [Repealed, 10 SR 765]

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765; 10 SR 1548*

NOTE The text of subpart 4 reads as printed in the errata at 10 State Register, page 1548, on January 13, 1986

## 5221.2300 PHYSICIAN SERVICES — RADIOLOGY.

*[For text of subpart 1, see M R. 1985]*

Subp. 2. **Diagnostic radiology.** The following codes, service descriptions, and maximum fees apply to diagnostic radiology procedures.

Head and Neck

| Code | Service | Maximum Fee |
|---|---|---|
| 70100 | Radiologic examination, mandible; partial, less than four views | $ 40 00 |
| 70130 | Radiologic examination, mastoids; complete, minimum of three views per side | 70.00 |
| 70134 | Radiologic examination, internal auditory meati, complete | 78.00 |
| 70210 | Radiologic examination, sinuses, paranasal, less than three views | 32.00 |
| 70220 | Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies | 60.00 |

Chest

| | | |
|---|---|---|
| 71010 | Radiologic examination, chest; single view, posteroanterior | $28.00 |
| 71015 | stereo, posteroanterior | 30.40 |
| 71020 | two views, posteroanterior and lateral | 40.00 |
| 71022 | Radiological examination, frontal and lateral; with oblique projections | 17.00 |
| 71100 | Radiologic examination, ribs, unilateral; two views | 44.00 |
| 71110 | Radiologic examination, ribs, bilateral; three views | 57.00 |
| 71120 | Radiologic examination; sternum, minimum of two views | 34.00 |

Spine and Pelvis

| | | |
|---|---|---|
| 72040 | Radiologic examination, spine, cervical; anteroposterior and lateral | $42.00 |
| 72070 | Radiologic examination, spine; thoracic, anteroposterior and lateral | 46.00 |
| 72090 | scoliosis study, including supine and erect studies | 42.00 |
| 72100 | Radiologic examination, spine, lumbosacral, anteroposterior and lateral | 51.00 |
| 72114 | complete, including bending views | 87.00 |
| 72170 | Radiologic examination, pelvis; anteroposterior only | 35 00 |
| 72190 | complete, minimum of three views | 46.25 |
| 72220 | Radiologic examination, sacrum and coccyx, minimum of two views | 43 00 |
| 72295 | Diskography, lumbar; supervision and interpretation only | 42 50 |

Upper Extremities

| | | |
|---|---|---|
| 73000 | Radiologic examination, clavicle, complete | $ 30.00 |
| 73020 | Radiologic examination, shoulder; one view | 30.00 |

| | | |
|---|---|---|
| 73030 | complete, minimum of two views | 40.25 |
| 73060 | humerus, minimum of two views | 35 00 |
| 73070 | Radiologic examination, elbow; anteroposterior and lateral views | 33.00 |
| 73090 | Radiologic examination, forearm, anteroposterior and lateral views | 32.00 |
| 73100 | Radiologic examination, wrist; anteroposterior and lateral views | 31.00 |
| 73110 | complete, minimum of three views | 36.75 |
| 73120 | Radiologic examination, hand; two views | 33.50 |
| 73140 | Radiologic examination, finger or fingers, minimum of two views | 29.50 |
| | Lower Extremities | |
| 73500 | Radiologic examination, hip; unilateral, one view | $ 29.50 |
| 73510 | complete, minimum of two views | 45.00 |
| 73520 | Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis | 45.00 |
| 73560 | Radiologic examination, knee; anteroposterior and lateral views | 35.00 |
| 73562 | anteroposterior and lateral, with oblique, minimum of three views | 44.00 |
| 73564 | complete, including oblique, or tunnel, or patellar, or standing views | 49.10 |
| 73581 | Radiologic examination, knee, arthography; complete procedure | 128.25 |
| 73590 | Radiologic examination; tibia and fibula, anteroposterior and lateral views | 36.50 |
| 73600 | Radiologic examination, ankle; anteroposterior and lateral views | 30.50 |
| 73610 | complete, minimum of three views | 37.00 |
| 73620 | Radiologic examination, foot; anteroposterior and lateral views | 31.00 |
| 73630 | complete, minimum of three views | 38.00 |
| 73650 | Radiologic examination; calcaneus, minimum of two views | 31.00 |
| 73660 | toe or toes, mimmum of two views | 29.50 |
| | Gastrointestinal Tract | |
| 74240 | Radiologic examination, gastrointestinal tract, upper, with or without delayed films, without KUB | $81.00 |
| 74241 | with or without delayed films, with KUB | 52.00 |
| 74270 | Radiologic examination, colon; barium enema | 80.00 |
| | Urinary Tract | |
| 74405 | Urography (pyelography), intravenous, including kidneys, ureters, and bladder with special hypertensive contrast | |

