CHAPTER 5221
DEPARTMENT OF LABOR AND INDUSTRY
FEES FOR MEDICAL SERVICES

5221.0100 DEFINITIONS.

Subpart 1. **Scope.** The following terms have the meanings given in this chapter unless the context clearly indicates a different meaning.

Subp. 1a. **Appropriate record.** "Appropriate record" is a legible medical record or report which substantiates the nature and necessity of a service being billed and its relationship to the work injury.

Subp. 2. **Bill or billing.** "Bill" or "billing" means a provider's statement of charges and services rendered for treatment of a work related injury.

Subp. 3. **Charge.** "Charge" means the payment requested by a provider on a bill for a particular service. This chapter does not prohibit a provider from billing usual and customary charges which are in excess of the amount listed in the fee schedule.

Subp. 4. **Code.** "Code" means the alphabetic or numeric designation, including code modifiers if appropriate, for a particular type of service, or supply, to categorize provider charges on a bill.

Subp. 5. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry.

Subp. 6. **Compensable injury.** "Compensable injury" means an injury or condition for which a payer is liable under Minnesota Statutes, chapter 176.

Subp. 7. **Excessive charge.** "Excessive charge" means a charge for a service rendered to treat a compensable injury, which meets any of the conditions of excessiveness described in part 5221.0500.

Subp. 8. **Excessive service.** "Excessive service" means any service rendered to treat a compensable injury that meets any of the conditions of excessiveness described in part 5221.0550.

Subp. 9. **Injury.** "Injury" is as defined in Minnesota Statutes, section 176.011, subdivision 16 as a "personal injury."

Subp. 10. **Medical fee schedule.** "Medical fee schedule" means the list of codes, service descriptions, and corresponding dollar amounts allowed under Minnesota Statutes, section 176.136, subdivisions 1 and 5, and parts 5221.1000 to 5221.3500.

Subp. 11. **Payer.** "Payer" refers to any entity responsible for payment and administration of workers' compensation claims under Minnesota Statutes, chapter 176.

Subp. 12. **Provider.** "Provider" is as defined in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 13. **Reasonable charge.** "Reasonable charge" means a charge or portion of a charge for treatment of a compensable injury that is not excessive under part 5221.0500.

Subp. 14. **Reasonable service.** "Reasonable service" means a service for treatment of a compensable injury that is not excessive under part 5221.0550.

Subp. 15. **Service or treatment.** "Service" or "treatment" means any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing or relieving an injured worker from the effects of a compensable injury under Minnesota Statutes, section 176.135, subdivision 1.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609; 15 SR 124*

5221.0200 AUTHORITY.

This chapter is adopted under the authority of Minnesota Statutes, sections 176.136 and 176.83, subdivision 4.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0300 PURPOSE.

This chapter is intended to prohibit health care providers treating employees with compensable injuries from receiving excessive reimbursement for their services. This chapter defines when medical charges and services are excessive.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0400 SCOPE.

The following are subject to this chapter: all entities responsible for payment and administration of medical claims compensable under Minnesota Statutes, chapter 176; and providers of medical services or supplies for compensable injuries under Minnesota Statutes, section 176.135, subdivision 1.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0500 EXCESSIVE CHARGES.

A charge is excessive if any of the following conditions apply to the charge:

A. the charge exceeds the amount for the type of service allowed in the medical fee schedule of this chapter; or

B. if not specified in the medical fee schedule, the charge exceeds that which prevails in the same geographic community for similar services or treatment as specified in Minnesota Statutes, section 176.135, subdivision 3; or

C. the charge wholly or partially duplicates another charge for the same service, such that the charge has been paid or will be paid in response to another billing; or

D. the charge exceeds the provider's current charge for the same type of service in cases unrelated to workers' compensation injuries; or

E. the charge does not comply with standards and requirements adopted pursuant to Minnesota Statutes, section 176.83, concerning the cost of treatment; or

F. the charge is described by a billing code that does not accurately reflect the actual service provided.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0550 EXCESSIVE SERVICES.

A service is excessive to the degree that any of the following standards apply to the service:

A. the service does not comply with the standards and requirements adopted under Minnesota Statutes, section 176.83, concerning the reasonableness and necessity, quality, coordination, and frequency of services; or

B. the service was performed by a provider prohibited from receiving reimbursement under Minnesota Statutes, chapter 176, pursuant to Minnesota Statutes, section 176.83; or

C. the service is not usual, customary, and reasonably required for the cure or relief of the effects of a compensable injury.

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609*

5221.0600 PAYER RESPONSIBILITIES.

Subpart 1. **Compensability.** This chapter does not require a payer to pay a charge for a service that is not for the treatment of a compensable injury or a charge that is the primary obligation of another payer.

Subp. 2. **Determination of excessiveness.** Subject to a determination of the commissioner or compensation judge, the payer shall determine whether a charge or service is excessive by evaluating the charge and service according to the conditions of excessiveness specified in parts 5221.0500 and 5221.0550.

Subp. 3. **Determination of charges.**

A. As soon as reasonably possible, and no later than 30 calendar days after receiving the bill, the payer shall:

(1) pay the charge or any portion of the charge that is not denied; and/or

(2) deny all or a portion of a charge on the basis that the injury is noncompensable, or the service or charge is excessive; and/or

(3) request specific additional information to determine whether the charge or service is excessive or whether the condition is compensable. The payer shall make a determination as set forth in subitems (1) and (2) no later than 30 calendar days following receipt of the provider's response to the initial request for specific additional information.

B. If a service is not included in the medical fee schedule under parts 5221.1100 to 5221.3600, and the charge and service are not otherwise excessive under parts 5221.0500 and 5221.0550, the payer shall evaluate the charge against the usual and customary charges prevailing in the same geographic community for similar services, in accordance with Minnesota Statutes, section 176.135, subdivision 3. If the charge submitted is less than or equal to the prevailing and customary charges, the payer shall pay the charge in full. If the charge exceeds the prevailing usual and customary charges, the payer shall pay an amount equal to the usual and customary charges for similar services.

Subp. 4. **Notification.** Within 30 calendar days of receipt of the bill, the payer shall provide written notification to the employee and provider of denial of part or all of a charge, or of any request for additional information. Written notification shall include:

A. the basis for denial of all or part of a charge that the payer has determined is not for a compensable injury under part 5221.0100, subpart 6;

B. the basis for denial or reduction of each charge and the specific amounts being denied or reduced for each charge meeting the conditions of an excessive charge under part 5221.0500;

C. the basis for denial of each charge meeting the conditions of an excessive service under part 5221.0500; and/or

D. a request for an appropriate record and/or the specific information requested to allow for proper determination of the bill under this part.

Subp. 5. **Penalties.** Failure to comply with the requirements of this part may subject the payer to the penalties provided in Minnesota Statutes, sections 176.221, 176.225, and 176.194.

Subp. 6. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reim-

bursement was excessive. The payer must demand reimbursement of the excessive payment from the provider within one year of the payment.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0700 PROVIDER RESPONSIBILITIES.

Subpart 1. **Usual charges.** No provider shall submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensation injuries.

Subp. 2. **Submission of information.** Providers shall include on bills the patient's name, date of injury, and the employer's name, service descriptions and codes which accurately describe the services provided and the injuries or conditions treated, the date on which each service was provided, and the providers' tax identification number. Providers must also supply a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge.

Subp. 3. **Billing code.** The provider shall undertake professional judgment to assign the correct approved billing code for the service rendered using the appropriate provider group designation.

A. Approved billing codes. Billing codes must be found in the most recent edition of the following: Physician's Current Procedural Terminology; Blue Cross/Blue Shield specialty procedure codes; HCFA (Health Care Financing Administration) Common Procedure Coding System (HCPCS); Code on Dental Procedures and Nomenclature maintained by the Council on Dental Care Programs; and for audiology and speech therapy, the "home–grown" codes specified by the Department of Human Services or any other code listed in the medical fee schedule.

B. Format of the terminology. CPT procedure terminologies have been developed as stand–alone descriptions of medical procedures. However, some of the procedures in CPT are not printed in their entirety but refer back to a common portion of the procedure listed in a preceding entry. This is evident when an entry is followed by one or more indentions. Any terminology after the semicolon shall have a subordinate status as do the subsequent indented entries.

Code	Service	Maximum fee
25100	Arthrotomy, wrist joint; for biopsy	
25105	for synovectomy	

The common part of code 25100 (that part before the semicolon) shall be considered part of code 25105. Therefore the full procedure represented by code 25105 should read:

25105	Arthrotomy, wrist joint; for synovectomy	

C. The codes for services in parts 5221.1100 to 5221.2400 may be submitted with two–digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in subitems (1) to (20).

(1) Modifier number 20 denotes microsurgery. This modifier is appropriate to surgical services performed using the techniques of microsurgery, requiring the use of an operating microscope. This modifier shall not apply for surgery done with the aid of a magnifying surgical loupe whether attached to the eyeglasses or a headband. Services with this modifier are not subject to the medical fee schedule.

(2) Modifier number 22 denotes unusual services. This modifier is appropriate where the service provided is significantly greater than what is usually required for the listed procedure, or where service was provided under highly unusual circumstances. Unusual circumstances include major complications or difficulties associated with the patient's condition, the medical facilities, or other causes. Unusual circumstances do not include common differences among services of a kind or magnitude which is typical within a particular

code category. This modifier does not exempt a service from the maximum fee for the five–digit code, except where the increased services or unusual circumstances may be reasonably expected to significantly increase the provider's cost.

(3) Modifier number 23 denotes unusual anesthesia.This modifier is appropriate to services which usually require no anesthesia or local anesthesia only, where unusual circumstances require that surgery be done under general anesthesia. Services with this modifier are not subject to the medical fee schedule.

(4) Modifier number 26 denotes professional component. This modifier is appropriate to services when the professional services are reported separately and do not include the technical component, (for example, laboratory, radiology, electrocardiogram, specific diagnostic and therapeutic services), where the physician component only is provided. This modifier does not exempt a service from the maximum fee for the five–digit code. If a separate maximum fee is provided for a five–digit code with the number 26 modifier, the separate maximum fee applies.

(5) Modifier number 47 denotes anesthesia by surgeon. This modifier is appropriate to services where regional or general, not local, anesthesia is provided by the surgeon. Services with this modifier are not subject to the maximum fee schedule.

(6) Modifier number 50 denotes bilateral procedures. Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session shall be identified by the appropriate five–digit code describing the first procedure. The second bilateral procedure shall be identified by adding modifier 50 to the procedure number.

(7) Modifier number 51 denotes multiple procedures. When multiple procedures are performed at the same operative session, the major procedure shall be reported as listed without modifiers. The secondary, additional, or lesser procedures shall be identified by adding the modifier 51 to the secondary procedure numbers.

(8) Modifier number 52 denotes reduced services. This modifier is appropriate where the service provided is significantly less than is usually required for the listed procedure. This modifier does not exempt the service from the maximum fee for the five–digit code.

(9) Modifier number 54 denotes surgical care only.This modifier is appropriate to services where the physician performs a surgical procedure, but does not provide preoperative or postoperative management. This modifier does not exempt the service from the maximum fee for the five–digit code.

(10) Modifier number 55 denotes postoperative management only. This modifier is appropriate to services where the physician provides postoperative management, but does not perform the surgical procedure. This modifier does not exempt the service from the maximum fee for the five–digit code.

(11) Modifier number 56 denotes preoperative management only. This modifier is appropriate to services where the physician provides preoperative management, but does not perform the surgical procedure. This modifier does not exempt the service from the maximum fee for the five–digit code.

(12) Modifier number 66 denotes surgical team. This modifier is appropriate to highly complex services carried out under the surgical team concept. These services require the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment. Services with this modifier are not subject to the medical fee schedule.

(13) Modifier number 75 denotes concurrent care. This modifier is appropriate to services where the patient's condition requires the additional services of more than one physician. This modifier does not exempt the service from the maximum fee for the five–digit code.

(14) Modifier number 76 denotes repeat procedure by same physician. This modifier is appropriate to a service repeated subsequent to the original service by the same physician. This modifier does not exempt the service from the maximum fee for the five–digit code.

(15) Modifier number 77 denotes repeat procedure by another physician. This modifier is appropriate to a service repeated subsequent to the original service by another physician. This modifier does not exempt the service from the maximum fee for the five–digit code.

(16) Modifier number 80 denotes assistant surgeon. This modifier is appropriate to services where a physician provides significant assistance to another physician performing a surgical procedure. This modifier does not exempt the service from the maximum fee for the five–digit code.

(17) Modifier number 81 denotes minimum assistant surgeon. This modifier is appropriate to services where a physician provides minimal assistance to another physician performing a surgical procedure. This modifier does not exempt the service from the maximum fee for the five–digit code.

(18) Modifier number 90 denotes reference or outside laboratory. This modifier is appropriate to laboratory services performed by a party other than the treating physician. This modifier does not exempt the service from the maximum fee for the five–digit code.

(19) Modifier number 99 denotes multiple modifiers. This modifier is appropriate to services where two or more modifiers may be necessary to completely describe the service. This modifier does not exempt the service from the maximum fee for the five–digit code, unless one or more of the component modifiers is exempt from the medical fee schedule.

(20) Modifier TC denotes technical component. This modifier applies to codes for services when the technical component is reported separately and does not include the professional component.

Subp. 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section 176.138, providers shall comply within seven working days with payers' proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness.

Subp. 5. **Collection of excessive charges.** No provider shall collect or attempt to collect payment from an injured employee or any other insurer or any other government for an excessive charge. A charge must be removed by the provider from subsequent billing statements if the payer has determined the charge is excessive and a claim for the excessive charge is not filed with the commissioner by the provider or employee, or it is determined by the commissioner, compensation judge, or on appeal to be excessive.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0800 DISPUTE RESOLUTION.

Pursuant to Minnesota Statutes, sections 176.106 and 176.271 and related statutes and rules, the employee, employer, or insurer may request a determination of whether a charge or service is excessive. Such requests shall be made to the commissioner in writing on a form prescribed for that purpose. Under Minnesota Statutes, section 176.136, subdivision 2, a provider may request a determination of whether a charge is excessive under part 5221.0500. An employee, employer, insurer, health care provider, or intervenor who disagrees with a determination under Minnesota Statutes, section 176.106 or 176.305 may request a formal hearing before a compensation judge at the Office of Administrative Hearings. The request shall be made on a form prescribed by the commissioner.

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.0900 [Repealed, 13 SR 2609]

5221.1000 INSTRUCTIONS FOR APPLICATION OF THE MEDICAL FEE SCHEDULE FOR REIMBURSEMENT OF WORKERS' COMPENSATION MEDICAL SERVICES.

Subpart 1. **Contents.** This chapter contains the medical fee schedule. The medical fee schedule shall contain codes and descriptions of services compensable under Minnesota

Statutes, section 176.135, and dollar amounts equal to the 75th percentile of the usual and customary charges for those services by provider groups in Minnesota during the preceding calendar year.

Subp. 2. **Revisions.** The commissioner shall revise the medical fee schedule at least annually to substitute charge data from the preceding calendar year. Until revisions are adopted, the current medical fee schedule remains in force. The commissioner may revise the medical fee schedule at any time to:

A. improve the schedule's accuracy, fairness, or equity;

B. simplify the administration of the schedule;

C. encourage providers to develop and deliver services; or

D. to accommodate improvements or correct data base deficiencies. The Medical Services Review Board shall advise the commissioner regarding these revisions.

Subp. 3. **Medical fee schedule instructions.** The instructions in this part and this chapter govern the use and application of fees in this chapter.

Subp. 4. **Applicability of the fee schedule.** The payer shall undertake reasonable investigations to ascertain whether a service and its corresponding charge is subject to the medical fee schedule. A charge is subject to the medical fee schedule if it conforms to a code under part 5221.0700, subpart 3, item A, and is included in the medical fee schedule for the appropriate provider group. If a service is not included in the medical fee schedule under parts 5221.1100 to 5221.3600, and the charge and service are not otherwise excessive under parts 5221.0500 and 5221.0550, the payer shall evaluate the charge against the usual and customary charges prevailing in the same geographic community for similar services in accordance with Minnesota Statutes, section 176.135, subdivision 3. If the charge submitted is less than or equal to the prevailing and customary charges, the payer shall pay the charge in full. If the charge exceeds the prevailing usual and customary charges, the payer shall pay an amount equal to the usual and customary charges for similar services.

Subp. 5. **Coding.** The payer shall undertake reasonable investigations to determine whether or not the code listed for a service by the provider is correct under part 5221.0700, subpart 3, item A, and subject to the medical fee schedule. If an incorrect code for a service has been listed, the payer may determine the correct code for the service, and may evaluate the service on the basis of the proposed change. Neither the provider nor the payer may divide a broad inclusive service into its component services, charges, and codes, if the broad inclusive service is subject to the medical fee schedule. If the broad inclusive service is not subject to the medical fee schedule, it may be divided into its component services if any of those components are subject to the medical fee schedule.

Subp. 6. **Ambiguity.** If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service and its corresponding charge is subject to the medical fee schedule or what the correct code for a particular service is, the payer shall contact the provider and attempt to resolve the ambiguity. The provider shall cooperate in resolving this ambiguity. If the parties are unable to come to an agreement, either party may file a request for a determination with the commissioner under part 5221.0800.

Subp. 7. [Renumbered 5221.0700, subpart 3, item C, subitems (1) to (20)]

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 13 SR 2609*

5221.1100 PHYSICIAN SERVICES; MEDICINE.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of medicine or a doctor of osteopathy. This includes services performed by or under the direct supervision of the physician.

Subp. 2. **Definitions.** The terms defined in this subpart have the meanings given them when used in subparts 3, 4, and 5 unless the context clearly indicates a different meaning.

A. New patient. "New patient" means a patient whose medical and administrative records for a work injury or condition need to be established, or a known patient with a new industrial injury or condition.

B. Established patient. "Established patient" means a patient whose medical and administrative records for the work injury or condition are available to the physician.

C. Level of service. "Level of service" refers to the quantity or quality of skill, effort, time, responsibility, or medical knowledge required for the diagnosis and treatment of injuries, and is appropriate to examinations, evaluations, treatment, conferences with or concerning patients, and similar services; and includes preparation of an appropriate record that documents the elements of the level of service. The levels of service are, in increasing order of complexity, minimal, brief, limited, intermediate, extended, and comprehensive. The minimal level of service does not apply to new patient office services or hospital services.

D. Minimal service. "Minimal service" means a level of service supervised by the physician but not necessarily requiring the physician's presence, including but not limited to services similar to the following in level:

(1) routine immunization for tetanus;

(2) removal of sutures from laceration; or

(3) blood pressure determination for adequacy of control.

E. Brief service. "Brief service" means a level of service pertaining to the evaluation and treatment of a condition requiring only an abbreviated history and examination, including but not limited to services similar to the following in level:

(1) examination of a patient with subconjunctival hemorrhage;

(2) examination of minor trauma;

(3) review of recent x–ray report and abbreviated discussion with patient under study;

(4) concurrent hospital care for a minor secondary diagnosis;

(5) examination for acute tonsillitis; or

(6) abbreviated evaluation of a hospitalized patient in stage of recovery from an uncomplicated renal colic.