| | | |
|---|---|---|
| | concentration or clearance studies | $140.40 |

Subp. 3. **Diagnostic ultrasound.** The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure, "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display, and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

| Code | Service | Maximum Fee |
|---|---|---|
| | Head and Neck | |
| 76511 | Ophthalmic ultrasound, echography; A-mode, spectral analysis with amplitude quantification | $150.00 |
| 76516 | Echography, ophthalmic, ultrasonic biometry; | 150.00 |
| | Chest | |
| 76604 | B-scan (includes Mediastinum) and/or real time with image documentation | $57.25 |
| | Pelvis | |
| 76805 | Echography, pelvic, B-scan (for example, real-time), in obstetrics, gynecology, or transplants; complete | $75.00 |
| | Vascular Studies | |
| 76925 | Peripheral imaging, B-scan, Doppler or real-time scan | $110 00 |

Subp. 4. **Therapeutic radiology.** The following codes, procedures and maximum fees apply to therapeutic radiology procedures. Listings for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion

Except where specified, clinical treatment management assumes treatment on a daily basis (four or five fractions per week) with the use of megavoltage photon or high energy particle sources. Daily and weekly clinical treatment management are mutually exclusive for the same dates. "Simple" means a single treatment area, single port or parallel opposed ports, simple blocks. "Intermediate" means two separate treatment areas, three or more ports on a single treatment area, use of special blocks. "Complex" means three or more separate treatment areas and highly complex blocking (mantle, inverted Y, tangential ports, wedges, compensators, or other special beam considerations)

| Code | Service | Maximum Fee |
|---|---|---|
| 77280 | Therapeutic radiology simulation aided field setting; simple | $105.50 |
| 77465 | Daily kilovoltage treatment management | 31.50 |

Subp. 5 **Nuclear medicine.** The following codes, service descriptions and maximum fees apply to nuclear medicine procedures. Procedures may be per-

formed independently or in the course of overall medical care. The services listed do not include the provision of radium or other radioelements.

Diagnostic — Gastrointestinal System

| Code | Service | Maximum Fee |
|---|---|---|
| 78201 | Liver imaging only | $67.30 |
| 78305 | Bone imaging; multiple areas | 73.50 |
| | Diagnostic — Cardiovascular System | |
| 78422 | Myocardium imaging, regional Myocardial perfusion at rest for evaluation of infarction (infarct avid imaging) | $68.90 |
| 78435 | Cardial flow imaging (i.e., angiocardiography) | 73.10 |
| 78445 | Vascular flow imaging (i.e., angiography, venography | 93.00 |
| | Diagnostic — Respiratory System | |
| 78581 | Pulmonary perfusion imaging; gaseous | $67.00 |
| 78594 | Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (e.g., anterior, posterior, lateral views) | 70.00 |

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.2400 PHYSICIAN SERVICES; PATHOLOGY AND LABORATORY.**

*[For text of subpart 1, see M R. 1985]*

Subp. 2. **Automated, multichannel tests.** The following codes, service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more tests among those listed below, the appropriate code from 80003 to 80072 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

Albumin
Albumin/globulin ratio
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Chloride
Cholesterol
Creatinine
Globulin
Glucose (sugar)
Lactic dehydrogenase (LDH)
Phosphatase, alkaline
Phosphorus (inorganic phosphate)
Potassium
Protein, total

Sodium
Transaminase, glutamic oxaloacetic (SGOT)
Transaminase, glutamic pyruvic (SGPT)
Urea nitrogen (BUN)
Uric acid

Automated Multichannel Tests

| Code | Service | Maximum Fee |
|---|---|---|
| 80003 | Automated multichannel tests; 3 clinical chemistry tests | $ 30.00 |
| 80007 | 7 clinical chemistry tests | 24.70 |
| 80009 | 9 clinical chemistry tests | 26.00 |
| 80011 | 11 clinical chemistry tests | 35.00 |
| 80012 | 12 clinical chemistry tests | 30.00 |
| 80016 | 13-16 clinical chemistry tests | 34.00 |
| 80059 | Hepatitis panel | 57.00 |
| 80062 | Cardiac evaluation (including coronary risk) panel | 26 00 |
| 80064 | Cardiac injury panel; with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination | 15.00 |
| 80072 | Arthritis panel | 42.65 |

Subp. 3. **Urinalysis.** The following codes, service descriptions, and maximum fees apply to urinalysis procedures.

| Code | Service | Maximum Fee |
|---|---|---|
| 81000 | Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy | $10.00 |
| 81002 | routine, without microscopy | 6.00 |
| 81004 | components, single, not otherwise listed, specify | 5.25 |
| 81005 | chemical, qualitative, any number of constituents | 4.90 |
| 81015 | microscopic only | 8.00 |

Subp. 4. **Chemistry and toxicology.** The following codes, service descriptions, and maximum fees apply to chemistry and toxicology procedures. The material for examination may be from any source. Examination is quantitative unless otherwise specified.

| Code | Service | Maximum Fee |
|---|---|---|
| 82011 | Acetylsalicylic acid, quantitative | $18.00 |
| 82012 | qualitative | 17.00 |
| 82150 | Amylase, serum; | 16.90 |
| 82250 | Bilirubin; blood, total OR direct | 13.00 |
| 82251 | Bilirubin; blood, total and direct | 15.75 |
| 82310 | Calcium, blood; chemical | 12.75 |
| 82372 | Carbamazepine, serum | 29.75 |
| 82435 | Chlorides; blood (specify chemical or electrometric) | 14.00 |
| 82465 | Cholesterol, serum; total | 12.50 |
| 82565 | Creatinine; blood | 12.60 |
| 82575 | clearance | 27.00 |

| | | |
|---|---|---|
| 82607 | Cyanocobalamin (Vitamin B-12); RIA | 31.50 |
| 82643 | Digoxin, RIA | 31.50 |
| 82660 | Drug screen (amphetamines, barbiturates, alkaloids) | 31.50 |
| 82756 | Free thyroxine index (T-7) | 28.00 |
| 82947 | Glucose; except urine (for example, blood, spinal fluid, joint fluid) | 12.50 |
| 82948 | blood, stick test | 8.50 |
| 82950 | post glucose dose (includes glucose) | 12.75 |
| 82996 | Gonadotropin, chorionic, bioassay, qualitative | 15.00 |
| 82998 | Gonadotropin, chorionic, RIA | 26.00 |
| 83000 | Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay | 40.00 |
| 83001 | RIA | 39.00 |
| 83002 | Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA | 40.00 |
| 83540 | Iron, serum; chemical | 14.85 |
| 83545 | automated | 13.65 |
| 83550 | Iron binding capacity, serum; chemical | 23.50 |
| 83555 | automated | 22.80 |
| 83725 | Lithium, blood, quantitative | 16.50 |
| 84030 | Phenylalanine (PKU), blood, Guthrie | 10.00 |
| 84035 | Phenylketones; blood, qualitative | 13.00 |
| 84045 | Phenytoin | 27.00 |
| 84060 | Phosphatase, acid; blood | 20.00 |
| 84065 | prostatic fraction | 21.25 |
| 84075 | Phosphatase, alkaline, blood; | 14.00 |
| 84078 | heat stable (total not included) | 13.20 |
| 84080 | isoenzymes, electrophoretic method | 39.00 |
| 84132 | Potassium, blood | 11.80 |
| 84133 | urine | 10.00 |
| 84165 | Protein, total, serum, electrophoretic fractionation and quantitation | 26.25 |
| 84180 | Protein, urine, quantitative, 24-hour specimen | 14.50 |
| 84190 | electrophoretic fractionation and quantitation | 25.50 |
| 84295 | Sodium; blood | 10.50 |
| 84420 | Theophylline, blood, or saliva | 30.00 |
| 84442 | Thyroxine binding globulin (TBG) | 29.00 |
| 84443 | Thyroid stimulating hormone (TSH), RIA | 36.60 |
| 84450 | Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method | 15.75 |
| 84455 | colorimetric or fluorometric | 12.00 |
| 84460 | Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method | 17.70 |
| 84478 | Triglycerides, blood | 15.00 |
| 84520 | Urea nitrogen, blood (BUN), quantitative | 12.75 |
| 84550 | Uric acid, blood, chemical | 12.75 |
| 84555 | uricase, ultraviolet method | 15.00 |