F. Limited service. "Limited service" means a level of service pertaining to the evaluation of a circumscribed acute illness or to the periodic reevaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings or medical management, including, but not limited to, services similar to the following in level:

(1) treatment of acute respiratory infection;

(2) review of interval history, physical status, and control of a diabetic patient;

(3) review of hospital course, studies, orders, and chest examination of patient with rheumatic heart disease recovering from acute congestive failure; revision of orders and limited exchange with nursing staff;

(4) review of interval history, physical status, and adjustment of medication in patient with compensated arteriosclerotic heart disease on chronic diuretic therapy;

(5) review of mental status findings, limited team conference for an exchange with nursing and ancillary personnel, and revision of medical management orders on a patient with a toxic psychosis; or

(6) review of recent history, determination of blood pressure, auscultation of heart and lungs, and adjustment of medication in essential hypertension.

G. Intermediate service. "Intermediate service" means a level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem, not necessarily relating to the primary diagnosis, that necessitates the obtaining and evaluation of pertinent history and physical or mental status findings, diagnostic tests and procedures, and the ordering of appropriate therapeutic management; or a formal patient, family, or hospital staff conference regarding patient medical management and progress, including, but not limited to, services similar to the following in level:

(1) the evaluation of a patient with arteriosclerotic heart disease with recent onset of unstable angina previously on an adequate therapeutic program involving a detailed interval history and physical examination and ordering of appropriate diagnostic tests and discussion of new therapeutic management;

(2) review of hospital studies and course in conjunction with a team conference for a formal meeting with nursing and ancillary personnel regarding medical management of a patient with acute schizophrenic symptoms;

(3) review of interval history, reexamination of musculoskeletal systems and abdomen, discussion of findings, and adjustment of therapeutic program in a patient with arthritic disorders with recently developed gastric complaints;

(4) review of recent illness, reexamination of pharynx, neck, axilla, groin, and abdomen, interpretation of laboratory tests, and prescription of treatment in a patient with chronic lymphocytic leukemia not responding to a previous management plant; or

(5) conference with patient family to review studies, hospital course, and findings in a teenager with acute hepatitis secondary to drug abuse.

H. Extended service. "Extended service" means a level of service requiring an unusual amount of effort or judgment including a detailed history, review of medical records, examination, and a formal conference with patient, family, or staff; or a comparable medical diagnostic or therapeutic service, including, but not limited to, services similar to the following in level:

(1) reexamination of neurological findings, detailed review of hospital studies and course, and formal conference with patient and family jointly concerning findings and plans in a diagnostic problem of suspected intracranial disease in a young adult;

(2) detailed intensive review of studies and hospital course and thorough reexamination of pertinent physical findings of a patient with a recent coronary infarct with complications requiring constant physician bedside attention;

(3) review of results of diagnostic evaluation, performance of a detailed examination and a thorough discussion of physical findings, laboratory studies, x–ray examinations, diagnostic conclusions, and recommendations for treatment of complicated chronic pulmonary disease;

(4) detailed review of studies and hospital course and thorough reexamination of pertinent physical findings of a patient with a recent coronary infarct and formal conference with patient or family to review findings and prognosis;

(5) reevaluation of a psychotic delusional patient who develops severe and acute abdominal pain involving a mental status reassessment but not a psychiatric diagnostic interview, and a conference with the consulting surgeon and nursing personnel; or

(6) detailed intensive review of studies and hospital course and thorough reexamination of pertinent findings of a patient with a recently diagnosed uterine adenocarcinoma who also has a pulmonary coin lesion under consideration for thoracotomy. This service involves several abbreviated conferences with consultants, and family or patient.

I. Comprehensive service. "Comprehensive service" means a level of service providing an in–depth evaluation of a patient with a new or existing problem requiring the development or complete reevaluation of medical data. This procedure includes the recording of a chief complaint, the present illness, family history, past medical history, personal history, system review, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures.

J. Brief initial hospital care. "Brief initial hospital care" includes brief history and treatment programs, and preparation of hospital records, and signifies a level of service for a condition involving variables for which neither comprehensive nor intermediate initial hospital care services are appropriate. This procedure includes documentation of the need for inpatient medical care, abbreviated history, pertinent examination, and a plan of investigation or medical management.

K. Intermediate initial hospital care. "Intermediate initial hospital care" includes intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records. It is a service involving the evaluation or reevaluation of a patient with an acute or active problem that requires hospitalization. This procedure includes the recording of the chief complaint, present illness or current medical history, an appropriate physical examination related to the acute or active problem in a patient who has had a previously documented evaluation current and available to the physician, and the ordering of appropriate medical diagnostic tests and procedures.

L. Comprehensive initial hospital care. "Comprehensive initial hospital care" includes comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records, and signifies a level of service consistent with the definition of comprehensive service.

M. Referral. "Referral" means a transfer of the total care or specific care of a patient from one physician to another and does not constitute a consultation.

N. Hospital discharge day management. "Hospital discharge day management" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge record.

Subp. 3. **Office services.** The following codes, service descriptions, and maximum fees apply to services provided at the physician's office, or if provided in an outpatient hospital clinic setting, for nonemergency services.

Code	Service	Maximum Fee
90000–00	Office and other outpatient medical service, new patient; brief service	$ 39.15
90010–00	limited service	47.00
90015–00	intermediate service	60.00
90017–00	extended service	85.00
90020–00	comprehensive service	160.00
90030–00	Office and other outpatient medical service, established patient; minimal service	20.50
90040–00	brief service	28.00
90050–00	limited service	34.00
90060–00	intermediate service	45.00
90070–00	extended service	70.00
90080–00	comprehensive service	110.00

Subp. 3a. **Home services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a home setting if provided in a private residence as a "house call." They do not apply to physician services provided at a nursing home, boarding home, domiciliary (temporary lodging), or custodial care involving periodic services provided to a patient who is institutionalized on a long–term basis.

Code	Service	Maximum Fee
90110–00	Home medical service, new patient; limited service	$ 72.00
90115–00	intermediate service	65.00
90130–00	Home medical service, established patient; minimal service	40.48
90140–00	brief service	43.27
90150–00	limited service	52.00
90160–00	intermediate service	58.00
90170–00	extended service	67.05

Subp. 4. **Hospital services.** The following codes, service descriptions, and maximum fees apply to services provided at a hospital. Initial hospital care is categorized under codes 90200 to 90220. Subsequent hospital care is categorized under codes 90240 to 90292.

Code	Service	Maximum Fee
	Initial Hospital Care	
90200–00	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	$ 80.80
90215–00	intermediate	100.75
90220–00	comprehensive	150.00
	Subsequent Hospital Care	
90240–00	Subsequent hospital care, each day; brief services	$ 35.00
90250–00	limited services	45.00
90260–00	intermediate services	62.00
90270–00	extended services	99.00
90280–00	comprehensive services	111.00
	Hospital Discharge Services	
90292–00	Hospital discharge day management	$ 65.00

Subp. 5. **Skilled nursing, intermediate care, and long–term care facilities.** The following codes, service descriptions, and maximum fees apply to physician services provided in a convalescent, rehabilitative, or long–term care facility and involves active, definitive professional care of a patient.

Code	Service	Maximum Fee
90300–00	Initial care, skilled nursing facility, intermediate care facility, or long–term care facility medical services; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 55.00
90315–00	intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	78.69
90320–00	comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	95.00
90340–00	Subsequent care, skilled nursing facility, intermediate care facility, or long–term care facility medical services; brief service	27.55
90350–00	limited service	36.00
90360–00	intermediate service	41.62
90370–00	extended service	63.00

Subp. 6. **Nursing home, boarding home, domiciliary, or custodial care medical services.** The following codes, service descriptions, and maximum fees apply to physician services provided in a domiciliary or custodial care facility involving periodic services, provided to a patient who is institutionalized on a long–term basis.

Code	Service	Maximum Fee
90400–00	Rest home (e.g., boarding home), domiciliary, or custodial care facility medical service, new patient; brief service	$ 50.00
90410–00	limited service	50.00
90415–00	intermediate service	65.00
90420–00	comprehensive service	75.00
90430–00	Rest home (e.g., boarding home), domiciliary, or custodial care facility medical service, established patient; minimal service	21.34
90440–00	brief service	26.02
90450–00	limited service	35.00
90460–00	intermediate service	63.00
90470–00	extended service	75.00

Subp. 7. **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. They do not apply when physicians elect to use the emergency room as a substitute for their office and an actual emergency situation does not exist.

Code	Service	Maximum Fee
90500–00	Emergency department service, new patient; minimal service	$ 32.00
90505–00	brief service	43.00
90510–00	limited service	58.10
90515–00	intermediate service	85.80
90517–00	extended service	117.60
90520–00	comprehensive service	157.50
90530–00	Emergency department service, established patient; minimal service	28.15
90540–00	brief service	40.00
90550–00	limited service	50.00
90560–00	intermediate service	66.00
90570–00	extended service	90.00
90580–00	comprehensive service	117.50

In physician directed emergency care advanced life support, the physician is located in a hospital emergency or critical care department and is in two–way voice communication with ambulance or rescue personnel outside the hospital. The physician directs the performance of necessary medical procedures, including but not limited to: telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous fluids and/or administration of intramuscular, intratracheal, or subcutaneous drugs; and/or electrical conversion of arrhythmia.

Code	Service	Maximum Fee
90590–00	Physician direction of Emergency Medical Systems (EMS), emergency care, advanced life support	$ 50.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1200 CONSULTATIONS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. **Definitions.** For the purposes of this part the following terms have the meanings given them unless the context clearly indicates a different meaning.

A. Consultation. "Consultation" includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation or management of the patient and the preparation of an appropriate record. When as a result of the consultation the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician cannot be billed as a consultation.

(1) Limited consultation. (90600) "Limited consultation" means a consultation where the physician confines the service to the examination or evaluation of a single organ system. This procedure includes documentation of the complaint, present illness, pertinent examination, review of medical data, and establishment of a plan of management relating to the specific problem, and the preparation of an appropriate record including, but not limited to, services similar in level to a dermatological opinion about an uncomplicated skin lesion.

(2) Intermediate consultation. (90605) "Intermediate consultation" means a consultation where the physician examines or evaluates an organ system, partially reviews the general history, and prepares recommendations and an appropriate record, including, but not limited to, services similar in level to the evaluation of the abdomen for possible surgery that does not proceed to surgery.

(3) Extensive consultation. (90610) "Extensive consultation" means a consultation where the physician evaluates problems that do not require a comprehensive evaluation of the patient as a whole, but includes the documentation of a history of the chief complaint, past medical history and pertinent physical examination, review and evaluation of the past medical data, establishment of a plan of investigative or therapeutic management, and the preparation of an appropriate record. This includes, but is not limited to, services similar in level to the examination of a cardiac patient who needs assessment before undergoing a major surgical procedure or general anesthesia.

(4) Comprehensive consultation. (90620) "Comprehensive consultation" means a consultation that involves an in–depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate record. This includes, but is not limited to, services similar in level to a consultation for a young person with fever, arthritis, and anemia or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of information with primary physician or nursing personnel or family members or other informants, and preparation of a record with recommendations.

(5) Complex consultation. (90630) "Complex consultation" means an uncommonly performed consultation that involves an in–depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate record. This includes, but is not limited to, services similar in level to a consultation for a person with acute myocardial infarction with major complication or a young psychotic adult unresponsive to extensive treatment efforts under consideration for residential care.

B. Follow–up consultation. "Follow–up consultation" means the consultant's reevaluation of a patient on whom the physician has previously rendered an opinion or advice and the preparation of an appropriate record. As an initial consultation, the consultant provides no patient management or treatment.

C. Confirmatory (additional opinion) consultation. "Confirmatory consultation" should be used when the consulting physician is aware of the confirmatory nature of the opinion that is sought, for example, when a patient requests a second or third opinion on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure and the preparation of an appropriate record.

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

Code	Service	Maximum Fee
	Initial Consultation	
90600–00	Initial consultation; limited	$ 73.00
90605–00	intermediate	93.00
90610–00	extended	121.00
90620–00	comprehensive	164.75
90630–00	complex	190.00
	Follow–up Consultation	
90640–00	Follow–up consultation; brief	$ 42.00
90641–00	limited	55.00
90642–00	intermediate	81.00
90643–00	complex	131.00
	Confirmatory (Additional Opinion) Consultation	
90650–00	Confirmatory consultation; limited	$ 70.00
90651–00	intermediate	90.00
90652–00	extended	110.00
90653–00	comprehensive	150.00
90654–00	complex	267.50

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1210 [Repealed, 16 SR 622]

5221.1215 INFUSION THERAPY.

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

Code	Service	Maximum Fee
90780–00	IV infusion therapy, administered by physician or under direct supervision of physician; up to one hour	$ 60.00
90781–00	each additional hour, up to eight hours	82.00

Statutory Authority: *MS s 176.136*

History: *14 SR 722; 15 SR 738; 16 SR 622*

5221.1220 THERAPEUTIC INJECTIONS.

Code	Service	Maximum Fee
90782–00	Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular	$ 15.00
90784–00	intravenous	25.00
90788–00	Intramuscular injection of antibiotic (specify)	17.00

90798–00	Intravenous therapy for severe or intractable allergic disease in physician's office or institution (e.g., theophyllines, corticosteroids, antihistamines)	38.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1300 PSYCHIATRY AND 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. For services provided by a licensed psychologist or social worker with a master of social work degree, see parts 5221.3100 and 5221.3150, respectively.

Code	Service	Maximum Fee
	General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures	
90801–00	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants will be seen in lieu of the patient).	$ 120.00
90825–00	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	80.00
90830–00	Psychological testing by physician, with written report, per hour	85.00
90841–00	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight–oriented, behavior–modifying, or supportive psychotherapy; time unspecified	120.00
90843–00	approximately 20 to 30 minutes	75.00
90844–00	approximately 45 to 50 minutes	110.00
90846–00	Family medical psychotherapy (without the patient present)	42.50
90847–00	Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation and drug management when indicated	95.00
90849–00	Multiple–family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated	155.00

90853–00	Group medical psychotherapy (other than of a multiple–family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated	40.00
90862–00	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	65.00
90870–00	Electroconvulsive therapy (includes necessary monitoring); single seizure	125.00
	Other Psychiatric Therapy	
90880–00	Medical hypnotherapy	$ 61.91
90882–00	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	100.00
90887–00	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	85.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1400 [Repealed, 13 SR 2609]

5221.1410 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
90900–00	Biofeedback training; by electromyogram application (e.g., in tension headache, muscle spasm)	$ 72.00
90906–00	regulation of skin temperature or peripheral blood flow	45.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1450 DIALYSIS.

The following codes, service descriptions, and maximum fees apply to dialysis procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Office and hospital services are not to be reported in addition to the dialysis procedures.

Code	Service	Maximum Fee
90935–00	Hemodialysis procedure with single physician evaluation	$ 261.00
90937–00	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	400.00

90945–00	Dialysis procedure other than hemodialysis (e.g., peritoneal, hemofiltration), with single physician evaluation	250.00
90988–00	Supervision of hemodialysis in hospital or other facility (excluding home dialysis), on monthly basis	132.00
90991–00	Home hemodialysis care, outpatient, for those services either provided by the physician primarily responsible for total hemodialysis care or under the physician's direct supervision, and excludes care for complicating illnesses unrelated to hemodialysis, on a monthly basis	15.32
90994–00	Supervision of chronic ambulatory peritoneal dialysis (CAPD), home or outpatient (monthly)	30.00

Statutory Authority: *MS s 176.136*

History: *15 SR 738; 16 SR 622*

5221.1500 OPHTHALMOLOGICAL SERVICES.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. **Definitions.** The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.

A. New patient and established patient. "New patient"and "established patient" have the meanings given them in part 5221.1100.

B. Level of service. "Level of service" for the purpose of this rule has the meaning given it in part 5221.1100, except for item C regarding intermediate opthalmological service and item D regarding comprehensive opthalmological service.

C. Intermediate ophthalmological service. "Intermediate ophthalmological service" means a level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination, and other diagnostic procedures as indicated and may include the use of mydriasis. Intermediate ophthalmological services do not usually include determination of the refractive state but may do so in an established patient who is under continuing active treatment. Intermediate ophthalmological services include, but are not limited to, services similar to the following in level:

(1) review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition not requiring comprehensive ophthalmological services; or

(2) review of interval history, external examination, ophthalmoscopy, biomicroscopy, and tonometry in established patient with a known cataract not requiring comprehensive ophthalmological services.

D. Comprehensive ophthalmological service. "Comprehensive ophthalmological service" means a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmological examination, gross visual fields, and basic sensorimotor examination. It often includes biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and treatment programs as indicated. Comprehensive ophthalmological services include, but are not limited to, service similar to diagnosis and treatment of a patient with symptoms indicating possible disease of the visual sys-

tem, such as glaucoma, cataract, or retinal disease, or to rule out disease of the visual system, in a new or established patient.

E. Determination of the refractive state. "Determination of the refractive state" means the quantitative procedure that yields the refractive data necessary to determine visual acuity with lenses and to prescribe lenses. It is not a separate medical procedure, or service entity, but is an integral part of the general ophthalmological services, carried out with reference to other diagnostic procedures. The evaluation of the need for and the prescription of lenses is never based on the refractive state alone. Determination of the refractive state is not reported separately. It is usually part of the comprehensive ophthalmological services, but may occasionally be a part of intermediate ophthalmological services to an established patient who, under continuing active treatment with periodic observation, may not require comprehensive reevaluation.