Subp 5. **Hematology.** The following codes, service descriptions, and maximum fees apply to hematology procedures.

| Code | Service | Maximum Fee |
|---|---|---|

| | | |
|---|---|---|
| 85005 | Blood count; basophil count, direct | $ 21.75 |
| 85007 | differential WBC count (includes RBC morphology and platelet estimation) | 9.00 |
| 85012 | eosinophil count, direct | 12.00 |
| 85014 | hematocrit | 7.00 |
| 85018 | hemoglobin, colorimetric | 7 50 |
| 85021 | hemogram, automated (RBC, WBC, Hgb, Hct and indices only) | 15.00 |
| 85022 | hemogram, automated, with platelet count | 21.25 |
| 85027 | hemogram, automated, and differential WBC count (CBC) | 12.75 |
| 85028 | Hemogram, automated, and differential WBC count (CBC) with platelet count | 22 45 |
| 85031 | hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices) | 20 15 |
| 85044 | reticulocyte count | 12.00 |
| 85048 | White blood cell (WBC) | 8.00 |
| 85210 | Clotting; factor 11, prothrombin, specific | 13.75 |
| 85580 | Platelet; count (Rees-Ecker) | 13.00 |
| 85585 | estimation on smear, only | 9.00 |
| 85590 | phase microscopy | 12.00 |
| 85595 | electronic technique | 11.00 |
| 85610 | Prothrombin time; | 11.00 |
| 85650 | Sedimentation rate (ESR), Wintrobe type | 9.00 |
| 85651 | Westergren type | 8.50 |
| 85660 | Sickling of RBC, reduction, slide method | 9.00 |

Subp. 6. **Immunology.** The following codes, service descriptions, and maximum fees apply to immunology procedures.

| Code | Service | Maximum Fee |
|---|---|---|
| 86006 | Antibody, qualitative, not otherwise specified; first antigen, slide or tube | $ 16.00 |
| 86008 | Antibody, quantitative titer, not otherwise specified; first antigen | 17.25 |
| 86060 | Antistreptolysin O; titer | 20.00 |
| 86063 | screen | 11 00 |
| 86105 | Blood typing; Rh genotyping, complete | 9.00 |
| 86140 | C-reactive protein | 11.75 |
| 86255 | Fluorescent antibody; screen | 28.50 |
| 86256 | titer | 27.50 |
| 86280 | Hemagglutination inhibition tests (HAI), each (for example, amebiasis, rubella, viral) | 15.00 |
| 86300 | Heterophile antibodies; screening (includes monotype test), slide or tube | 12.00 |
| 86305 | quantitative titer | 16.50 |
| 86430 | Rheumatoid factor, latex fixation | 16.00 |
| 86580 | Skin test; tuberculosis, patch, or intradermal | 8.50 |
| 86585 | tuberculosis, tine test | 7.00 |

Subp. 7. **Microbiology.** The following codes, service descriptions, and maximum fees apply to microbiology procedures.