Subp. 3. **Ophthalmological services and fees.** The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, 92002–00 to 92020–00, 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 92225–00 to 92260–00, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

Code	Service	Maximum Fee
	General Services	
92002–00	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	$ 61.00
92004–00	comprehensive, new patient, one or more visits	65.00
92012–00	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	48.00
92014–00	comprehensive, established patient, one or more visits	65.00
92018–00	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	392.00
92020–00	Gonioscopy with medical diagnostic evaluation (separate procedure)	34.73
	Special Services	
92060–00	Sensorimotor examination with medical diagnostic evaluation (separate procedure)	$ 40.00
92065–00	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	50.00
92070–00	Fitting of contact lens for treatment of disease, including supply of lens	80.00

92081–00	Visual field examination with medical diagnostic evaluation; limited examination (e.g. tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	30.00
92082–00	intermediate examination (e.g., multistimulus level, full field, quantitative perimetry, several isopters on Goldmann perimeter or multilevel, full field automated test, such as Octopus program 33 or 34 equivalent)	55.00
92083–00	extended examination, quantitative perimetry (e.g., manual static and kinetic perimetry on Goldmann or Tubingen perimeter or equivalent, or automated static perimetry, complex, such as octopus program 31+41 or 32+41)	68.00
92100–00	Serial tonometry with medical diagnostic evaluation (separate procedure), one or more sessions, same day	26.02
92120–00	Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method	15.00
92140–00	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	18.00

Ophthalmoscopy

92225–00	Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomicroscopy), with medical diagnostic evaluation; initial	$ 43.00
92226–00	subsequent	39.00
92230–00	Ophthalmoscopy, with medical diagnostic evaluation; with fluorescein angioscopy (observation only)	39.00
92235–00	with fluorescein angiography (includes multiframe photography)	169.00
92250–00	with fundus photography	45.00
92260–00	with ophthalmodynamometry	50.00

Other Specialized Services

92270–00	Electro–oculography, with medical diagnostic evaluation	$ 125.00
92275–00	Electroretinography, with medical diagnostic evaluation	189.00
92280–00	Visually evoked potential (response) study, with medical diagnostic evaluation	175.00
92284–00	Dark adaptation examination, with medical diagnostic evaluation	60.00

92285–00	External ocular photography with medical diagnostic evaluation for documentation of medical progress (e.g., close–up photography, slit lamp photography, goniophotography, stereophotography)	37.00
92286–00	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	160.00
	Contact Lenses	
92310–00	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	$ 75.00
92311–00	corneal lens for aphakia, one eye	100.00
92314–00	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	150.00
92325–00	Modification of contact lens (separate procedure), with medical supervision of adaptation	60.00
92326–00	Replacement of contact lens	75.00
	Spectacle Services	
92340–00	Fitting of spectacles, except for aphakia; monofocal	$ 35.00
92358–00	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	21.85

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1600 MR 1987 [Repealed, 12 SR 662]

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
92504–00	Binocular microscopy (separate diagnostic procedure)	$ 12.00
92506–00	Medical evaluation speech, language and/or hearing problems	120.00

92507–00	Speech, language, or hearing therapy, with continuing medical supervision; individual	40.00
92508–00	group	41.00
92511–00	Nasopharyngoscopy with endoscope (separate procedure)	90.00
92512–00	Nasal function studies, e.g., rhinomanometry	56.00
92532–00	Positional nystagmus	24.00
92541–00	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	43.00
92542–00	Positional nystagmus test, minimum of four positions, with recording	43.00
92543–00	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	60.00
92544–00	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	34.00
92545–00	Oscillating tracking test, with recording	32.50
92546–00	Torsion swing test, with recording	175.00
92547–00	Use of vertical electrodes in any or all of above tests counts as one additional test	33.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1700 [Repealed, 13 SR 2609]

5221.1800 CARDIOVASCULAR.

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
	Cardiovascular Services	
92950–00	Cardiopulmonary resuscitation (e.g., cardiac arrest)	$ 233.54
92960–00	Cardioversion, elective, electrical conversion of arrhythmia, external	270.00
92977–00	Thrombolysis, coronary; by intravenous infusion	800.00
92982–00	Percutaneous transluminal coronary angioplasty; single vessel	2,300.00
92984–00	each additional vessel	578.00
93000–00	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	48.00
93005–00	tracing only, without interpretation and/or report	46.55
93010–00	interpretation and report only	22.00
93012–00	Telephonic or telemetric transmission of electrocardiogram rhythm strip	75.00
93015–00	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report	232.00

93017–00	tracing only, without interpretation and report	180.00
93018–00	interpretation and report only	104.00
93024–00	Ergonovine provocation test	473.00
93040–00	Rhythm ECG, one to three leads; with interpretation and report	26.00
93041–00	tracing only without interpretation and report	27.00
93042–00	interpretation and report only	21.50
93220–00	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	56.50
93224–00	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation	250.00
93225–00	recording (includes hook–up, recording, and disconnection)	85.00
93226–00	scanning analysis with report	170.00
93230–00	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor–based analysis with report, physician review and interpretation	265.00
93235–00	Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and noncontinuous recording, and real–time data analysis utilizing a device capable of producing intermittent full–sized waveform tracings, possibly patient activated; includes monitoring and real–time data analysis with report, physician review and interpretation	230.00
93236–00	monitoring and real–time data analysis with report	169.00
93268–00	Patient demand single or multiple event recording with presymptom memory loop, transmission, physician review and interpretation	33.00
93307–00	Echocardiography, real–time with image documentation (2D) with or without M–mode recording; complete	250.00
93308–00	follow–up or limited study	140.00
93312–00	Echocardiography, real–time with image documentation (2D) (with or without M–mode recording), transesophageal	320.00
93320–00	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	96.00
93321–00	follow–up or limited study	139.80
93325–00	Doppler color flow velocity mapping	135.50

93350–00	Echocardiography, real–time with image documentation (2D), with or without M–mode recording, during rest and cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, including electrocardiographic monitoring, with interpretation and report	620.00

Cardiac Catheterization

93501–00	Right heart catheterization	$ 636.00
93503–00	Insertion and placement of flow directed catheter (e.g., Swan–Ganz) for monitoring purposes	399.00
93505–00	Endomyocardial biopsy	730.00
93510–00	Left heart catheterization, retrograde, from the brachial artery, axillary artery, or femoral artery; percutaneous	873.60
93544–00	Injection procedure during cardiac catheterization; for aortography	325.00
93545–00	for selective coronary angiography (injection of radiopaque material may be by hand)	575.00
93547–00	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries, and selective left ventricular angiography	945.00
93548–00	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries, selective left ventriculography, with aortic root aortography	1,000.00
93549–00	Combined right and left heart catheterization, selective coronary angiography, one or more coronary arteries, and selective left ventricular angiography	1,365.00
93550–00	with selective visualization of bypass graft	1,650.00
93551–00	Selective opacification of aortocoronary bypass grafts, one or more coronary arteries (injection of radiopaque material may be made by hand)	575.00
93552–00	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries, selective left ventricular cineangiography and visualization of bypass grafts	1,250.00
93561–00	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)	100.00
93562–00	subsequent measurement of cardiac output	100.00

Intracardiac Electrophysiological Procedures

93618–00	Induction of arrhythmia by electrical pacing	$ 705.00

93620–00	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording and induction of arrhythmia	2,600.00
93640–00	Electrophysiologic evaluation of cardioverter–defibrillator lead and/or device	750.00
	Other Vascular Studies	
93720–00	Plethysmography, total body; with interpretation and report	$ 32.00
93731–00	Electronic analysis of dual–chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of waveform, and/or testing of sensory function of pacemaker); without reprogramming	45.00
93732–00	with reprogramming	71.70
93733–00	telephone analysis	65.00
93734–00	Electronic analysis of single–chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of waveform, and/or testing of sensory function of pacemaker); without reprogramming	45.00
93735–00	with reprogramming	69.00
93736–00	telephonic analysis	59.50
93784–00	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours; including recording, scanning analysis, interpretation, and report	225.00
	Other Procedures	
93797–00	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	.65.00
93798–00	with continuous ECG monitoring (per session)	42.00
	Noninvasive Vascular Diagnostic Studies	
93850–00	Noninvasive studies of cerebral arteries other than carotid (e.g., periorbital flow direction with arterial compression, periorbital photoplethysmography with arterial compression, ocular plethysmography with brachial blood pressure, ocular and ear pulse wave timing, vertebral arteries flow direction measurement)	$ 98.50
93860–00	Noninvasive studies of carotid arteries, nonimaging (e.g., phonoangiography with or without spectrum analysis, flow velocity pattern evaluation, analog velocity waveform analysis, diastolic flow evaluation)	125.00

93870–00	Noninvasive studies of carotid arteries, imaging (e.g., flow imaging by ultrasonic arteriography, high resolution B–scan with or without pulsed Doppler flow evaluation, Doppler flow or duplex scan with spectrum analysis)	244.00
93890–00	Noninvasive studies of upper extremity arteries (e.g., segmental blood pressure measurements, continuous wave Doppler analog waveform analysis, evocative pressure response to exercise or reactive hyperemia, photoplethysmographic or pulse volume digit waveform analysis, flow velocity signals)	200.00
93910–00	Noninvasive studies of lower extremity arteries (e.g., segmental blood pressure measurements, continuous wave Doppler analog waveform analysis, evocative pressure response to exercise or reactive hyperemia, photoplethysmography or pulse volume digit waveform analysis, flow velocity signals)	158.50
93950–00	Noninvasive studies of extremity veins (e.g., Doppler studies with evaluation of venous flow patterns and responses to compression and other maneuvers, phleborheography, impedance plethysmography)	95.00
93960–00	Quantitative venous flow studies (e.g., capacitance and outflow measurement of calf, measurement of calf venous reflux, quantitative photoplethysmography)	118.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

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
94010–00	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation	$ 37.00
94060–00	Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise	87.00
94070–00	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after test dose of bronchodilator (aerosol only) or antigen, with spirometry as in 94010	90.80
94150–00	Vital capacity, total (separate procedure)	19.75

94160–00	Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate	20.00
94200–00	Maximum breathing capacity, maximal voluntary ventilation	26.00
94240–00	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	54.00
94250–00	Expired gas collection, quantitative, single procedure (separate procedure)	32.00
94260–00	Thoracic gas volume	57.00
94350–00	Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equalibration time	75.00
94360–00	Determination of resistance to airflow, oscillatory or plethysmographic methods	49.00
94375–00	Respiratory flow volume loop	36.00
94620–00	Pulmonary stress testing, simple or complex	195.00
94640–00	Nonpressurized inhalation treatment for acute airway obstruction	30.00
94650–00	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation	30.00
94656–00	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	165.50
94657–00	subsequent days	62.00
94660–00	Continuous positive airway pressure ventilation (CPAP), initiation and management	102.50
94664–00	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	40.00
94665–00	subsequent	40.00
94681–00	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted	120.30
94700–00	Analysis of arterial blood gas (oxygen saturation, pO2, pCO2, CO2, pH); rest only	40.00
94705–00	rest and exercise (including cannulization of artery)	169.10
94710–00	three or more (O2 administration, IPPB, exercise)	30.00
94715–00	Hemoglobin–oxygen affinity (pO2 for 50 percent hemoglobin saturation with oxygen)	38.00
94720–00	Carbon monoxide diffusing capacity, any method	68.50
94750–00	Pulmonary compliance study, any method	20.00
94760–00	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	37.40
94761–00	multiple determinations (e.g., during exercise)	52.60

94762–00	by continuous overnight monitoring (separate procedure)	110.00
94770–00	Carbon dioxide, expired gas determination by infrared analyzer	45.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.1950 ALLERGY AND CLINICAL IMMUNOLOGY.

Subpart 1. **Allergy sensitivity tests.** Allergy sensitivity tests are the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the patient. The number of tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the same number of sensitivity tests.

Subp. 2. **Immunotherapy (desensitization, hyposensitization).** Immunotherapy is the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy. Indications for immunotherapy are determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases.

Subp. 3. **Other therapy.** Other therapy for medical conferences on the use of mechanical and electronic devices (precipitators, air conditioners, air filters, humidifiers, dehumidifiers), climatotherapy, physical therapy, occupational and recreational therapy, see 95105–00. (For definitions of Levels of Service see the Introduction.) (For Medical Service Procedures, see 90000–00 to 90699–00.)

Code	Service	Maximum Fee
95000–00	Percutaneous tests (scratch, puncture, prick) with allergenic extracts; up to 30 tests (per test)	$ 3.00
95001–00	31–60 tests (per test)	3.00
95002–00	61–90 tests (per test)	2.50
95003–00	more than 90 tests (per test)	3.00
95020–00	Intracutaneous (intradermal) tests with allergenic extracts, immediate reaction 15–20 minutes; up to 10 tests (per test)	4.50
95021–00	11–20 tests (per test)	4.50
95022–00	21–30 tests (per test)	4.00
95023–00	more than 30 tests (per test)	3.50
95027–00	Skin end point titration	5.00
95040–00	Patch or application tests; up to ten tests (per test)	8.50
95041–00	11–20 tests (per test)	6.00
95042–00	21–30 tests (per test)	4.25
95060–00	Ophthalmic mucous membrane tests	12.00
95070–00	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds	60.50
95078–00	Provocative testing (e.g., Rinkel test)	13.00
95115–00	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	10.00
95117–00	multiple injections	10.75
95120–00	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single antigen	12.00

95125–00	multiple antigens (specify number of injections)	13.00
95130–00	single stinging insect venom	18.00
95131–00	two stinging insect venoms	16.00
95132–00	three stinging insect venoms	26.20

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

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
95819–00	Electroencephalogram (EEG) including recording awake, drowsy, and asleep, with hyperventilation and/or photic stimulation; standard or portable, same facility	$ 175.00
95821–00	portable, to an alternate facility	175.00
95822–00	Electroencephalogram (EEG); sleep only	187.00
95828–00	Polysomnography (recording, analysis, and interpretation of the multiple simultaneous physiological measurements of sleep)	769.80
95831–00	Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	42.00
95851–00	Range of motion measurements and report (separate procedure); each extremity, excluding hand	40.00
95857–00	Tensilon test for myasthenia gravis	95.00
95860–00	Electromyography; one extremity and related paraspinal areas	200.00
95861–00	two extremities and related paraspinal areas	253.10
95863–00	three extremities and related paraspinal areas	240.00
95869–00	Electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)	104.00
95881–00	Assessment of higher cerebral function with medical interpretation; developmental testing	100.00
95882–00	cognitive testing and others	22.50
95900–00	Nerve conduction, velocity, and/or latency study; motor, each nerve	58.90
95904–00	sensory, each nerve	64.80
95925–00	Somatosensory testing (e.g., cerebral evoked potentials), one or more nerves	220.00
95935–00	'H' or 'F' reflex study, by electrodiagnostic testing	60.00
95937–00	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method	75.00

95951–00	Monitoring for localization of cerebral seizure focus, by attached electrodes or radiotelemetry; combined EEG and videorecording and interpretation, initial 24 hours	950.00
95952–00	each additional 24 hours, with or without videorecording	950.00
95955–00	Electroencephalogram (EEG) during nonintracranial surgery (e.g., carotid surgery	239.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2050 CHEMOTHERAPY INJECTIONS.

The codes, service descriptions, and maximum fees of this part apply to chemotherapy injections, and to a provider licensed as a doctor of medicine, a doctor of osteopathy, or by a qualified assistant under supervision of the physician.

Code	Service	Maximum Fee
96400–00	Chemotherapy administration; subcutaneous or intramuscular, with or without local anesthesia	$ 410.00
96408–00	Chemotherapy administration, intravenous; push technique	50.00
96410–00	infusion technique, up to one hour	97.50
96412–00	infusion technique, one to 8 hours, each additional hour	68.00
96414–00	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	90.00
96450–00	Chemotherapy administration, into CNS (e.g., intrathecal), requiring lumbar puncture	153.85
96520–00	Refilling and maintenance of portable pump	36.00
96530–00	Refilling and maintenance of implantable pump or reservoir	63.00
96545–00	Provision of chemotherapy agent	95.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2070 DERMATOLOGICAL PROCEDURES.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to dermatological procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. **Services.** Dermatologic services are typically consultative, and any of the levels of consultation described in part 5221.1200 may be appropriate. In addition, physician services for dermatological procedures are the same as the definitions described in part 5221.1100.

Code	Service	Maximum Fee
96900–00	Actinotherapy (ultraviolet light)	$ 10.00
96910–00	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	16.00
96912–00	psoralens and ultraviolet A (PUVA)	35.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

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.

Code	Service	Maximum Fee
	Modalities	
97260–00	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area. For manipulation under general anesthesia, see appropriate anatomic section in musculoskeletal system	$ 35.60
97261–00	each additional area	9.50

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2150 CASE MANAGEMENT SERVICES.

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

Code	Service	Maximum Fee
98900–00	Medical conference by physician regarding medical management with patient and/or relative or guardian; approximately 30 minutes	$ 80.00
98902–00	approximately 60 minutes	135.00
98910–00	Medical conference by physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes	85.00
98912–00	approximately 60 minutes	125.00
98920–00	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new	

	information from other health care professionals into the medical treatment plan, or to adjust therapy)	10.00
98921–00	intermediate (e.g., to provide advice to an established patient on new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)	22.00
98922–00	complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health care professionals working on different aspects of the total patient care plan)	67.50

Statutory Authority: *MS s 176.136*

History: *16 SR 622*

5221.2200 SPECIAL SERVICES AND REPORTS.

Special services and reports apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include a means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. (See part 5221.1100 for definitions on levels of services.)

Code	Service	Maximum Fee
	Miscellaneous Services	
99000–00	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	$ 10.00
99001–00	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)	14.00
99002–00	Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (e.g., designing, fitting, packaging, handling, delivery, or mailing) when devices such as orthotics, protectives, and prosthetics are fabricated by an outside laboratory or shop but which items have been designed and are to be fitted and adjusted by the attending physician	6.00
99025–00	Initial, new patient visit; when asterisked (*) surgical procedure constitutes major service at that visit	30.00
99052–00	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service	28.50

99054–00	Services requested on Sundays and holidays in addition to basic services	36.50
99058–00	Office services provided on an emergency basis	28.00
99062–00	Emergency care facility services: when the nonhospital–based physician is in the hospital, but is involved in patient care elsewhere and is called to the emergency facility to provide emergency services	45.29
99064–00	Emergency care facility services: when the nonhospital–based physician is called to the emergency facility from outside the hospital to provide emergency services; not during regular office hours	60.00
99065–00	during regular office hours	52.04
99075–00	Medical testimony	Reasonableness of charges reviewable by commissioner
99080–00	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
99090–00	Analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	25.00
	Prolonged Services	
99150–00	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery); 30 minutes to one hour	$ 140.00
99151–00	more than one hour	302.00

Critical Care Services

Critical care services (codes 99160–00 to 99173–00) 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
	Critical Care	
99160–00	Critical care, initial, 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 hour	$ 210.00
99162–00	additional 30 minutes	100.00
99170–00	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)	86.00
99171–00	Critical care, subsequent follow–up visit; brief examination, evaluation and/or treatment for same illness	66.70
99172–00	limited examination, evaluation, and/or treatment for same or new illness	75.00
99173–00	intermediate examination, evaluation, and/or treatment, same or new illness	100.00
99174–00	extended re–examination, re–evaluation, and/or treatment, same or new illness	200.00
	Other Services	
99175–00	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	$ 84.00
99180–00	Hyperbaric oxygen pressurization; initial	784.00
99195–00	Phlebotomy, therapeutic (separate procedure)	34.60

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2250 PHYSICIAN SERVICES; SURGERY.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. **Instructions.** The instructions in items A to F govern the assignment of codes and the evaluation of services described in this part.

A. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated in–hospital follow–up care, provided by the surgeon both pre– and postoperative. This concept is referred to as a "package" for surgical procedures. For the purposes of this definition, preoperative care does not include any care administered before the provider determines that surgery is required.

B. Follow–up care includes reports and records as the operation requires and the physician commonly provides. This includes special reports concerning the medical appropriateness of a service for services which are rarely provided, unusual, variable, or new. Information included in these reports is 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.

C. Follow–up care for diagnostic procedures, such as endoscopy or injection procedures for radiography, includes only that care related to recovery from the diagnostic pro-

cedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

D. Follow–up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be reported with the identification of appropriate procedures.

E. Certain minor surgical services involve a readily identifiable surgical procedure but include variable preoperative and postoperative services. Because of the indefinite pre– and postoperative services the usual package concept for surgical services cannot be applied. These procedures are identified by an asterisk (*) following the code number. When an asterisk follows a surgical procedure code, the following rules apply.

(1) The service as listed includes the surgical procedure only. Associated pre– and postoperative services are not included in the service as listed.

(2) Preoperative services shall be listed when:

(a) the asterisked procedure is carried out at the time of an initial visit (new patient) and this procedure constitutes the major service at that visit, procedure number 99025 is listed in lieu of the initial visit as an additional service;

(b) the asterisked procedure is carried out at the time of an initial or other visit involving significant identifiable services, for example, removal of a small skin lesion at the time of a comprehensive history and physical examination, the appropriate visit is listed in addition to the asterisked procedure and its follow–up care;

(c) the asterisked procedure is carried out at the time of a follow–up of an established patient visit and this procedure constitutes the major service at that visit, no visit service shall be added; or

(d) the asterisked procedure requires hospitalization, an appropriate hospital visit is listed in addition to the asterisked procedure and its follow–up care.