| Code | Service | Maximum Fee |
|---|---|---|
| 87060 | Culture, bacterial, definitive, aerobic, throat or nose | $10.00 |
| 87072 | Culture, presumptive, pathogenic organisms, by commercial kit, any source except urine | 12.00 |
| 87081 | Culture, bacterial, screening only, for single organisms | 11 00 |
| 87082 | Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms | 11.00 |
| 87086 | Culture, bacterial, urine; quantitative, colony count | 16.00 |
| 87088 | identification, in addition to quantitative or commercial kit | 20.00 |
| 87101 | Culture, fungi, isolation; skin | 15 75 |
| 87140 | Culture, typing; fluorescent method, each antiserum | 12.65 |
| 87181 | Sensitivity studies, antibiotic; agar diffusion method, each antibiotic | 15 00 |
| 87184 | disc method, each plate (12 or less discs) | 16.00 |
| 87186 | microtiter, minimum inhibitory concentration (MIC), 8 or less antibiotics | 22.00 |
| 87205 | Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types | 10.00 |
| 87210 | wet mount with simple stain and interpretation, for bacteria, fungi, ova, or parasites | 10.00 |
| 87211 | wet and dry mount, with interpretation, for ova and parasites | 9.50 |
| 87220 | Tissue examination for fungi (for example, KOH slide) | 11.00 |

Subp. 8. **Anatomic pathology.** The following codes, service descriptions, and maximum fees apply to anatomic pathology procedures.

Cytopathology

| Code | Service | Maximum Fee |
|---|---|---|
| 88104 | Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and cervical or vaginal; smears and interpretation | $ 30.00 |
| 88109 | smears and cell block with interpretation | 50.00 |

Subp. 9. **Surgical pathology.** The following codes, service descriptions, and maximum fees apply to surgical pathology procedures The services listed include accession, handling, and reporting. Only one of the codes listed (88302 to 88307) should be used in reporting specimens (single or multiple) that are removed during a single surgical procedure

| Code | Service | Maximum Fee |
|---|---|---|
| 88302 | Surgical pathology, gross and microscopic; examination for | |

| | | |
|---|---|---|
| | identification and record purposes (for example, uterine tubes, vas deferens, sympathetic ganglion) | $ 42.00 |
| 88304 | diagnostic exam, small or uncomplicated specimen (for example, skin lesion, needle biopsy) | 40.00 |
| 88307 | complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides | 90.00 |
| 88309 | Complex diagnostic problem with or without extensive dissection | 150.00 |

Subp. 10. **Miscellaneous.** The following codes, service descriptions, and maximum fees apply to miscellaneous pathology and laboratory services.

| Code | Service | Maximum Fee |
|---|---|---|
| 89007 | Test combinations assigned individual procedure numbers for secretarial convenience only; CBC, urinalysis, serology, blood typing, and Rh grouping (includes codes 85022 or 85031, 81000, 86592, 86082, and 86100) | $ 38.50 |
| 89180 | Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of stools, others (specify) | 10.00 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.2500 DENTISTS.**

*[For text of subpart 1, see M R. 1985]*

Subp. 2. **Diagnostic.** The following codes, service descriptions, and maximum fees apply to diagnostic services.

| Code | Service | Maximum Fee |
|---|---|---|
| 02825 | Removal of tooth, soft tissue impaction | $65.00 |
| 02826 | Removal of tooth, partial bony impaction | 75.00 |
| 02827 | Removal of tooth, complete bony impaction | 75.00 |
| 02832 | Alveolectomy with or without alveoloplasty, six teeth (quadrant) | 70.00 |

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Subp. 6. [Repealed, 10 SR 765]

Subp. 7. [Repealed, 10 SR 765]

Subp. 8. [Repealed, 10 SR 765]

Subp. 9. [Repealed, 10 SR 765]

Subp. 10. [Repealed, 10 SR 765]

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.2600 OPTOMETRISTS, OPTICIANS.**

*[For text of subpart 1, see M R. 1985]*

Subp. 2. **Basic optometric services.** The following codes, service descriptions, and maximum fees apply to basic optometric services.

| Code | Service | Maximum Fee |
|---|---|---|
| 06503 | Trifocal lens | $108.00 |
| 06506 | Frames | 69 00 |
| 06587 | Contact lens, soft | 161.00 |
| 06589 | Dispensing fee, single vision lens | 36.10 |
| 06592 | Dispensing fee, special lenses (e g. prisms, tints, or lenticular) | 10 00 |
| 06593 | Dispensing fee, frames | 45.20 |
| 09201 | Eye examination with complete visual fields included | 40.00 |
| 09203 | Eye examination with slit lamp angle testing | 49.00 |
| 09206 | Orthoptic evaluation | 35.00 |
| 09213 | Eye refraction | 38.00 |

Subp 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp 5. [Repealed, 10 SR 765]

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.2700 AUDIOLOGISTS AND SPEECH PATHOLOGISTS.**

*[For text of subpart 1, see M R 1985]*

Subp. 2 **Audiology.** The following codes, service descriptions, and maximum fees apply to audiology services.

| Code | Service | Maximum Fee |
|---|---|---|
| 06665 | Monaural dispensing fee | $190.00 |

Subp. 3. [Repealed, 10 SR 765]

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.**

*[For text of subpart 1, see M R 1985]*

Subp. 2. **Physical therapy.** The following codes, service descriptions, and maximum fees apply to physical therapy procedures

Evaluations

| Code | Service | Maximum Fee |
|---|---|---|
| 90900 | Biofeedback training, by electromyogram application (e.g. in tension headache, muscle spasm) | $22.00 |

Modalities

| | | |
|---|---|---|
| 97039 | Unlisted modality (specify) procedures | $30 00 |
| 97120 | Iontophoresis, first 30 minutes | 15.00 |
| 97128 | Ultrasound, first 30 minutes | 14.00 |
| 97145 | Physical medicine treatment to one | |

| | | |
|---|---|---|
| | area, each additional 15 minutes | 10.00 |
| 97500 | Orthotics training (dynamics bracing, splinting), upper extremities, initial 30 minutes, each visit | 20.00 |
| 97501 | each additional 15 minutes | 12.00 |
| 97540 | Activities of daily living (ADL) and diversional activities, initial 30 minutes, each visit | 15.40 |
| 97541 | each additional 15 minutes | 10.00 |
| | Tests and Measurements | |
| 97720 | Extremity testing for strength, dexterity, or stamina; initial 30 minutes, each visit | 50.00 |
| 97740 | Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes | 15.00 |

Subp. 3. [Repealed, 10 SR 765]

**Statutory Authority:** *MS s 176.136*

**History:** *10 SR 765*

**5221.2900 CHIROPRACTORS.**

*[For text of subpart 1, see M.R 1985]*

Subp. 2. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services

| Code | Service | Maximum Fee |
|---|---|---|
| 09510 | Routine initial examination, history and diagnosis | $ 35.00 |
| 09502 | Extensive examination with history and diagnosis, complete history and physical examination of one or more systems, with report | 60.00 |
| 09509 | Home or nursing home visit with routine chiropractic examination and/or treatment which includes adjustment, manipulation, and/or one unit of conjunctive therapy for the same or new condition | 40.00 |
| 09009 | Same visit, each additional conjunctive or manipulative therapy per anatomical area of diagnosis, for example, neck, back, extremities — anatomical areas include associated soft tissues and nerves. Includes office visit | 12.00 |
| 09504 | Treatment, one unit of manipulative or conjunctive therapy (specify). Includes office visit | 20.00 |
| 09505 | Treatment, one unit of manipulative and one unit of conjunctive therapy (specify). Includes office visit | 30 00 |
| 09507 | Ambulation traction application | 10.00 |

Subp. 3. **Radiology.** The following codes, service descriptions, and maximum fees apply to radiology services, and include both the technical and professional (interpretive) components of the service.