(3) All postoperative care is added on a service–by–service basis.

(4) Complications are added on a service–by–service basis as with surgical procedures.

F. Special situations.

(1) Multiple procedures (more than one procedure is performed at a single operative session through the same incision.)

(a) The major or primary procedures must be billed with the applicable 5–digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 50 percent of the Medical Fee Schedule, whichever is less.

(2) Multiple procedures (more than one procedure is performed at a single operative session through different incisions.)

(a) The major or primary procedures must be billed with the applicable 5–digit procedure code listed in the Medical Fee Schedule. The reimbursement must be at the provider's usual charge or rate set in the Medical Fee Schedule, whichever is less.

(b) The secondary, additional, or lesser procedures must be billed by adding modifier 51 to the applicable procedure code listed in the Medical Fee Schedule. The reimbursement for these procedures must be at the provider's usual charge or 75 percent of the Medical Fee Schedule, whichever is less.

(3) Bilateral procedures (pertaining to two sides and requiring separate incisions.)

(a) When bilateral procedures are performed at the same operative session and the descriptor for the procedure code specifies bilateral procedures, the procedures must be reported using the applicable procedure code listed in the Medical Fee Schedule. Reimbursement must be at the provider's usual charge or the Medical Fee Schedule, whichever is less.

(b) When the descriptor of the procedure code does not specify that it is bilateral, the primary procedure must be reported twice using the applicable procedure codes.

For the first procedure, the applicable 5–digit procedure code must be billed without a modifier. Reimbursement will be at the provider's usual rate or the rate set in the Medical Fee Schedule, whichever is less.

For the second procedure, the applicable 5–digit code must be billed with modifier 50. Reimbursement must be at the provider's usual rate or 75 percent of the rate set in the Medical Fee Schedule, whichever is less.

Subp. 3. **Integumentary system.**

A. Instructions for integumentary system:

(1) Excision of benign lesions (codes 11200–00 to 11444–00) 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.

(2) Treatment of burns (codes 16000–00 to 16030–00) refer to local treatment of the burned surface only.

(3) Level of repair.

(a) Simple repair (codes 12001–00 to 12020–00) 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.

(b) Intermediate repair (codes 12031–00 to 12053–00) 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.

(c) Complex repair (codes 13101–00 to 13152–00) 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.

(4) The instructions in units (a) to (c) also apply to coding of repair services (codes 12001–00 to 13152–00):

(a) When multiple wounds are repaired, the lengths of those of the same classification shall be added together and reported as a single item. When more than one classification of wounds are repaired, the most complicated shall be listed as the primary procedure and the less complicated as the secondary procedure, using modifier number 50.

(b) Only when gross contamination requires prolonged cleansing is decontamination or debridement to be considered a separate procedure. Debridement is considered a separate procedure only when appreciable amounts of devitalized or contaminated tissue are removed.

(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.

B. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system.

Code	Service	Maximum Fee
	Incision/Excision	
10000*00	Incision and drainage of infected or noninfected sebaceous cyst; one lesion	$ 62.00

10003*00	Incision and drainage of infected or noninfected epithelial inclusion cyst ("sebaceous cyst") with complete removal of sac and treatment of cavity	77.95
10020*00	Incision and drainage of furuncle	51.50
10040*00	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	35.00
10060*00	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	65.75
10061–00	complicated	160.00
10080*00	Incision and drainage of pilonidal cyst; simple	73.00
10100*00	Incision and drainage of onychia or paronychia; single or simple	63.00
10120*00	Incision and removal of foreign body, subcutaneous tissues; simple	63.25
10121*00	complicated	140.00
10140*00	Incision and drainage of hematoma; simple	60.10
10141–00	complicated	150.00
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst	54.10
10180–00	Incision and drainage, complex, postoperative wound infection	410.09
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	47.00
11040–00	Debridement; skin, partial thickness	54.00
11041–00	skin, full thickness	60.00
11043–00	skin, subcutaneous tissue and muscle	385.00
11044–00	skin, subcutaneous tissue, muscle, and bone	495.00
	Paring or Curettement	
11050*00	Paring or curettement of benign lesion or shaving with or without chemical cauterization (such as verrucae or or clavi); single lesion	$ 36.00
11051–00	two to four lesions	50.00
11052–00	more than four lesions	70.00
	Biopsy	
11100–00	Biopsy of skin, subcutaneous tissue, and/or mucous membrane, including simple closure, unless otherwise listed separate procedure); one lesion	$ 77.00
11101–00	each additional lesion	49.00
	Excision — Benign Lesions	
11200*00	Excision (including simple closure or ligature strangulation), skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions	$ 64.40

11400–00	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 0.5 centimeter or less	81.00
11401–00	lesion diameter 0.6 to 1.0 centimeter	96.00
11402–00	lesion diameter 1.1 to 2.0 centimeters	118.00
11403–00	lesion diameter 2.1 to 3.0 centimeters	152.00
11404–00	lesion diameter 3.1 to 4.0 centimeters	171.25
11406–00	lesion diameter over 4.0 centimeters	270.00
11420–00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter	96.50
11421–00	lesion diameter 0.6 to 1.0 centimeter	120.00
11422–00	lesion diameter 1.1 to 2.0 centimeters	145.75
11423–00	lesion diameter 2.1 to 3.0 centimeters	176.25
11424–00	lesion diameter 3.1 to 4.0 centimeters	220.00
	Excision — Malignant Lesions	
11600–00	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 centimeter or less	$ 136.00
11601–00	lesion diameter 0.6 to 1.0 centimeter	189.00
11602–00	lesion diameter 1.1 to 2.0 centimeters	242.00
11603–00	lesion diameter 2.1 to 3.0 centimeters	310.00
11604–00	lesion diameter 3.1 to 4.0 centimeters	362.00
11620–00	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 centimeter or less	198.90
11621–00	lesion diameter 0.6 to 1.0 centimeter	252.00
11622–00	lesion diameter 1.1 to 2.0 centimeters	405.00
11640–00	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 centimeter or less	252.00
11641–00	lesion diameter 0.6 to 1.0 centimeter	348.00
11642–00	lesion diameter 1.1 to 2.0 centimeters	395.00
11643–00	lesion diameter 2.1 to 3.0 centimeters	432.00
	Nails	
11700*00	Debridement of nails, manual; five or less	$ 32.62
11701–00	each additional, five or less	17.36

11710*00	Debridement of nails, electric grinder; five or less	27.50
11730*00	Avulsion of nail plate, partial or complete, simple; single	76.00
11740–00	Evacuation of subungual hematoma	52.20
11750–00	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal	220.00
11760–00	Reconstruction of nail bed; simple	224.00
11765–00	Wedge excision of skin of nail fold (e.g., for ingrown toenail)	79.00
	Miscellaneous	
11770–00	Excision of pilonidal cyst or sinus; simple	$ 640.00
11771–00	extensive	679.00
	Introduction	
11900*00	Injection, intralesional, up to and including seven lesions	$ 43.00
11901*00	more than seven lesions	60.00
11950–00	Subcutaneous injection of "filling" material (e.g., silicone); 1 cc or less	250.00
11954–00	over ten cc	50.00
11960–00	Insertion of tissue expander(s)	1,790.00
11970–00	Replacement of tissue expander with permanent prosthesis	1,200.00
	Repair — Simple	
12001*00	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; 2.5 centimeters or less	$ 70.00
12002*00	2.6 to 7.5 centimeters	104.00
12004*00	7.6 to 12.5 centimeters	145.00
12005–00	12.6 to 20.0 centimeters	176.40
12011*00	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; 2.5 centimeters or less	97.00
12013*00	2.6 to 5.0 centimeters	137.00
12014–00	5.1 to 7.5 centimeters	146.07
12015–00	7.6 to 12.5 centimeters	215.00
	Repair — Intermediate	
12031*00	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; 2.5 centimeters or less	$ 104.00
12032*00	2.6 to 7.5 centimeters	147.90
12034–00	7.6 to 12.5 centimeters	197.00
12035–00	12.6 to 20.0 centimeters	277.00
12041*00	Layer closure of wounds of neck, hands, feet, or external genitalia; 2.5 centimeters or less	120.00
12042–00	2.6 to 7.5 centimeters	160.00

12051*00	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes; 2.5 centimeters or less	142.50
12052–00	2.6 to 5.0 centimeters	195.00
12053–00	5.1 to 7.5 centimeters	252.00
	Repair — Complex	
13101–00	Repair, complex, trunk; 2.6 to 7.5 centimeters	$ 285.00
13120–00	Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 centimeters	290.00
13121–00	2.6 to 7.5 centimeters	350.00
13131–00	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 to 2.5 centimeters	350.00
13132–00	2.6 to 7.5 centimeters	535.00
13150–00	Repair, complex, eyelids, nose, ears and/or lips; 1.0 centimeter or less	250.00
13151–00	1.1 to 2.5 centimeters	432.72
13152–00	2.6 to 7.5 centimeters	800.00
13160–00	Secondary closure of surgical wound or dehiscence, extensive or complicated	475.00
13300–00	Repair, unusual, complicated, over 7.5 centimeters, any area	1,100.00
	Adjacent Tissue Transfer or Rearrangement	
14040–00	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect ten square centimeters or less	$ 925.00
14060–00	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect ten square centimeters or less	1,140.00
	Miscellaneous Procedures	
15823–00	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	$ 1,150.00
15850–00	Removal of sutures under anesthesia (other than local), same surgeon	26.00
	Burns, Local Treatment	
16000–00	Initial treatment, first degree burn, when no more than local treatment is required	$ 63.00
16010–00	Dressings and/or debridement, initial or subsequent; under anesthesia, small	106.00
16020*00	without anesthesia, office or hospital, small	55.00
16025*00	without anesthesia, medium (e.g., whole face or whole extremity)	82.00
16030–00	without anesthesia, medium (e.g., whole face or whole extremity)	144.10

	Destruction	
17000*00	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion	$ 55.00
17001–00	second and third lesions, each	37.04
17002–00	over three lesions, each additional lesion	20.00
17100*00	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	59.50
17101–00	second lesion	35.00
17102–00	over two lesions, each additional lesion up to 15 lesions	27.00
17104–00	15 or more lesions	90.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	54.00
17200*00	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	56.25
17250*00	Chemical cauterization of a wound	46.00
17304–00	Chemosurgery (Mohs' technique); first stage, fresh tissue technique, including the removal of all gross tumor and delineation of margins by means of up to five horizontal, microscopic specimens	520.00
17305–00	second stage, fixed or fresh tissue, up to five specimens	167.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2)	38.00

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 modifier number 76 to the usual procedure number to indicate "repeat procedure by same physician."

Code	Service	Maximum Fee
	Excision — General	
20205–00	Biopsy, muscle; deep	$ 418.00
	Introduction or Removal — General	
20520*00	Removal of foreign body in muscle or tendon sheath; simple	$ 91.50
20550*00	Injection, tendon sheath, ligament, trigger points, or ganglion cyst	54.00
20600*00	Arthrocentesis, aspiration, or injection; small joint, bursa, or ganglion cyst (e.g., fingers, toes)	53.45
20605*00	intermediate joint, bursa, or ganglion cyst (e.g., temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)	69.00

20610*00	major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)	71.25
20670*00	Removal of implant; superficial (e.g., buried wire, pin, or rod)	123.00
20680–00	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod, or plate)	389.00
	Head — Repair, Revision, or Reconstruction	
21310–00	Treatment of closed or open nasal fracture without manipulation	$ 65.00
21315*00	Manipulative treatment, nasal bone fracture; *without stabilization*	137.00
21320–00	with stabilization	430.00
	Neck (Soft Tissues) and Thorax — Fracture or Dislocation	
21800–00	Treatment of rib fracture; closed, uncomplicated, each	$ 80.00
	Spine (Vertebral Column)	
22612–00	Arthrodesis, posterior or posterolateral technique, with local bone or bone allograft and/or internal fixation; lumbar	$ 2,900.00
22820–00	Harvesting of bone autograft (e.g., ilium, fibula) for arthrodesis	850.00
	Shoulders — Fracture or Dislocation	
23420–00	Repair of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$ 1,826.00
23455–00	Capsulorrhaphy for recurrent dislocation, anterior; Bankart type operation with or without stapling	1,720.00
23472–00	Arthroplasty with glenoid and proximal humeral replacement (e.g., total shoulder)	3,898.00
23500–00	Treatment of closed clavicular fracture; without manipulation	148.00
23600–00	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation	232.50
23650–00	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	180.50
23655–00	requiring anesthesia	348.00
23700*00	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	255.00
	Humerus (Upper Arm) and Elbow — Fracture or Dislocation	
24500–00	Treatment of closed humeral shaft fracture; without manipulation	$ 281.00
24600–00	Treatment of closed elbow dislocation; without anesthesia	216.00
24650–00	Treatment of closed radial head or neck fracture without manipulation	200.00

24670–00	Treatment of closed ulnar fracture, proximal end (olecranon process), without manipulation	189.00
24685–00	Open treatment of closed or open ulnar fracture proximal end (olecranon process), with or without internal or external skeletal fixation	805.10
	Forearm and Wrist	
25111–00	Excision of ganglion, wrist (dorsal or volar); primary	$ 466.00
25246–00	Injection procedure for wrist arthrography	117.77
25500–00	Treatment of closed radial shaft fracture; without manipulation	$ 210.00
25560–00	Treatment of closed radial and ulnar shaft fractures; without manipulation	260.00
25565–00	with manipulation	560.50
25600–00	Treatment of closed distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	231.00
25605–00	with manipulation	390.00
25610–00	Treatment of closed, complex, distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning	600.00
25622–00	Treatment of closed carpal scaphoid (navicular) fracture; without manipulation	280.00
	Hand and Fingers — Incision, Excision, Repair, Revision, or Reconstruction	
26055–00	Tendon sheath incision for trigger finger	$ 450.00
26115–00	Excision, tumor or vascular malformation, hand or finger; subcutaneous	334.50
26116–00	deep, subfascial, intramuscular	522.00
26123–00	Fasciectomy, palmar, with or without z–plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); partial excision with release of single digit including proximal interphalangeal joint	1,653.00
26160–00	Excision of lesion of tendon sheath or capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger	350.00
26410–00	Extensor tendon repair, dorsum of hand, single, primary or secondary; without free graft, each tendon	461.97
26418–00	Extensor tendon repair, dorsum of finger, single, primary or secondary; without free graft, each tendon	452.00
	Hands and Fingers — Fractures or Dislocations	

26600–00	Treatment of closed metacarpal fracture, single; without manipulation, each bone	$ 152.00
26605–00	with manipulation, each bone	250.00
26720–00	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	120.00
26725–00	with manipulation, each	173.00
26750–00	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	72.00
26760–00	Treatment of open distal phalangeal fracture, finger or thumb, with uncomplicated soft tissue closure, each	164.84
26770–00	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia	80.00
	Hand and Fingers — Amputation	
26951–00	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	$ 467.00
	Pelvis and Hip Joint	
27125–00	Partial hip replacement (hemiarthroplasty); prosthesis (e.g., femoral stem prosthesis, bipolar arthroplasty)	$ 2,400.00
27130–00	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft	3,430.00
27134–00	Revision of total hip arthroplasty; both components, with or without autograft or allograft	4,921.00
27137–00	acetabular component only, with or without autograft or allograft	3,325.00
27235–00	Treatment of closed or open femoral fracture, proximal end, neck, in situ pinning of undisplaced or impacted fracture	1,696.00
27236–00	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	2,129.00
27244–00	Open treatment of closed or open intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture, with internal fixation	1,850.00
	Femur (Thigh Region) and Knee Joint — Repair, Revision, or Reconstruction	
27425–00	Lateral retinacular release (any method)	$ 1,508.00
27446–00	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	2,620.00

27447–00	medial and lateral compartments with or without patella resurfacing (total knee replacement)	3,453.00
27487–00	Revision of total knee arthroplasty, with or without allograft; all components	5,155.00
27506–00	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation	1,850.00
27560–00	Treatment of closed patellar dislocation; without anesthesia	145.00
	Amputation	
27590–00	Amputation, thigh, through femur, any level	$ 1,225.00
	Leg (Tibula and Fibula) and Ankle Joint — Fractures or Dislocations	
27750–00	Treatment of closed tibial shaft fracture; without manipulation	$ 350.00
27760–00	Treatment of closed distal tibial fracture (medial malleolus) without manipulation	239.50
27780–00	Treatment of closed proximal fibula or shaft fracture; without manipulation	180.00
27786–00	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation	240.00
27792–00	Open treatment of closed or open distal fibular fracture (lateral malleolus), with fixation	876.00
27800–00	Treatment of closed tibia and fibula fractures, shafts; without manipulation	381.00
27802–00	with manipulation	650.00
27808–00	Treatment of closed bimalleolar ankle fracture, (including Potts); without manipulation	291.00
27814–00	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation	1,135.00
27822–00	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	1,365.00
27880–00	Amputation leg, through tibia and fibula	1,200.00
	Foot	
28080–00	Excision of interdigital (Morton) neuroma, single, each	$ 475.00
28090–00	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot	388.00

28190*00	Removal of foreign body, foot; subcutaneous	67.50
28285–00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy)	452.00
28290–00	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)	545.00
28296–00	with metatarsal osteotomy (Mitchell, Chevron, or concentric type procedure)	1,100.00
28400–00	Treatment of closed calcaneal fracture; without manipulation	219.00
28470–00	Treatment of closed metatarsal fracture; without manipulation, each	158.00
28490–00	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	85.00
28510–00	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	65.50
28820–00	Amputation, toe; metatarsophalangeal joint	276.00

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.