Chest

| Code | Service | Maximum Fee |
|---|---|---|
| 71010 | Radiologic examination, chest, (single view, posteroanterior) | $ 25.00 |
| 71100 | Radiologic examination, ribs, unilateral; two views | 86.00 |
| | Spine and Pelvis | |
| 72010 | Radiologic examination, spine, entire, survey study (14 x 36, anteroposterior and lateral) | $ 55.00 |
| 72020 | Radiologic examination, spine, single view, (specify level) | 40.00 |
| 72080 | thoracic, limited (anteroposterior and lateral) | 44.00 |
| 72090 | scoliosis study, comprehensive | 40.00 |
| 72100 | Radiologic examination, spine, lumbar, limited (anteroposterior and lateral) | 56.00 |
| | Upper Extremities | |
| 73020 | Radiologic examination, shoulder; limited (one projection) | $ 30.00 |
| 73120 | Radiologic examination, hand | 25.00 |
| | Lower Extremities | |
| 73500 | Radiologic examination, hip; limited (one view) | $22.00 |
| 73610 | Radiologic examination, ankle; comprehensive (minimum of three views) | 48.00 |
| | Miscellaneous | |
| 76140 | Consultation on x-ray examination made elsewhere, written report | $ 30.00 |

Subp. 4. **Laboratory.** The following codes, service descriptions, and maximum fees apply to laboratory procedures. Automated, standard chemistry profiles include the following tests:

Albumin
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Cephalin flocculation
Chlorides
Cholesterol
Creatinine
Hemoglobin
Hematocrit
Lactic dehydrogenase
Phosphatase, acid
Phosphatase, alkaline
Phosphorus
Potassium
Protein, total
Red blood cell count

Sodium
Sugar (glucose)
Thymol turbidity
Transaminase, gluten, exalic (SGOT)
Transaminase, gluten, pyruvic (SGPT)
Triglycerides
Urea nitrogen
Uric acid
White blood cell count

| Code | Service | Maximum Fee |
|---|---|---|
| 80016 | Automated multichannel test; 13-16 clinical chemistry tests | $90.00 |
| 80019 | 19 or more clinical chemistry tests (indicate instrument used and number of tests performed) | 69.00 |
| 81015 | Urinalysis; microscopic only | 10.00 |
| 87164 | Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection | 35.00 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765; 10 SR 974*

NOTE The text of subpart 3 reads as printed in the errata at 10 State Register, page 974 on October 21, 1985

**5221.3000 PODIATRISTS.**

*[For text of subpart 1, see M.R. 1985]*

Subp 2. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Office Medical Services

| Code | Service | Maximum Fee |
|---|---|---|
| 90000 | New patient, brief service | $25.00 |
| 90010 | New patient, limited service | 35.00 |
| 90015 | New patient; intermediate service | 25.00 |
| 90017 | New patient, extended service | 25.00 |
| 90020 | New patient, comprehensive service | 28.00 |
| 90030 | Established patient, minimal service | 16.00 |
| 90040 | Established patient; brief service | 20.00 |
| 90050 | Established patient; limited service | 22 00 |
| 90060 | Established patient; intermediate service | 22.00 |
| 90070 | Established patient, extended service | 25 00 |
| 90080 | Established patient; comprehensive service | 25.00 |

Hospital Medical Services

| | | |
|---|---|---|
| 90200 | Brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records | $60.00 |
| 90215 | Intermediate examination | 40.00 |

| | | |
|---|---|---|
| | Therapeutic Injections | |
| 90782 | Therapeutic injection of medication (specify), subcutaneous or intramuscular | $20.00 |
| | Physical Medicine | |
| 95851 | Range of motion measurements and report (separate procedure); each extremity | $ 8.00 |
| 97010 | Physical medicine treatment to one area; hot or cold packs | 28.00 |
| 97022 | Whirlpool | 17.50 |
| 97110 | Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises | 24.50 |
| 97128 | Ultrasound | 13.00 |
| | Other Procedures | |
| 02229 | Radical excision of nail | $175 00 |

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.3100 PSYCHOLOGISTS AND SOCIAL WORKERS.**

*[For text of subpart 1, see M R 1985]*

Subp. 2. **Psychological services.** The following codes, service descriptions, and maximum fees apply to psychological services.

| Code | Service | Maximum Fee |
|---|---|---|
| 09050 | Initial consultation, one hour | $75.00 |
| 09064 | Biofeedback, per hour | 58.50 |
| 09066 | Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed consulting psychologist, one hour | 70.00 |
| 09068 | Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour | 45.00 |
| 09070 | Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge) | 65.00 |