Code	Service	Maximum Fee
	Body and Upper Extremity Casts	
29065–00	Application; shoulder to hand (long arm)	$ 97.00
29075–00	elbow to finger (short arm)	80.00
29085–00	hand and lower forearm (gauntlet)	80.00
	Splints	
29105–00	Application of long arm splint (shoulder to hand)	$ 57.00
29125–00	Application of short arm splint (forearm to hand); static	49.00
29126–00	dynamic	100.00
29130–00	Application of finger splint; static	32.50
	Strapping	
29260–00	Strapping; elbow or wrist	$ 22.00
29280–00	hand or finger	31.50
29345–00	Application of long leg cast (thigh to toes)	122.00
29355–00	walker or ambulatory type	140.00
29365–00	Application of cylinder cast (thigh to ankle)	97.00
29405–00	Application of short leg cast (below knee to toes)	95.00
29425–00	walking or ambulatory type	105.00
29435–00	Application of patellar tendon bearing (PTB) cast	139.00

	Splints	
29505–00	Application of long leg splint (thigh to ankle or toes)	$ 70.40
29515–00	Application of short leg splint (calf to foot)	54.00
	Strapping	
29530–00	Strapping; knee	$ 51.00
29540–00	ankle	41.00
29550–00	toes	30.00
29580–00	Unna boot	36.25
	Removal or Repair	
29700–00	Removal or bivalving; gauntlet, boot or body cast	$ 35.00
29705–00	full arm or full leg cast	40.00
29720–00	Repair of spica, body cast, or jacket	25.50
	Arthroscopy	
29870–00	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	$ 735.00
29874–00	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation	1,400.00
29875–00	synovectomy, limited (e.g., plica or shelf resection)	1,415.00
29877–00	debridement/shaving of articular cartilage (chondroplasty)	1,575.00
29879–00	abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling	1,740.00
29880–00	with meniscectomy (medial AND lateral, including any meniscal shaving)	1,940.00
29881–00	with meniscectomy (medial or lateral including any meniscal shaving)	1,661.00
29888–00	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	3,596.00

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

Code	Service	Maximum Fee
	Nose	
30110–00	Excision, nasal polyp(s), simple	$ 157.50
30115–00	Excision, nasal polyp(s), extensive	427.00
30200*00	Injection into turbinate(s), therapeutic	50.00
30300*00	Removal foreign body, intranasal; office type procedure	45.00

	Nose — Repair	
30420–00	Rhinoplasty, primary; including major septal repair	$ 2,390.00
30520–00	Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft	1,180.00
	Other Procedures	
30901*00	Control nasal hemorrhage, anterior, simple (cauterization)	$ 62.00
30903*00	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing)	116.00
30905*00	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cauterization; initial	255.00
31000*00	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium	65.00
31020–00	Sinusotomy, maxillary (antrotomy); intranasal	560.00
31030–00	radical; (Cadwell–Luc) without removal of antrochoanal polyps	1,400.00
31200–00	Ethmoidectomy; intranasal, anterior	756.00
31250–00	Nasal endoscopy, diagnostic (includes examination of the medial meatus, infundibulum and sinus ostia)	100.00
	Larynx	
31500–00	Intubation, endotracheal, emergency procedure	$ 171.00
31505–00	Laryngoscopy, indirect (separate procedure); diagnostic	45.00
31535–00	Laryngoscopy, direct, operative, with biopsy;	593.00
31541–00	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope	800.00
31575–00	Laryngoscopy, flexible fiberscopic; diagnostic	123.00
31579–00	with stroboscopy	475.00
	Trachea and Bronchi	
31600–00	Tracheostomy, planned (separate procedure)	$ 573.00
31622–00	Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing	517.00
	Lungs	
32000*00	Thoracocentesis, puncture of pleural cavity for aspiration, initial or subsequent	$ 130.00
32020–00	Tube thoracostomy with or without water seal (e.g., for abscess, hemothorax, empyema) (separate procedure)	461.00
32100–00	Thoracotomy, major; with exploration and biopsy	2,150.00
32480–00	Lobectomy, total or segmental	2,300.00

32500–00	Wedge resection of lung, single or multiple	1,935.00

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.

Code	Service	Maximum Fee
	Heart	
33010*00	Pericardiocentesis; initial	$ 350.00
33206–00	Insertion of permanent pacemaker with transvenous electrode(s); atrial	1,600.00
33207–00	ventricular	1,570.00
33208–00	AV sequential	1,950.00
33210–00	Insertion of temporary transvenous cardiac electrode, or pacemaker catheter (separate procedure)	545.00
33212–00	Insertion or replacement of pacemaker pulse generator or automatic implantable cardioverter–defibrillator pulse generator only	1,000.00
33405–00	Replacement, aortic valve, with cardiopulmonary bypass	5,470.00
	Coronary Artery Procedures	
33510–00	Coronary artery bypass, autogenous graft, (e.g., saphenous vein or internal mammary artery); single graft	$ 5,038.00
33511–00	two coronary grafts	5,850.00
33512–00	three coronary grafts	5,987.00
33513–00	four coronary grafts	6,435.00
33514–00	five coronary grafts	6,855.00
	Arteries and Veins	
34201–00	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	$ 1,500.00
35081–00	Direct repair of aneurysm or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm or occlusive disease, abdominal aorta	3,377.00
35102–00	for aneurysm or occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)	3,900.00
35141–00	for aneurysm or occlusive disease, common femoral artery (profunda femoris, superficial femoral)	2,500.00
35301–00	Thromboendarterectomy, with or without patch graft; carotid, vertebral, subclavian, by neck incision	2,325.00
35556–00	Bypass graft, with vein; femoral–popliteal	2,080.00
35656–00	Bypass graft, with other than vein; femoral–popliteal	2,449.00

Vascular Injection Procedures

36000*00	Introduction of needle or intracatheter, vein	$ 58.00
36010–00	Introduction of catheter, in superior or inferior vena cava, right heart or pulmonary artery	370.90
36415*00	Routine venipuncture for collection of specimen(s)	8.50
36468–00	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	140.00
36470*00	Injection of sclerosing solution; single vein	53.00
36471*00	multiple veins, same leg	79.50
36489*00	Placement of central venous catheter (subclavian, jugular, or other vein) (e.g., for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous	148.00
36491*00	cutdown	585.00
36497–00	Removal of implantable intravenous infusion pump or venous access port	250.00
36600*00	Arterial puncture, withdrawal of blood for diagnosis	51.50
36620–00	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	119.70
36800–00	Insertion of cannula for hemodialysis, other purpose; vein to vein	320.50
36830–00	Creation of arteriovenous fistula; nonautogenous graft	1,515.00
36861–00	Cannula declotting; with balloon catheter	1,076.00
37609–00	Ligation or biopsy, temporal artery	274.00
37720–00	Ligation and division and complete stripping of long or short saphenous veins	820.00
37730–00	Ligation and division and complete stripping of long and short saphenous veins	1,050.00
37785–00	Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg	214.00

Subp. 8. **Hemic and lymphatic systems.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the hemic (blood) and lymphatic systems.

Code	Service	Maximum Fee
	Hemic and Lymphatic Systems	
38100–00	Splenectomy (separate procedure); total	$ 1,300.00
38230–00	Bone marrow harvesting for transplantation	1,230.00
38500–00	Biopsy or excision of lymph node(s); superficial (separate procedure)	225.00
38510–00	deep cervical node(s)	391.00
38525–00	deep axillary node(s)	485.00
	Mediastinum and Diaphragm	

39400–00	Mediastinoscopy, with or without biopsy	$ 613.00

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

Code	Service	Maximum Fee
	Mouth	
40490–00	Biopsy of lip	$ 103.50
40808–00	Biopsy, vestibule of mouth	104.00
40812–00	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	200.00
41100–00	Biopsy of tongue; anterior two–thirds	113.00
42700*00	Incision and drainage abscess; peritonsillar	146.00
42800–00	Biopsy; oropharynx	83.00
42809–00	Removal of foreign body from pharynx	95.00
42821–00	Tonsillectomy and adenoidectomy	580.00
42826–00	Tonsillectomy, primary or secondary	580.00
	Esophagus	
43200–00	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure	$ 415.00
43215–00	for removal of a foreign body	610.00
43220–00	for dilation, direct, and method	681.00
43234–00	Upper gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible fiberscope)	495.00
43235–00	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	420.00
43239–00	for biopsy and/or collection of specimen by brushing or washing	485.70
43243–00	for injection sclerosis of esophageal and/or gastric varices	863.00
43245–00	for dilation of gastric outlet for obstruction	608.00
43246–00	for directed placement of percutaneous gastrostomy tube	830.00
43247–00	for removal of foreign body	577.00
43255–00	for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)	635.50
43260–00	Endoscopic retrograde cholangiopancreatography (ERCP), with or without biopsy and/or collection of specimen	620.00
43262–00	for sphincterotomy/papillotomy	1,128.00
43264–00	for removal of stone(s) from biliary and/or pancreatic ducts	1,287.00
43450*00	Dilation of esophagus, by unguided sound or bougie, single or multiple passes; initial session	98.00
43451*00	subsequent session	82.75
43453–00	Dilation of esophagus, over guide wire or string	254.00

	Stomach	
43520–00	Pyloromyotomy, cutting of pyloric muscle (Fredet–Ramstedt type operation)	$ 1,150.00
43635–00	Hemigastrectomy or distal subtotal gastrectomy including pyloroplasty, gastroduodenostomy or gastrojejunostomy; with vagotomy, any type	2,175.00
43640–00	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	1,646.00
43750–00	Percutaneous placement of gastrostomy tube	775.00
43760*00	Change of gastrostomy tube	76.00
43830–00	Gastrostomy, temporary (tube, rubber, or plastic)(separate procedure)	800.00
	Intestines	
44005–00	Enterolysis (freeing of intestinal adhesion) for acute bowel obstruction (separate procedure)	$ 1,265.00
44120–00	Enterectomy, resection of small intestine; with anastomosis	1,732.50
44140–00	Colectomy, partial; with anastomosis	1,670.00
44143–00	with end colostomy and closure of distal segment (Hartmann type procedure)	2,000.00
44145–00	with coloproctostomy (low pelvic anastomosis)	2,310.00
44160–00	Colectomy with removal of terminal ileum and ileocolostomy	2,300.00
44625–00	Closure of enterostomy, large or small intestine; with resection and anastomosis	1,583.00
	Appendix	
44950–00	Appendectomy	$ 900.00
44960–00	for ruptured appendix with abscess or generalized peritonitis	1,104.00
	Rectum	
45110–00	Protectomy; complete, combined abdominoperineal, with colostomy, one of two stages	$ 2,900.00
45300–00	Proctosigmoidoscopy; diagnostic (separate procedure)	87.00
45305–00	for biopsy	125.00
45310–00	for removal of polyp or papilloma	200.00
45330–00	Sigmoidoscopy, flexible fiberoptic; diagnostic	130.00
45331–00	for biopsy and/or collection of specimen by brushing or washing	184.00
45333–00	for removal of polypoid lesion(s)	269.00
45355–00	Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple	155.00
45378–00	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure	640.00

45380–00	for biopsy and/or collection of specimen by brushing or washing	700.00
45385–00	for removal of polypoid lesion(s)	825.00
45500–00	Proctoplasty; for stenosis	900.00
45505–00	for prolapse of mucous membrane	950.00
	Anus	
46000*00	Fistulotomy, subcutaneous	$ 147.00
46040–00	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)	320.00
46050*00	Incision and drainage, perianal abscess, superficial	115.00
46080*00	Sphincterotomy, anal, division of sphincter (separate procedure)	148.00
46083–00	Incision of thrombosed hemorrhoid, external	82.00
46200–00	Fissurectomy, with or without sphincterotomy	515.00
46220–00	Papillectomy or excision of single tag, anus (separate procedure)	91.50
46221–00	Hemorrhoidectomy, by simple ligature (e.g., rubber band)	104.06
46230–00	Excision of external hemorrhoid tags and/or multiple papillae	121.50
46255–00	Hemorrhoidectomy, internal and external; simple	725.00
46260–00	Hemorrhoidectomy, internal and external, complex or extensive	929.50
46275–00	Fistulectomy; submuscular	900.00
46320*00	Enucleation or excision of external thrombotic hemorrhoid	108.00
46600–00	Anoscopy; diagnostic (separate procedure)	36.80
46900*00	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	40.00
46910*00	electrodesiccation	98.00
46924–00	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method	660.00
46934–00	Destruction of hemorrhoids, any method; internal	165.00
46945–00	Ligation of internal hemorrhoids; single procedure	151.25
	Liver	
47000*00	Biopsy of liver; percutaneous needle	$ 231.00
47600–00	Cholecystectomy	1,394.00
47605–00	with cholangiography	1,581.00
47610–00	Cholecystectomy with exploration of common duct	1,800.00
	Abdomen	
49000–00	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)	$ 945.00

49080*00	Peritoneocentesis, abdominal paracentesis, or peritoneal lavage; initial	110.00
49200–00	Excision or destruction by any method of intra–abdominal or retroperitoneal tumors or cysts or endometriomas	1,414.00
49421–00	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent	645.00
49505–00	Repair inguinal hernia	834.00
49515–00	with excision of hydrocele or spermatocele	960.00
49520–00	Repair inguinal hernia; recurrent	945.00
49525–00	sliding	880.00
49530–00	incarcerated	1,058.00
49550–00	Repair femoral hernia; groin incision	925.00
49560–00	Repair ventral (incisional) hernia (separate procedure)	1,000.00
49565–00	recurrent	1,120.00
49581–00	Repair umbilical hernia;	812.50

Subp. 10. **Urinary system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the urinary system.

Code	Service	Maximum Fee
	Kidney	
50200*00	Renal biopsy; percutaneous, by trocar or needle	$ 390.00
50230–00	Nephrectomy, including partial ureterectomy, any approach including rib resection; radical, with regional lymphadenectomy	2,233.00
50394–00	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)	55.00
50590–00	Lithotripsy, extracorporeal shock wave	2,000.00
50690–00	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure)	39.50
	Bladder	
51010–00	Aspiration of bladder; with insertion of suprapubic catheter	$ 153.00
51595–00	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including bowel anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	3,859.00
51700*00	Bladder irrigation, simple, lavage and/or instillation	37.00
51705*00	Change of cystostomy tube; simple	44.00
51720–00	Bladder instillation of anticarcinogenic agent (including detention time)	60.30
51725–00	Simple cystometrogram (CMG) (e.g., spinal manometer)	82.11
51726–00	Complex cystometrogram (e.g., calibrated electronic equipment)	117.00

51736–00	Simple uroflowmetry (UFR) (e.g., stopwatch flow rate, mechanical uroflowmeter)	70.00
51741–00	Complex uroflowmetry (e.g., calibrated electronic equipment)	78.66
51772–00	Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique	185.00
51785–00	Electromyography studies (EMG) of anal or urethral sphincter, any technique	135.00
51840–00	Anterior vesicourethropexy, or urethropexy (Marshall–Marchetti–Kranz type); simple	1,260.00
51845–00	Abdomino–vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)	1,473.38
	Endoscopy	
52000–00	Cystourethroscopy (separate procedure)	$ 165.00
52005–00	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	276.00
52204–00	Cystourethroscopy with biopsy	277.00
52214–00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	344.40
52224–00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 centimeter) lesion(s) with or without biopsy	310.00
52234–00	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 centimeters)	500.00
52235–00	MEDIUM bladder tumor(s) (2.0 to 5.0 centimeters)	1,044.00
52240–00	LARGE bladder tumor(s)	1,403.00
52260–00	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	282.00
52281–00	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female	270.00
52285–00	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra,	

	bladder neck, and/or trigone	416.00
52310–00	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	358.00
52320–00	Cystourethroscopy; (including ureteral catheterization); with removal of ureteral calculus	690.30
52332–00	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double–J type)	445.00
52336–00	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method); with removal or manipulation of calculus (ureteral catheterization is included)	1,570.00
52601–00	Transurethral resection of prostate, including control of postoperative bleeding, complete; (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	1,446.10
	Urethra	
53600*00	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial	$ 44.00
53601*00	subsequent	28.61
53620*00	Dilation of urethral stricture by passage of filiform and follower, male; initial	72.00
53621*00	subsequent	43.00
53660*00	Dilation of female urethra including suppository and/or instillation; initial	36.00
53661*00	subsequent	35.00
53670*00	Catheterization, urethral; simple	31.00
53675*00	complicated (may include difficult removal of balloon catheter)	80.00

Subp. 11. **Reproductive system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the reproductive system.

Code	Service	Maximum Fee
	Male Reproductive System	
54050*00	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	$ 36.00
54055*00	electrodesiccation	77.00
54235–00	Injection of corpora cavernosa with pharmacologic agent(s) (e.g., papaverine, phentolamine)	56.97
54240–00	Penile plethysmography	80.00
54250–00	Nocturnal penile tumescence and/or rigidity test	150.00
54640–00	Orchiopexy, any type, with or without hernia repair	1,040.00
55000*00	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication	50.00

55040–00	Excision of hydrocele; unilateral	695.10
55700–00	Biopsy, prostate; needle or punch, single or multiple, any approach	150.00
55845–00	Prostatectomy, retropubic radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	2,750.00
	Female Reproductive System	
56420*00	Incision and drainage of Bartholin's gland abscess, unilateral	$ 100.00
56440–00	Marsupialization of Bartholin's gland cyst	403.00
56501–00	Destruction of lesion(s), vulva; simple, any method	65.00
56600*00	Biopsy of vulva (separate procedure)	100.00
57061–00	Destruction of vaginal lesion(s); simple, any method	77.00
57100*00	Biopsy of vaginal mucosa; simple, (separate procedure)	88.50
57150*00	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease	21.00
57240–00	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele (separate procedure)	875.00
57260–00	Combined anteroposterior colporrhaphy	1,140.00
57410*00	Pelvic examination under anesthesia	54.00
57452*00	Colposcopy (vaginoscopy); (separate procedure)	155.00
57454*00	with biopsies, or biopsy of the cervix	185.00
57500*00	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	83.00
57505–00	Endocervical curettage (not done as part of a dilation and curettage)	115.00
57510–00	Cauterization of cervix; electro or thermal	85.00
57511*00	cryocautery, initial or repeat	117.00
57513–00	laser surgery	600.00
57520–00	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair	575.00
58100*00	Endometrial biopsy, suction type (separate procedure)	93.00
58102–00	Office endometrial curettage	148.00
58120–00	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	388.00
58140–00	Myomectomy, excision of fibroid tumor of uterus, single or multiple (separate procedure); abdominal approach	1,340.00
58150–00	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	1,550.00
58152–00	with colpo–urethrocystopexy (Marshall–Marchetti–Krantz type)	2,160.00
58260–00	Vaginal hysterectomy	1,534.00

58265–00	with plastic repair of vagina, anterior and/or posterior colporrhaphy	1,740.00
58270–00	with repair of enterocele	1,924.00
58340*00	Injection procedure for hysterosalpingography	130.00
58720–00	Salpingo–oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	1,095.00
58740–00	Lysis of adhesions (salpingolysis, ovariolysis)	2,100.25
58925–00	Ovarian cystectomy, unilateral or bilateral	1,179.00
58940–00	Oophorectomy, partial or total, unilateral or bilateral	1,075.00
58960–00	Laparotomy, for staging or restaging of ovarian malignancy ("second look"), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para–aortic lymphadenectomy	3,220.00
58980–00	Laparoscopy, surgical	705.00
58982–00	with fulguration of oviducts (with or without transection)	800.00
58983–00	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)	850.00
58984–00	with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	975.00
58985–00	with lysis of adhesions	859.00
58986–00	with biopsy (single or multiple)	1,000.00
58987–00	with aspiration (single or multiple)	859.75
58990–00	Hysteroscopy; diagnostic	550.00

Subp. 12. **Endocrine system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the endocrine (glandular) system.

Code	Service	Maximum Fee
60100*00	Biopsy thyroid, percutaneous needle	$ 142.00
60220–00	Total thyroid lobectomy, unilateral	1,360.00
60500–00	Parathyroidectomy or exploration of parathyroid(s)	1,780.00

Subp. 13. **Nervous system.** The following codes, service descriptions, and maximum fees apply to surgical procedures of the nervous system.

Code	Service	Maximum Fee
61154–00	Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural	$ 2,000.00
61210*00	for implanting ventricular catheter, reservoir, or pressure recording device (separate procedure)	1,000.00
61510–00	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	4,000.00
61512–00	for excision of meningioma, supratentorial	4,536.00

61712–00	Microdissection, intracranial or spinal procedure (list separately in addition to code for primary procedure)	1,300.00
62223–00	Creation of shunt; ventriculo–peritoneal, –pleural, other terminus	2,250.00
	Spine and Spinal Cord — Puncture for Injection, Drainage, or Aspiration	
62270*00	Spinal puncture lumbar diagnostic	$ 123.00
	Spine and Spinal Cord — Laminectomy or Laminotomy, for Exploration or Decompression	
63005–00	Laminectomy for exploration/decompression of spinal cord and/or cauda equina, one or two segments; lumbar, except for spondylolisthesis	$ 2,650.00
63017–00	Laminectomy for exploration/ decompression of spinal cord and/or cauda equina, more than two segments; lumbar	3,000.00
63020–00	Laminotomy (hemilaminectomy), for decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical	2,500.00
63030–00	one interspace, lumbar	2,550.00
63042–00	Laminectomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, re–exploration; lumbar	3,095.00
63047–00	Laminectomy, including unilateral or bilateral complete facetectomy or foraminotomy for decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis), single segment; lumbar	3,454.77
63075–00	Diskectomy, anterior, for decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	2,735.00
63780–00	Insertion, subarachnoid or epidural catheter, with reservoir and/or pump for drug infusion, without laminectomy	1,585.00
	Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System	
64405*00	Injection, anesthetic agent; greater occipital nerve	$ 150.00
64417*00	axillary nerve	74.00
64421*00	intercostal nerves, multiple, regional block	259.00
64435*00	paracervical (uterine) nerve	70.00
64440*00	paravertebral nerve (thoracic, lumbar, sacral, coccygeal), single vertebral level	55.00

64442*00	paravertebral facet joint nerve, lumbar, single level	165.00
64450*00	other peripheral nerve or branch	100.00
64510*00	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	238.00
64520*00	lumbar or thoracic (paravertebral sympathetic)	259.70
64550–00	Application of surface (transcutaneous) neurostimulator	50.00
64718–00	Neuroplasty and/or transposition; ulnar nerve at elbow	1,134.00
64721–00	median nerve at carpal tunnel	798.00

Subp. 14. **Eye and ocular adnexa.** The following codes, service descriptions, and maximum fees apply to surgical procedures involving the eye and ocular adnexa.

Code	Service	Maximum Fee
65205*00	Removal foreign body, external eye; conjunctival superficial	$ 46.00
65210*00	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	52.00
65220*00	corneal, without slit lamp	65.00
65222*00	corneal, with slit lamp	75.00
65420–00	Excision or transposition of pterygium; without graft	609.50
65430*00	Scraping of cornea, diagnostic, for smear and/or culture	95.00
65435*00	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)	80.00
65730–00	Keratoplasty (corneal transplant), penetrating (except in aphakia), includes autografts, and fresh or preserved homografts	2,945.00
65855–00	Trabeculoplasty by laser surgery (one or more sessions) (defined treatment series)	835.00
66170–00	Fistulization of sclera for glaucoma; trabeculectomy ab externo	1,248.00
66250–00	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	1,200.00
66761–00	Iridotomy by photocoagulation (one or more sessions) (e.g., for glaucoma)	750.00
66802–00	Discission of lens capsule; laser surgery (one or more stages)	577.50
66820–00	Discission of secondary membranous cataract ("after cataract"), and/or anterior hyaloid; incisional technique (Ziegler or Wheeler Knife)	525.00
66821–00	laser surgery (e.g., YAG laser) (one or more stages)	730.00
66983–00	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	1,581.13

66984–00	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	1,933.00
66985–00	Insertion of intraocular lens subsequent to cataract removal (separate procedure	1,430.00
67036–00	Vitrectomy, mechanical, pars plana approach	3,035.00
67105–00	Repair of retinal detachment, one or more sessions; photocoagulation (laser or xenon arc, one or more sessions), with or without drainage of subretinal fluid	875.00
67107–00	scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant	2,288.00
67141–00	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy	900.00
67145–00	photocoagulation (laser or xenon arc)	770.00
67210–00	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), one or more sessions; photocoagulation (laser or xenon arc)	930.00
67227–00	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions; cryotherapy, diathermy	850.00
67228–00	photocoagulation (laser or xenon arc)	875.00
67311–00	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); one muscle	1,211.00
67312–00	two muscles, one or both eyes	1,253.00
67500*00	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	150.00
67515*00	Injection of therapeutic agent into Tenon's capsule	65.00
67700*00	Blepharotomy, drainage of abscess, eyelid	95.00
67800–00	Excision of chalazion; single	91.50
67801–00	multiple, same lid	137.00
67805–00	multiple, different lids	143.00
67810*00	Biopsy of eyelid	120.50
67820*00	Correction of trichiasis; epilation, by forceps only	39.00
67825*00	epilation, (e.g., by electrosurgery or cryotherapy)	132.00
67840*00	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	117.50
67880–00	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy	406.00

67904–00	Repair of blepharoptosis; (tarso) levator resection, external approach	1,550.00
67917–00	Repair of ectropion; blepharoplasty, extensive (e.g., Kuhnt–Szymanowski operation)	780.00
67921–00	Repair of entropion; suture	587.00
67923–00	blepharoplasty, excision tarsal wedge	750.00
67924–00	blepharoplasty, extensive (e.g., Wheeler operation)	800.00
67938–00	Removal of embedded foreign body; eyelid	57.00
68110–00	Excision of lesion, conjunctiva; up to one centimeter	160.00
68200*00	Subconjunctival injection	56.00
68720–00	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)	1,750.00
68760–00	Closure of lacrimal punctum (e.g., thermocauterization, ligation, or laser photocoagulation)	133.00
68800*00	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral	46.00
68820*00	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral	75.00
68825–00	requiring general anesthesia	300.00
68840*00	Probing of lacrimal canaliculi, with or without irrigation	70.75

Subp. 15. **Auditory system.** The following codes, service descriptions, and maximum fees apply to surgical procedures involving the auditory system.

Code	Service	Maximum Fee
69000*00	Drainage external ear, abscess or hematoma; simple	$ 84.00
69200–00	Removal foreign body from external auditory canal; without general anesthesia	50.75
69205–00	with general anesthesia	290.00
69210–00	Removal impacted cerumen (separate procedure), one or both ears	27.00
69220–00	Debridement, mastoidectomy cavity, simple (e.g., routine cleaning)	48.00
69420*00	Myringotomy, including aspiration and/or eustachian tube inflation	120.00
69424–00	Ventilating tube removal when originally inserted by another physician	79.88
69433*00	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	249.00
69436–00	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	295.00
69610–00	Tympanic membrane repair, with or without site preparation or perforation for closure with or without patch	94.00
69620–00	Myringoplasty (surgery confined to drumhead and donor area)	1,575.00

69631–00	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	2,159.00
69632–00	with ossicular chain reconstruction (e.g., postfenestration)	2,546.00
69660–00	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material	2,350.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 10 SR 1548; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 124; 15 SR 738; 16 SR 622*

5221.2300 PHYSICIAN SERVICES; RADIOLOGY.

Subpart 1. **General.** The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine, a doctor of osteopathy, or a technician under the supervision of a doctor of medicine or osteopathy.

A. Single charge including both professional and technical component. The maximum fee represents the appropriate charges for professional services plus expenses of nonradiologist personnel, materials, facilities, and space used and for diagnostic or therapeutic services rendered, but excludes the cost of radio–isotopes. This value is applicable in any situation in which a single charge is made to include both professional services and the cost involved in providing that service.

B. Two charges distinguishing between technical and professional component.

(1) Professional component: the professional component represents the professional services of the doctor, including examination of the patient, when indicated, performance and supervision of the procedure, interpretation and reporting of the examination, and consultation with the attending doctor. This component is applicable in any situation in which the doctor submits a charge for these professional services only. It is distinct from and does not include the time devoted by technologists, nor costs of materials, equipment, and space.

When the physician component is billed separately, the procedure may be identified by adding the modifier "–26" to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 40 percent of the fee maximum.

(2) Technical component: certain procedures (e.g., laboratory, radiology, electrocardiogram, specific diagnostic, and therapeutic services) are a combination of a physician component and a technical component. When the technical component is billed separately, the procedure may be identified by adding the modifier "T.C." to the usual procedure number as appropriate. The total cost of procedure cannot exceed the basic fee. Payment is made on the basis of up to and including 60 percent of the fee maximum.

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

Code	Service	Maximum Fee
	Head and Neck	
70100–00	Radiologic examination, mandible; partial, less than four views	$ 65.00
70110–00	complete, minimum of four views	90.00
70120–00	Radiologic examination, mastoids; less than three views per side	76.00
70130–00	complete, minimum of three views per side	103.00

70140–00	Radiologic examination, facial bones; less than three views	59.00
70150–00	complete, minimum of three views	70.50
70160–00	Radiologic examination, nasal bones; complete, minimum of three views	60.00
70200–00	Radiologic examination; orbits, complete, minimum of four views	90.00
70210–00	Radiologic examination, sinuses, paranasal, less than three views	44.00
70220–00	Radiologic examination, sinuses, paranasal, complete, minimum of three views	81.00
70240–00	Radiologic examination, sella turcica	67.50
70250–00	Radiologic examination, skull; less than four views, with or without stereo	70.00
70260–00	complete, minimum of four views, with or without stereo	97.00
70300–00	Radiologic examination, teeth; single view	22.05
70310–00	partial examination, less than full mouth	29.00
70320–00	complete, full mouth	66.25
70330–00	Radiological examination, temporomandibular joint, open and closed mouth; bilateral	175.00
70333–00	Temporomandibular joint arthrography; complete procedure	265.00
70336–00	Magnetic resonance (e.g., proton) imaging, temporomandibular joint	985.00
70355–00	Orthopantogram	50.00
70360–00	Radiologic examination; neck, soft tissue	42.00
70450–00	Computerized axial tomography, head or brain; without contrast material	443.00
70460–00	with contrast material(s)	485.00
70470–00	without contrast material, followed by contrast material(s) and further sections	589.00
70480–00	Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	443.00
70481–00	with contrast material(s)	463.90
70486–00	Computerized axial tomography, maxillofacial area; without contrast material	148.00
70491–00	Computerized axial tomography, soft tissue neck; with contrast material(s)	489.95
70551–00	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material	955.00
70552–00	with contrast material(s)	1,065.00

Chest

71010–00	Radiologic examination, chest; single view, frontal	$ 42.50
71015–00	stereo, (frontal)	50.00
71020–00	Radiologic examination, chest, two views, frontal and lateral	59.00
71021–00	with apical lordotic procedure	50.25

71030–00	Radiologic examination, chest, complete, minimum of four views	65.00
71035–00	Radiologic examination, chest, special views (e.g., lateral decubitus, Bucky studies)	42.45
71100–00	Radiologic examination, ribs, unilateral; two views	64.00
71101–00	including posteroanterior chest, minimum of three views	76.00
71110–00	Radiologic examination, ribs, bilateral; three views	81.00
71120–00	Radiologic examination; sternum, minimum of two views	58.00
71250–00	Computerized axial tomography, thorax; without contrast material	502.20
71260–00	with contrast material(s)	595.00
71270–00	without contrast material, followed by contrast material(s) and further sections	652.00
71550–00	Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy)	939.00
	Spine and Pelvis	
72010–00	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral	$ 107.00
72020–00	Radiologic examination, spine, single view, specify level	53.00
72040–00	Radiologic examination, spine, cervical; anteroposterior and lateral	63.80
72050–00	minimum of four views	97.00
72052–00	complete, including oblique and flexion and/or extension studies	117.00
72070–00	Radiologic examination, spine; thoracic, anteroposterior and lateral	70.00
72072–00	thoracic, anteroposterior and lateral, including swimmer's view of the cervicothoracic junction	78.00
72074–00	thoracic, complete, including obliques, minimum of four views	90.00
72080–00	thoracolumbar, anteroposterior and lateral	75.00
72090–00	scoliosis study, including supine and erect studies	63.00
72100–00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	78.00
72110–00	complete, with oblique views	112.00
72114–00	complete, including bending views	90.70
72120–00	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	90.00
72125–00	Computerized axial tomography, cervical spine; without contrast material	575.00
72128–00	Computerized axial tomography, thoracic spine; without contrast material	550.00
72131–00	Computerized axial tomography, lumbar spine; without contrast material	535.00

72132–00	with contrast material	550.00
72141–00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material	967.00
72146–00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, thoracic; without contrast material	975.00
72148–00	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material	975.00
72149–00	with contrast material(s)	1,000.00
72170–00	Radiologic examination, pelvis; anteroposterior only	50.00
72190–00	complete, minimum of three views	67.00
72192–00	Computerized axial tomography, pelvis; without contrast material	246.00
72193–00	with contrast material(s)	535.00
72196–00	Magnetic resonance (e.g., proton) imaging, pelvis	925.00
72200–00	Radiologic examination, sacroiliac joints; less than three views	59.00
72202–00	three or more views	76.00
72220–00	Radiologic examination, sacrum and coccyx, minimum of two views	63.00
72241–00	Myelography, cervical; complete procedure	684.00
72266–00	Myelography, lumbosacral; complete procedure	638.00

Upper Extremities

73000–00	Radiologic examination; clavicle, complete	$ 46.00
73010–00	scapula, complete	56.00
73020–00	Radiologic examination, shoulder; one view	43.05
73030–00	complete, minimum of two views	57.00
73041–00	complete procedure	255.00
73050–00	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	63.00
73060–00	humerus, minimum of two views	52.00
73070–00	Radiologic examination, elbow; anteroposterior and lateral views	47.00
73080–00	complete, minimum of three views	58.75
73090–00	Radiologic examination; forearm, anteroposterior and lateral views	49.50
73100–00	Radiologic examination, wrist; anteroposterior and lateral views	48.00
73110–00	complete, minimum of three views	53.00
73116–00	Radiologic examination, wrist, arthrography; complete procedure	245.00
73120–00	Radiologic examination, hand; two views	47.70
73130–00	minimum of three views	52.50
73140–00	Radiologic examination, finger or fingers, minimum of two views	42.00
73200–00	Computerized axial tomography, upper extremity; without contrast material	500.00
73220–00	Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint	955.00

73221–00	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity	910.00
	Lower Extremities	
73500–00	Radiologic examination, hip; unilateral, one view	$ 42.00
73510–00	complete, minimum of two views	65.50
73520–00	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	75.00
73550–00	Radiologic examination, femur, anteroposterior and lateral views	56.70
73560–00	Radiologic examination, knee; anteroposterior and lateral views	49.00
73562–00	anteroposterior and lateral, with oblique(s), minimum of three views	61.00
73564–00	complete, including oblique(s), and/or tunnel, and/or patellar and/or standing views	75.00
73581–00	Radiologic examination, knee, arthrography; complete procedure	256.60
73590–00	Radiologic examination; tibia and fibula, anteroposterior and lateral views	52.00
73600–00	Radiologic examination, ankle; anteroposterior and lateral views	45.00
73610–00	complete, minimum of three views	54.00
73620–00	Radiologic examination, foot; anteroposterior and lateral views	47.00
73630–00	complete, minimum of three views	56.00
73650–00	Radiologic examination; calcaneus, minimum of two views	46.00
73660–00	toe or toes, minimum of two views	43.25
73700–00	Computerized axial tomography, lower extremity; without contrast material	600.00
73720–00	Magnetic resonance (e.g., proton) imaging, lower extremity, other than joint	910.00
73721–00	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity	910.00
	Abdomen	
74000–00	Radiologic examination, abdomen; single anteroposterior view	$ 50.00
74010–00	anteroposterior and additional oblique and cone views	71.90
74020–00	complete, including decubitus and/or erect views	67.20
74022–00	complete acute abdomen series, including supine, erect, and/or decubitus views, upright PA chest	100.00
74150–00	Computerized axial tomography, abdomen; without contrast material	491.00
74160–00	with contrast material(s)	573.50
74170–00	without contrast material, followed by contrast material(s) and further sections	654.60
74181–00	Magnetic resonance (e.g., proton) imaging, abdomen	967.00

	Gastrointestinal Tract	
74220–00	Radiological examination; esophagus	$ 125.00
74230–00	Swallowing function, pharynx and/or esophagus, with cineradiography and/or video	39.25
74240–00	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	145.00
74241–00	with or without delayed films, with KUB	156.00
74245–00	with small bowel, includes multiple serial films	199.50
74246–00	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films; without KUB	138.00
74247–00	with or without delayed films, with KUB	181.50
74250–00	Radiologic examination, small bowel, includes multiple serial films	148.00
74270–00	Radiologic examination, colon; barium enema	148.25
74280–00	air contrast with specific high density barium, with or without glucagon	184.00
74290–00	Cholecystography, oral contrast	87.00
74305–00	Cholangiography and/or pancreatography; postoperative	131.00
	Urinary Tract	
74400–00	Urography, (pyelography) intravenous, with or without KUB	$ 178.25
74405–00	with special hypertensive contrast concentration and/or clearance studies	180.00
74410–00	Urography, infusion, drip technique and/or bolus technique	168.00
74415–00	with nephrotomography	204.00
74420–00	Urography, retrograde, with or without KUB	126.25
74431–00	Cystography, minimum of three views; complete procedure	125.00
74451–00	Urethrocystography, retrograde; complete procedure	117.00
74456–00	Urethrocystography, voiding; complete procedure	178.00
	Gynecological and Obstetrical	
74741–00	Hysterosalpingography; complete procedure	$ 185.00
	Veins and Lymphatics	
75821–00	Venography, extremity, unilateral; complete procedure	$ 250.00
	Miscellaneous	
76000–00	Fluoroscopy (separate procedure), up to one hour physician time	$ 87.00

76020–00	Bone age studies	55.00
76040–00	Bone length studies (orthoroentgenogram, scanogram)	77.60
76061–00	Radiologic examination, osseous survey; limited (e.g., for metastases)	171.36
76062–00	complete (axial and appendicular skeleton)	269.00
76066–00	Joint survey, single view, one or more joints (specify)	85.00
76090–00	Mammography; unilateral	62.00
76091–00	bilateral	78.00
76092–00	Screening mammography, bilateral (two view film study of each breast)	75.00
76096–00	Localization of breast nodule or calcification before operation, with marker and confirmation of its position with appropriate imaging (e.g., radiologic or ultrasound)	211.00
76098–00	Radiological examination, breast surgical specimen	27.00
76100–00	Radiologic examination, single plane body section (e.g., tomography), other than urography	170.00
76101–00	Radiologic examination, complex motion (e.g., hypercycloidal) body section (e.g., mastoid polytomography), other than with urography; unilateral	126.70
76102–00	bilateral	152.40
76140–00	Consultation on x–ray examination made elsewhere, written report	37.80
76361–00	Computerized tomography guidance for needle biopsy; complete procedure	601.00
76370–00	Computerized tomography guidance for placement of radiation therapy fields	240.40
76375–00	Computerized tomography, coronal, sagittal, multiplanar, oblique and/or three dimensional reconstruction	70.00

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	
76511–00	Ophthalmic ultrasound, echography; A–mode, with amplitude quantification	$ 163.75
76512–00	contact B–scan	165.00
76516–00	Ophthalmic, biometry by ultrasound echography, A–mode	160.00
76519–00	with intraocular lens power calculation	155.00