Subp. 3. [Repealed, 10 SR 765]

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*

**5221.3200 HOSPITAL; SEMI-PRIVATE ROOM CHARGES.**

*[For text of subpart 1, see M.R 1985]*

Subp. 2. **Group 1.** The following hospitals make up group 1:

*[For text of subp 2, items A to BB, see M R 1985]*

| Service | Maximum Fee |
|---|---|
| Group 1 semi-private room charge for one day | $223.00 |

Subp. 3. **Group 2.** The following hospitals make up group 2.

*[For text of subp 3, items A to MMMM, see M.R. 1985]*

NNNN. Regina Memorial Hospital, Hastings
OOOO. Renville County Hospital, Olivia
PPPP. Rice County District One Hospital, Faribault
QQQQ. Rice Memorial Hospital, Willmar
RRRR Riverview Hospital, Crookston
SSSS. Roseau Area Hospital, Roseau
TTTT. Rush City Hospital, Rush City
UUUU Saint Ansgar Hospital, Moorhead
VVVV. Saint Elizabeth Hospital, Wabasha
WWWW. Samt Francis Hospital, Breckenridge
XXXX. Saint Francis Regional Medical Center, Shakopee
YYYY. Samt Gabriel's Hospital, Little Falls
AAAAA. Saint John's Hospital, Red Lake Falls
BBBBB Saint John's Hospital, Red Wing
CCCCC. Saint Joseph's Hospital, Bramerd
DDDDD. Saint Joseph's Hospital, Park Rapids
EEEEE. Saint Mary's Hospital, Detroit Lakes
FFFFF. Samt Mary's Hospital, Winstead
GGGGG. Saint Michael's Hospital, Sauk Centre
HHHHH. Saint Olaf Hospital, Austin
IIIII. Sandstone Area Hospital, Sandstone
JJJJJ. Sanford Memorial Hospital, Farmington
KKKKK. Sioux Valley Hospital, New Ulm
LLLLL. Sleepy Eye Municipal Hospital, Sleepy Eye
MMMMM. Springfield Community Hospital, Springfield
NNNNN. Stevens County Memorial Hospital, Morris
OOOOO. Swift County-Benson Hospital, Benson
PPPPP. Tracy Municipal Hospital, Tracy
QQQQQ Tri-County Hospital, Wadena
RRRRR. Trimont Community Hospital, Trimont
SSSSS Trinity Hospital, Baudette
TTTTT. Tweeten Memorial Hospital, Spring Grove
UUUUU. United District Hospital, Staples
VVVVV. United Hospital, Blue Earth
WWWWW. Virginia Regional Medical Center, Virginia
XXXXX. Waconia Ridgeview Hospital, Waconia
YYYYY. Warren Community Hospital, Warren
AAAAAA. Watonwan Memorial Hospital, St. James
BBBBBB. Weiner Memorial Medical Center, Marshall
CCCCCC Wells Municipal Hospital, Wells
DDDDDD. Wheaton Community Hospital, Wheaton
EEEEEE. White Community Hospital, Aurora

FFFFFF. Windom Area Hospital, Windom
GGGGGG. Winona General Hospital, Winona
HHHHHH Worthington Regional Hospital, Worthington
IIIIII. Zumbrota Community Hospital, Zumbrota

| Service | Maximum Fee |
|---|---|
| Group 2 semi-private room charge for one day | $179.00 |

Subp 4. **Group 3.** The following hospitals make up group 3:
*[For text of subp 4, items A to C, see M R. 1985]*

| Service | Maximum Fee |
|---|---|
| Group 3 semi-private room charge for one day | $278.86 |

Subp. 5. **Group 4.** The following hospitals make up group 4:
*[For text of subp 5, items A and B, see M R. 1985]*

| Service | Maximum Fee |
|---|---|
| Group 4 semi-private room charge for one day | $158.86 |

**Statutory Authority:** *MS s 176 136*

**History:** *10 SR 765*