76536–00	Echography, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), B–scan and/or real time with image documentation	250.70
	Chest	
76645–00	Echography, breast(s) (unilateral or bilateral), B–scan and/or real time with image documentation	$ 118.00
	Abdomen and Retroperitoneum	
76700–00	Echography, abdominal, B–scan; and/or real time with image documentation; complete	$ 200.50
76705–00	limited (e.g., single organ, quadrant, follow–up)	167.00
76770–00	Echography, retroperitoneal (e.g., renal, aorta, nodes), B–scan and/or real time with image documentation; complete	180.00
76775–00	limited	125.00
	Pelvis	
76805–00	Echography, pregnant uterus, B–scan and/or real time with image documentation; complete (complete maternal and fetal evaluation)	$ 151.00
76815–00	limited (gestational age, heart beat, placental location, fetal position, or emergency in the delivery room)	105.00
76816–00	follow–up or repeat	80.00
76818–00	Fetal biophysical profile	131.25
76830–00	Echography, transvaginal	125.00
76855–00	Echography, pelvic area (Doppler)	194.00
76856–00	Echography, pelvic (nonobstetric), B–scan and/or real time with image documentation; complete	155.00
76857–00	limited or follow–up (e.g., for follicles)	80.00
	Genitalia	
76870–00	Echography, scrotum and contents	$ 250.70
76872–00	Echography, prostate, transrectal	235.00
	Extremities	
76880–00	Echography, extremity, nonvascular B–scan and/or real time with image documentation	$ 202.22
	Vascular studies	
76925–00	Echography, peripheral vascular system (e.g., B–scan, Doppler or real time scan)	$ 140.00
76926–00	Echography, head and trunk, vascular system (e.g., duplex Doppler)	147.70
	Ultrasonic Guidance Procedures	
76943–00	Ultrasonic guidance for needle biopsy; complete procedure	$ 337.80

76947–00	Ultrasonic guidance for amniocentesis; complete procedure	185.00
	Miscellaneous	
76970–00	Ultrasound study follow–up (specify)	$ 60.10

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
77261–00	Therapeutic radiology treatment planning; simple	$ 122.60
77262–00	intermediate	185.00
77263–00	complex	375.00
77280–00	Therapeutic radiology simulation–aided field setting; simple	214.45
77285–00	intermediate	330.00
77290–00	complex	461.40
77300–00	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment	88.00
77310–00	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (three or more treatment ports directed to a single area of interest)	197.45
77315–00	complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex rotational blocking or special beam considerations)	282.90
77331–00	Special dosimetry (e.g., TLD, microdosimetry) (specify)	113.40
77332–00	Treatment devices, design and construction; simple (simple block, simple bolus)	147.00
77333–00	intermediate (multiple blocks, stents, bite blocks, special bolus)	152.25
77334–00	complex (irregular blocks, special shields, compensators, wedges, molds, or casts)	288.70
77336–00	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance	127.35

77400–00	Daily megavoltage treatment management; simple	103.00
77405–00	intermediate	125.00
77410–00	complex	157.00
77415–00	Therapeutic radiology treatment port film interpretation and verification, per treatment course	24.00
77420–00	Weekly megavoltage treatment management; simple	373.00
77425–00	intermediate	477.00
77430–00	complex	907.40
77465–00	Daily kilovoltage treatment management	75.00

Subp. 5. **Nuclear medicine.** The following codes, service descriptions, and maximum fees apply to nuclear medicine procedures. Procedures may be performed independently or in the course of overall medical care. The services listed do not include the provision of radium or other radioelements.

Code	Service	Maximum Fee
	Diagnostic – Endocrine System	
78000–00	Thyroid uptake; single determination	$ 76.80
78010–00	Thyroid imaging; only	148.00
	Diagnostic — Gastrointestinal System	
78215–00	Liver and spleen imaging; static only	$ 220.10
	Diagnostic — Musculoskeletal System	
78300–00	Bone imaging; limited area (e.g., skull, pelvis)	$ 230.00
78305–00	multiple areas	295.00
78306–00	whole body	340.60
78315–00	by three phase technique	383.10
78351–00	Bone density (bone mineral content) study; dual photon absorptiometry	119.60
	Cardiovascular System	
78460–00	Myocardial imaging; resting only, quantitative or qualitative	$ 136.00
78461–00	exercise and redistribution, qualitative or quantitative, with or without pharmacological intervention	342.00
78464–00	tomographic (SPECT), at rest only, qualitative or quantitative	275.00
78465–00	tomographic (SPECT) with exercise and redistribution, qualitative or quantitative, with or without pharmacologic intervention	665.00
	Diagnostic — Respiratory System	
78580–00	Pulmonary perfusion imaging; particulate	$ 367.00
	Diagnostic — Genitourinary System	
78707–00	Kidney imaging; with vascular flow and function study	$ 438.30

Miscellaneous Studies

78890–00	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes	$ 49.00
78891–00	complex manipulations and interpretation, exceeding 30 minutes	98.00
78990–00	Provision of diagnostic radionuclide(s)	116.00
79000–00	Radionuclide therapy, hyperthyroidism; initial, including evaluation of patient	553.70
79900–00	Provision of therapeutic radionuclide(s)	4.55

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2400 PHYSICIAN SERVICES; PATHOLOGY AND LABORATORY.

Subpart 1. **Scope.** The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

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 80002–00 to 80090–00 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

A. Albumin

B. Albumin/globulin ratio

C. Bilirubin, direct

D. Bilirubin, total

E. Calcium

F. Carbon dioxide content

G. Chlorides

H. Cholesterol

I. Creatinine

J. Globulin

K. Glucose (sugar)

L. Lactic dehydrogenase (LDH)

M. Phosphatase, alkaline

N. Phosphorus (inorganic phosphate)

O. Potassium

P. Protein, total

Q. Sodium

R. Transaminase, glutamic oxaloacetic (SGOT)

S. Transaminase, glutamic pyruvic (SGPT)

T. Urea nitrogen (BUN)

U. Uric acid

Code	Service	Maximum Fee
	Automated Multichannel Tests	
80002–00	Automated multichannel test; one or two clinical chemistry test(s)	$ 22.00
80003–00	three clinical chemistry tests	30.00
80004–00	four clinical chemistry tests	29.90
80005–00	five clinical chemistry tests	31.20
80006–00	six clinical chemistry tests	32.00
80007–00	seven clinical chemistry tests	36.00
80008–00	eight clinical chemistry tests	30.00
80009–00	nine clinical chemistry tests	37.10
80010–00	ten clinical chemistry tests	44.00
80011–00	11 clinical chemistry tests	32.00
80012–00	12 clinical chemistry tests	46.80
80016–00	13–16 clinical chemistry tests	42.93
80018–00	17–18 clinical chemistry tests	50.00
80019–00	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	37.00
	Therapeutic Drug Monitoring	
80031–00	Therapeutic quantitative drug monitoring in body fluids and/or excreta; measurement of one drug (if drug not specified by code number)	$ 51.00
80032–00	two drugs measured	74.00
80040–00	Serum radioimmunoassay for circulating antibiotic levels	55.00
	Organ or Disease Oriented Panels	
80050–00	General health screen panel	$ 49.50
80053–00	Executive profile	70.25
80055–00	Obstetric profile	46.00
80056–00	Amenorrhea profile	168.00
80058–00	Hepatic function panel	38.25
80059–00	Hepatitis panel	65.00
80060–00	Hypertension panel	35.00
80061–00	Lipid profile	36.00
80062–00	Cardiac evaluation (including coronary risk) panel	38.00
80063–00	Cardiac injury panel	40.00
80064–00	with creatine phosphokinase (CPK) and/or lactic dehydrogenase (LDH) isoenzyme determination	50.00
80065–00	Metabolic panel	60.50
80070–00	Thyroid panel	43.20
80071–00	with thyrotropin releasing hormone (TRH)	53.20
80072–00	Arthritis panel	49.50
80073–00	Renal panel	28.00
80085–00	Microcytic anemia panel	70.50
80086–00	Macrocytic anemia panel	47.70
80090–00	Antibody panel (e.g., TORCH: toxoplasma IFA, rubella HI, cytomegalovirus CF, herpes virus CF)	100.00

	Consultations (Clinical Pathology)	
80500–00	Clinical pathology consultation; limited, without review of patient's history and medical records	$ 31.80
80502–00	comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	30.25

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

Code	Service	Maximum Fee
81000–00	Urinalysis (pH, specific gravity, protein, tests for reducing substances as glucose); with microscopy	$ 15.00
81002–00	without microscopy	10.00
81004–00	Urinalysis; components, single, not otherwise listed, specify	7.50
81005–00	chemical, qualitative, any number of constituents	8.00
81007–00	bacteriuria screen, by nonculture technique, commercial kit (specific type)	7.00
81015–00	microscopic only	11.00
81020–00	two or three glass test	11.00

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
82010–00	Acetone; quantitative	$ 7.75
82011–00	Acetylsalicylic acid; quantitative	23.75
82024–00	Adrenocorticotropic hormone (ACTH), RIA	80.50
82040–00	Albumin; serum	12.00
82055–00	Alcohol (ethanol), blood; chemical	32.00
82070–00	Alcohol (ethanol), urine; by gas–liquid chromatography	38.00
82085–00	Aldolase, blood; kinetic ultraviolet method	29.50
82130–00	Amino acids, urine or plasma, chromatographic fractionation and quantitation, one or more	114.20
82137–00	Aminophylline	42.93
82138–00	Amitryptyline	54.00
82140–00	Ammonia; blood	52.30
82150–00	Amylase, serum	25.70
82156–00	Amylase, urine (diastase)	27.10
82157–00	Androstenedione, RIA	106.25
82164–00	Angiotensin–converting enzyme	47.00
82172–00	Apolipoprotein, immunoassay	25.00
82205–00	Barbiturates; quantitative	37.00
82210–00	quantitative and identification	34.50
82232–00	Beta–2 microglobulin, RIA; serum	90.00
82250–00	Bilirubin; blood, total OR direct	18.00
82251–00	blood, total AND direct	17.50
82270–00	Blood; occult, feces, screening	9.75

82306–00	Calcifediol (25–OH Vitamin D–3), chromatographic technique	154.30
82307–00	Calciferol (Vitamin D), RIA	66.00
82310–00	Calcium, blood; chemical	13.70
82325–00	atomic absorption flame photometry	15.20
82330–00	fractionated, diffusible	28.60
82340–00	Calcium, urine; quantitative, timed specimen	24.50
82355–00	Calculus (stone), qualitative; chemical	37.00
82360–00	Calculus (stone), quantitative; chemical	40.00
82365–00	infrared spectroscopy	62.25
82372–00	Carbamazepine, serum	40.50
82374–00	Carbon dioxide, combining power or content	9.40
82375–00	Carbon monoxide, (carboxyhemoglobin); quantitative	52.50
82380–00	Carotene, blood	36.00
82382–00	Catecholamines (dopamine, norepinephrine, epinephrine); total urine	68.00
82384–00	fractionated	92.00
82390–00	Ceruloplasmin, chemical (copper oxidase), blood	28.30
82435–00	Chlorides; blood (specify chemical or electrometric)	9.40
82465–00	Cholesterol, serum; total	15.00
82470–00	total and esters	39.00
82480–00	Cholinesterase; serum	29.20
82486–00	Chromatography; gas–liquid, compound and method not elsewhere specified	62.40
82495–00	Chromium, urine	16.00
82507–00	Citrate	87.90
82512–00	Clonazepam	52.60
82525–00	Copper; blood	40.00
82532–00	Cortisol; CPB, urine	59.00
82533–00	Cortisol; RIA, plasma	54.50
82534–00	RIA, urine	60.00
82540–00	Creatine; blood	23.00
82545–00	urine	21.00
82546–00	Creatine and creatinine	21.00
82550–00	Creatine phosphokinase (CPK), blood; timed kinetic ultraviolet method	26.60
82552–00	isoenzymes	43.50
82555–00	colorimetric	37.00
82565–00	Creatinine; blood	16.00
82570–00	urine	16.53
82575–00	clearance	37.00
82595–00	Cryoglobulin, blood	46.30
82606–00	Cyanocobalamin (Vitamin B–12); bioassay	39.00
82607–00	RIA	43.00
82615–00	Cystine and homocystine, urine; qualitative	64.90
82626–00	Dehydroepiandrosterone (DHEA), RIA	96.50
82628–00	Desipramine	62.00
82634–00	Deoxycortisol, 11–(compound S), RIA	184.00
82640–00	Digitoxin (digitalis); blood, RIA	32.50
82643–00	Digoxin, RIA	45.25
82656–00	Doxepin	63.75

82660–00	Drug screen (amphetamines, barbiturates, alkaloids)	51.00
82670–00	Estradiol, RIA (placental)	78.90
82672–00	Estrogens; total	97.50
82692–00	Ethosuximide	50.00
82705–00	Fat or lipids, feces; screening	22.00
82710–00	quantitative, 24 or 72 hour specimen	83.20
82728–00	Ferritin, specify method (e.g., RIA, immunoradiometric assay)	47.10
82730–00	Fibrinogen, quantitative	16.00
82745–00	Folic acid (folate), blood; bioassay	35.00
82746–00	RIA	46.50
82756–00	Free thyroxine index (T–7)	40.00
82784–00	Gamma globulin, A, D, G, M nephelometric, each	33.17
82785–00	Gamma globulin, E (e.g., RIA, EIA)	40.00
82792–00	Gases, blood, oxygen saturation; by oximetry	31.50
82803–00	Gases, blood; pH, pCO2, pO2 simultaneous	56.00
82941–00	Gastrin, RIA	57.80
82946–00	Glucagon tolerance test	32.00
82947–00	Glucose; except urine (e.g., blood, spinal fluid, joint fluid)	16.00
82948–00	blood, stick test	13.50
82950–00	post glucose dose (includes glucose)	20.00
82951–00	tolerance test (GTT), three specimens (includes glucose)	48.00
82952–00	tolerance test, each additional beyond three specimens	15.00
82954–00	Glucose, urine	7.00
82977–00	Glutamyl transpeptidase, gamma (GGT)	18.50
83000–00	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	56.00
83001–00	RIA	60.10
83002–00	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	57.00
83003–00	Growth hormone, human (HGH) (somatotropin); RIA	54.00
83015–00	Heavy metal screen (arsenic, bismuth, mercury, antimony); chemical (e.g., Reinsch, Gutzeit)	91.00
83020–00	Hemoglobin; electrophoresis (includes A2, S, C, etc.)	11.50
83036–00	glycosylated (A1C)	27.00
83050–00	methemoglobin, quantitative	16.00
83051–00	plasma	9.00
83052–00	sickle, turbidimetric	20.00
83150–00	Homovanillic acid (HVA), urine	93.70
83497–00	Hydroxyindolacetic acid, 5–(HIAA), urine	57.00
83498–00	Hydroxyprogesterone, 17–d, RIA	82.70
83523–00	Imipramine	58.00
83525–00	Insulin, RIA	45.00
83540–00	Iron, serum; chemical	17.10
83545–00	automated	14.30
83550–00	Iron binding capacity, serum; chemical	24.00
83555–00	automated	35.10
83565–00	radioactive uptake method	29.75
83582–00	Ketogenic steroids, urine; 17–(17–KGS)	48.10
83610–00	Lactic dehydrogenase (LDH), RIA	15.00

83615–00	Lactic dehydrogenase (LDH), blood; kinetic ultraviolet method	19.50
83620–00	colorimetric or fluorometric	18.00
83625–00	isoenzymes, electrophoretic separation and quantitation	36.70
83645–00	Lead, screening; blood	17.10
83655–00	Lead, quantitative; blood	40.00
83690–00	Lipase, blood	26.60
83700–00	Lipids, blood; total	17.35
83705–00	fractionated (cholesterol, triglycerides, phospholipids)	29.00
83715–00	Lipoprotein, blood; electrophoretic separation and quantitation (phenotyping)	30.00
83717–00	analytic ultracentrifugation separation and quantitation (atherogenic index)	25.00
83718–00	Lipoprotein high density cholesterol (HDL cholesterol) by precipitation method	23.00
83719–00	Lipoprotein very low density cholesterol (VLDL cholesterol) by ultracentrifugation	25.00
83720–00	Lipoprotein cholesterol fractionation calculation by formula	17.06
83725–00	Lithium, blood, quantitative	28.00
83735–00	Magnesium, blood; chemical	20.00
83750–00	atomic absorption	29.75
83765–00	Magnesium, urine; atomic absorption	23.00
83835–00	Metanephrines, urine	55.00
83872–00	Mucin, synovial fluid (Ropes test)	12.00
83912–00	Nucleic acid probe, with electrophoresis, with examination and report	126.00
83915–00	Nucleotidase 5'–	33.30
83916–00	Oligoclonal immune globulin (Ig), CSF, by electrophoresis	76.80
83930–00	Osmolality; blood	24.00
83935–00	urine	24.00
83945–00	Oxalate, urine	48.00
83970–00	Parathormone (parathyroid hormone), RIA	115.00
83986–00	pH, body fluid, except blood	9.50
84030–00	Phenylalanine (PKU), blood; Guthrie	15.00
84035–00	Phenylketones; blood, qualitative	21.25
84037–00	urine, qualitative	8.00
84045–00	Phenytoin	40.00
84060–00	Phosphatase, acid; blood	25.00
84065–00	prostatic fraction	32.50
84066–00	prostatic fraction, RIA	45.00
84075–00	Phosphatase, alkaline, blood	19.50
84080–00	isoenzymes, electrophoretic method	48.10
84100–00	Phosphorus (phosphate); blood	15.30
84105–00	urine	18.75
84126–00	Porphyrins, feces, quantitative	40.25
84132–00	Potassium; blood	15.50
84133–00	urine	20.00
84136–00	Pregnanediol; other method (specify)	17.00
84141–00	Primidone	46.00
84142–00	Procainamide	53.90
84144–00	Progesterone, any method	60.20

84146–00	Prolactin (mammotropin), RIA	61.50
84150–00	Prostaglandin, any one, RIA	66.10
84155–00	Protein, total, serum; chemical	16.10
84165–00	electrophoretic fractionation and quantitation	34.30
84175–00	Protein, other sources, quantitative	22.20
84176–00	Protein, special studies (e.g., monoclonal protein analysis)	133.00
84180–00	Protein, urine; quantitative, 24–hour specimen	21.50
84190–00	electrophoretic fractionation and quantitation	39.00
84195–00	Protein, spinal fluid; semiquantitative (Pandy)	22.75
84202–00	Protoporphyrin, RBC; quantitative	25.00
84203–00	screen	10.00
84208–00	Pyrophosphate vs urate, crystals (polarization)	21.50
84230–00	Quinidine, blood	40.00
84231–00	Radioimmunoassay (RIA) not elsewhere specified	83.00
84236–00	Receptor assay; progesterone and estrogen	248.85
84238–00	nonendocrine (e.g., acetylcholine) (specify receptor)	120.10
84244–00	Renin (angiotensin I); (RIA)	83.60
84295–00	Sodium; blood	16.00
84300–00	urine	19.55
84403–00	Testosterone, blood, RIA	93.70
84408–00	Tetrahydrocannabinol THC (marijuana)	20.60
84420–00	Theophylline, blood, or saliva	40.00
84435–00	Thyroxine, (T–4), CPB or resin uptake	20.00
84436–00	Thyroxine, true (TT–4), RIA	22.90
84439–00	Thyroxine, free (FT–4), RIA (unbound T–4 only)	31.00
84442–00	Thyroxine binding globulin (TBG)	48.80
84443–00	Thyroid stimulating hormone (TSH), RIA or EIA	50.00
84445–00	Thyrotropin releasing factor (TRF), RIA; plus long acting (LATS)	176.60
84446–00	Tocopherol alpha (Vitamin E)	37.40
84447–00	Toxicology, screen; general	55.00
84448–00	sedative (acid and neutral drugs, volatiles)	61.00
84450–00	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method	20.40
84455–00	colorimetric or fluorometric	16.00
84460–00	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	23.50
84465–00	colorimetric or fluorometric	20.00
84478–00	Triglycerides, blood	17.50
84479–00	Triiodothyronine (T–3), resin uptake	23.70
84480–00	Triiodothyronine, true (TT–3), RIA	60.00
84520–00	Urea nitrogen, blood (BUN); quantitative	15.30
84550–00	Uric acid; blood, chemical	17.50
84555–00	uricase, ultraviolet method	17.00
84560–00	Uric acid, urine	29.20
84585–00	Vanillylmandelic acid (VMA), urine	65.60

84590–00	Vitamin A, blood;	37.40
84630–00	Zinc, quantitative; blood	33.00
84702–00	Gonadotropin, chorionic; quantitative	45.00
84703–00	qualitative	24.00

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

Code	Service	Maximum Fee
85000–00	Bleeding time; Duke	$ 15.00
85002–00	Ivy or template	25.00
85007–00	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)	14.60
85009–00	differential WBC count, buffy coat	20.00
85012–00	eosinophil count, direct	17.00
85014–00	hematocrit	10.50
85018–00	hemoglobin, colorimetric	12.00
85021–00	hemogram, automated (RBC, WBC, Hgb, Hct, and indexes only)	21.00
85022–00	hemogram, automated, and manual differential WBC count (CBC)	27.00
85023–00	hemogram and platelet count, automated, and manual differential WBC count (CBC)	34.00
85024–00	hemogram and platelet count, automated, and automated partial differential WBC count (CBC)	28.00
85025–00	hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	26.00
85027–00	hemogram, and platelet count, automated	23.30
85029–00	Additional automated hemogram indices (e.g., red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram); one to three indices	9.00
85030–00	four or more indices	12.00
85031–00	Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indexes)	25.00
85041–00	red blood cell (RBC) only	10.00
85044–00	reticulocyte count, manual	16.70
85048–00	white blood cell (WBC)	12.00
85060–00	Blood smear, peripheral, interpretation by physician with written report	64.40
85095–00	Bone marrow smear and/or cell block; aspiration only	108.35
85097–00	smear interpretation only, with or without differential cell count	91.50
85100–00	aspiration, staining, and interpretation	181.50
85102–00	Bone marrow biopsy, needle or trocar	110.00
85103–00	staining and interpretation	165.00
85109–00	staining and preparation only	45.00

85210–00	Clotting; factor II, prothrombin, specific	21.00
85220–00	factor V (AcG or proaccelerin), labile factor	53.50
85240–00	factor VIII (AHG); one stage	98.10
85300–00	Clotting inhibitors or anticoagulants; antithrombin III, except antigen assay	116.25
85302–00	protein C assay	69.80
85362–00	Fibrin degradation (split) products (FDP) (FSP); agglutination, slide	43.30
85376–00	Fibrinogen; thrombin with plasma dilution	37.50
85426–00	Fibrinolytic mechanisms; von Willebrand factor assay	61.50
85540–00	Leukocyte alkaline phosphatase with count	52.50
85544–00	Lupus erythematosus (LE) cell prep	26.00
85548–00	Morphology of red blood cells, only	60.00
85575–00	Platelet; adhesiveness (in vivo)	19.00
85576–00	aggregation (in vitro), any agent	188.70
85580–00	count (Rees–Ecker)	17.00
85585–00	estimation on smear, only	9.00
85590–00	phase microscopy	18.25
85595–00	electronic technique	15.25
85610–00	Prothrombin time	16.50
85650–00	Sedimentation rate (ESR); Wintrobe type	12.25
85651–00	Westergren type	12.60
85660–00	Sickling of RBC, reduction, slide method	10.47
85670–00	Thrombin time; plasma	15.30
85730–00	Thromboplastin time, partial (PTT); plasma or whole blood	24.00
85732–00	substitution, plasma	18.70

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

Code	Service	Maximum Fee
86000–00	Agglutinins; febrile, each antigen	$ 40.25
86006–00	Antibody, non–RBC qualitative; first antigen, slide or tube	17.50
86007–00	each additional antigen	15.00
86008–00	Antibody, non–RBC quantitative; first antigen	34.30
86012–00	Antibody absorption, cold auto absorption; per serum	26.00
86016–00	Antibody screen, RBC, each serum	40.10
86031–00	Antihuman globulin test; direct (Coombs) (broad, IgG and non–IgG), each	18.15
86032–00	indirect, qualitative (broad, gamma or nongamma), each	29.00
86033–00	indirect, titer (broad, gamma or nongamma), each	11.25
86034–00	enzyme technique, qualitative	18.00
86038–00	Antinuclear antibodies (ANA), RIA	36.00
86060–00	Antistreptolysin O; titer	30.05
86063–00	screen	16.00
86067–00	Antitrypsin, alpha–1; other method (specify)	50.00

86068–00	Blood compatibility test; crossmatch by immediate spin and antihuman globulin technique, each unit	43.68
86070–00	crossmatch by immediate spin technique only	29.40
86080–00	Blood typing; ABO only	12.75
86082–00	ABO and Rho(D)	27.10
86083–00	ABO, Rh(D) and RBC antibody screening	37.75
86095–00	RBC antigens, other than ABO and/or Rho(D) antigen	23.40
86100–00	Rho(D) only	14.00
86105–00	Rh genotyping, complete	10.50
86115–00	anti–Rh immunoglobulin testing (RhoGAM type)	88.00
86128–00	Collection, processing and storage of predeposited autologous whole blood or components	148.50
86140–00	C–reactive protein	23.95
86149–00	Carcinoembryonic antigen (CEA); gel diffusion	53.00
86151–00	RIA or EIA	67.50
86158–00	Complement; C'1 esterase	63.75
86162–00	total (CH 50)	56.70
86163–00	C'3 esterase	30.75
86164–00	C'4 esterase	32.00
86171–00	Complement fixation tests, each antigen	29.75
86215–00	Deoxyribonuclease, antibody	70.00
86225–00	Deoxyribonucleic acid (DNA) antibody	43.00
86235–00	Antibody to specific nuclear antigen, any method, each	60.00
86244–00	Fetoprotein, alpha–1, RIA or EIA	57.00
86255–00	Fluorescent antibody; screen	39.25
86256–00	titer	44.00
86265–00	Frozen blood, preparation for freezing, each unit, including processing and collection	102.00
86280–00	Hemagglutination inhibition tests (HAI), each (e.g., rubella, viral)	24.00
86282–00	Hemolysins and agglutinins, auto, screen, each	25.00
86287–00	Hepatitis B surface antigen (HBsAg) (Australian antigen, HAA), RIA, or EIA	27.00
86288–00	Hepatitis B core antigen (HBcAg), RIA	37.50
86289–00	Hepatitis B core antibody (HBcAb); RIA or EIA	41.60
86290–00	IgM antibody (e.g., RIA, EIA, RPHA)	63.40
86291–00	Hepatitis B surface antibody (HBsAb) (e.g., RIA, EIA, RPHA)	32.00
86293–00	Hepatitis Be antigen (HBeAg) (e.g., RIA, EIA)	32.00
86295–00	Hepatitis Be antibody (HBeAb) (e.g., RIA, EIA)	41.90
86296–00	Hepatitis A antibody (HAAb) (e.g., RIA, EIA)	42.40
86299–00	IgM antibody	40.75
86300–00	Heterophile antibodies; screening (includes monotype test), slide or tube	18.00
86305–00	quantitative titer	30.50
86311–00	HIV antigen test	38.90

86312–00	HIV (HTLV–III) antibody detection; immunoassay	30.00
86314–00	confirmatory test (e.g., Western blot)	60.00
86316–00	Immunoassay for tumor antigen (e.g., prostate specific antigen, cancer antigen 125)	70.00
86317–00	Immunoassay for infectious agent antigen or antibody, each	20.00
86318–00	Immunoassay for chemical constituent	53.90
86319–00	Immunoassay technique for drugs	45.50
86320–00	Immunoelectrophoresis; serum, each specimen (plate)	83.20
86325–00	other fluids (e.g., urine) with concentration, each specimen	83.20
86327–00	crossed (2 dimensional assay)	113.00
86329–00	Immunodiffusion; quantitative, each IgA, IgG, IgM, ceruloplasmin, transferrin, alpha–2, macroglobulin, complement fractions, alpha–1 antitrypsin, or other (specify)	39.90
86331–00	gel diffusion, qualitative (Ouchterlony), each antigen or antibody	114.20
86334–00	Immunofixation electrophoresis	90.00
86335–00	Immunoglobulin typing (Gc, Gm, Inv), each	60.00
86340–00	Intrinsic factor antibodies, RIA	59.40
86342–00	Irradiation of blood products, each	21.90
86353–00	Lymphocyte transformation, spontaneous blastogenesis or phytomitogen (phytohemagglutination, PHA) or other mitogen culture (MC) (e.g., tuberculin, candida)	96.10
86357–00	Lymphocytes; T and B differentiation	157.30
86376–00	Microsomal antibody (thyroid); RIA	27.70
86377–00	other method (specify)	60.60
86382–00	Neutralization test, viral	45.00
86403–00	Particle agglutination, rapid test for infectious agent, each antigen	18.80
86405–00	Precipitin test for blood (species identification)	49.00
86421–00	Radioallergosorbent test, in vitro testing for allergen–specific IgE (e.g., RAST, MAST, FAST, IP, PRIST); up to five tests	27.60
86422–00	six or more tests	16.00
86423–00	Radioimmunosorbent test (RIST) IgE, quantitative	39.00
86430–00	Rheumatoid factor, latex fixation	21.00
86455–00	Skin test; anergy testing, one or more antigens	8.75
86490–00	coccidioidomycosis	16.00
86510–00	histoplasmosis	14.50
86540–00	mumps	25.39
86580–00	tuberculosis, intradermal	11.50
86585–00	tuberculosis, tine test	10.00
86590–00	Streptokinase, antibody	27.00
86592–00	Syphilis test; qualitative (e.g., VDRL, RPR, ART)	14.00
86593–00	quantitative	13.50
86594–00	Thyroid autoantibodies	75.00
86600–00	Toxoplasmosis, dye test	29.00

86650–00	Treponema antibodies, fluorescent, absorbed (FTA–abs)	37.00
86800–00	Thyroglobulin antibody, RIA	53.00
86807–00	Serum screening for cytotoxic percent reactive antibody (PRA); standard method	231.40
86812–00	Tissue typing; HLA typing, A, B, or C (e.g., A10, B7, B27), single antigen	78.50
86813–00	HLA typing, A, B, and/or C (e.g., A10, B7, B27), multiple antigens	319.00

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

Code	Service	Maximum Fee
87015–00	Concentration (any type), for parasites, ova, or tubercle bacillus (TB, AFB)	$ 22.00
87040–00	Culture, bacterial, definitive; blood (includes anaerobic screen)	40.50
87045–00	stool	37.00
87060–00	throat or nose	16.00
87070–00	any other source	32.50
87072–00	Culture or direct bacterial identification method, each organism, by commercial kit, any source except urine	16.00
87075–00	Culture, bacterial, any source; anaerobic (isolation)	37.00
87076–00	definitive identification, each anaerobic organism, including gas chromatography	80.00
87081–00	Culture, bacterial, screening only, for single organisms	17.00
87082–00	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	15.00
87083–00	multiple organisms	14.00
87084–00	with colony estimation from density chart	16.00
87086–00	Culture, bacterial, urine; quantitative, colony count	22.20
87087–00	commercial kit	15.00
87088–00	identification, in addition to quantitative or commercial kit	26.70
87101–00	Culture, fungi, isolation (with or without presumptive identification); skin	23.00
87102–00	other source (except blood)	14.75
87103–00	blood	64.80
87106–00	Culture, fungi, definitive identification of each fungus	35.10
87109–00	Culture, mycoplasma, any source	40.00
87110–00	Culture, Chlamydia	40.00
87117–00	Culture, tubercle or other acid–fast bacilli (e.g., TB, AFB, mycobacteria); concentration plus isolation	46.30
87118–00	Culture, mycobacteria, definitive identification of each organism	46.50
87140–00	Culture, typing; fluorescent method, each antiserum	16.50

87147–00	serologic method, agglutination grouping, per antiserum	12.00
87151–00	serologic method, speciation	25.45
87158–00	other methods	28.50
87163–00	Culture, any source, additional identification methods required	35.00
87164–00	Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection	11.00
87174–00	Endotoxin, bacterial (pyrogens); chemical	40.00
87177–00	Ova and parasites, direct smears, concentration and identification	32.20
87178–00	Microbial identification, nucleic acid probes, each probe used	40.00
87181–00	Sensitivity studies, antibiotic; agar diffusion method, per antibiotic	19.00
87184–00	disc method, per plate (12 or less discs)	21.00
87186–00	microtiter, minimum inhibitory concentration (MIC), any number of antibiotics	27.00
87205–00	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	18.60
87206–00	fluorescent and/or acid fast stain for bacteria, fungi, or cell types	30.00
87207–00	special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala–azar, herpes)	25.00
87208–00	direct or concentrated, dry, for ova and parasites	15.00
87210–00	wet mount with simple stain, for bacteria, fungi, ova, and/or parasites	15.00
87211–00	wet and dry mount, for ova and parasites	14.50
87220–00	Tissue examination for fungi (e.g., KOH slide)	15.00
87230–00	Toxin or antitoxin assay, tissue culture (e.g., Clostridium difficile toxin)	60.00
87250–00	Virus identification; inoculation of embryonated eggs, or small animal, includes observation and dissection	55.00
87252–00	tissue culture inoculation and observation	58.80
87253–00	tissue culture, additional studies (e.g., hemabsorption, neutralization) each isolate	48.40

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

Code	Service	Maximum Fee
	Cytopathology	
88104–00	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears with interpretation	$ 38.15

88106–00	filter method only with interpretation	54.00
88107–00	smears and filter preparation with interpretation	36.20
88130–00	Sex chromatin identification; Barr bodies	39.45
88150–00	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou), up to three smears; screening by technician under physician supervision	18.00
88151–00	requiring interpretation by physician	20.00
88155–00	with definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index)	17.00
88160–00	Cytopathology, any other source; screening and interpretation	31.90
88161–00	preparation, screening and interpretation	42.00
88170–00	Fine needle aspiration with or without preparation of smears; superficial tissue (e.g., thyroid, breast, prostate)	110.00
88172–00	Evaluation of fine needle aspirate with or without preparation of smears; immediate cytohistologic study to determine adequacy of specimen(s)	108.00
88180–00	Flow cytometry; each cell surface marker	70.00
88182–00	cell cycle or DNA analysis	145.80
88261–00	Chromosome analysis; count five cells, one karyotype, with banding	546.75
88262–00	count 15–20 cells, two karyotypes, with banding	603.10
88267–00	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotype, with banding	730.00
88269–00	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6–12 colonies, one karyotype, with banding	430.00
88280–00	Chromosome analysis; additional karyotypes, each study	75.00
88285–00	additional cells counted, each study	25.00

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 (88300–00 to 88307–00) should be used in reporting specimens (single or multiple) that are removed during a single surgical procedure.

Code	Service	Maximum Fee
88300–00	Surgical pathology, gross examination only	$ 30.00
88302–00	Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes	45.00
88304–00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen	50.00
88305–00	single complicated specimen or specimen composed of multiple uncomplicated tissues, without complex dissection	100.00

88307–00	single complicated specimen requiring complex dissection or a specimen composed of multiple complicated tissues	128.90
88309–00	complex diagnostic problem with or without extensive dissection	220.75
88311–00	Decalcification procedure (list separately in addition to code for surgical pathology examination)	24.31
88312–00	Special stains; Group I for microorganisms (e.g., Gridley, acid fast, methenamine silver), each	34.50
88313–00	Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each	25.90
88319–00	Determinative histochemistry or cytochemistry to identify enzyme constituents, each	59.00
88321–00	Consultation and report on referred slides prepared elsewhere	60.00
88325–00	Consultation, comprehensive, with review of records and specimens, with report on referred material	79.00
88329–00	Consultation during surgery;	73.00
88331–00	with frozen section(s), single specimen	115.00
88332–00	each additional tissue block with frozen section(s)	52.00
88342–00	Immunocytochemistry (including tissue immunoperoxidase), each antibody	73.65
88346–00	Immunofluorescent study, each antibody; direct method	100.00
88347–00	indirect method	144.00
88348–00	Electron microscopy; diagnostic	408.00

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

Code	Service	Maximum Fee
89050–00	Cell count, miscellaneous body fluids (e.g., CSF, joint fluid), except blood	$ 25.00
89051–00	with differential count	17.90
89060–00	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)	19.60
89125–00	Fat stain, feces, urine, or sputum	30.80
89190–00	Nasal smear for eosinophils	15.00
89205–00	Occult blood, any source except feces	15.00
89300–00	Semen analysis; presence and/or motility of sperm, including Huhner test	33.85
89310–00	motility and count	28.00
89320–00	complete (volume, count, motility and differential)	61.25
89325–00	Sperm antibodies	211.90
89329–00	Sperm evaluation; hamster penetration test	332.00
89330–00	cervical mucus penetration test, with or without spinnbarkheit test	34.00

89350–00	Sputum, obtaining specimen, aerosol induced technique (separate procedure)	71.80
89360–00	Sweat collection by iontophoresis	120.10

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2500 DENTISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to persons licensed as doctors of dental surgery or a comparable degree.

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

Code	Service	Maximum Fee
	Restorative	
02110–00	Amalgam; one surface, primary	$ 34.00
02120–00	two surfaces, primary	46.00
02130–00	three surfaces, primary	59.00
02131–00	four surfaces, primary	73.00
02140–00	Amalgam; one surface, permanent	35.00
02150–00	two surfaces, permanent	49.00
02160–00	three surfaces, permanent	64.00
02161–00	four or more surfaces, permanent	76.00
	Filled or Unfilled Restorations	
02330–00	Resin; one surface, anterior	$ 49.00
02331–00	two surfaces, anterior	68.00
02332–00	three surfaces, anterior	90.00
02335–00	four or more surfaces or (involving incisal angle)	90.00
	Inlay Restorations	
02530–00	Inlay – metallic; three surfaces	$ 450.00
02540–00	Onlay – metallic; per tooth (in addition to inlay)	425.00
	Crowns – Single Restoration Only	
02740–00	Crown; porcelain/ceramic substrate	$ 458.00
02750–00	porcelain fused to high noble metal	440.00
02751–00	porcelain fused to predominantly base metal	415.00
02752–00	porcelain fused to noble metal	425.00
02790–00	full cast high noble metal	425.00
02791–00	full cast predominantly base metal	360.00
02792–00	full cast noble metal	385.00
02810–00	3/4 cast metallic	425.00
	Other Restorative Services	
02910–00	Recement inlays	$ 35.00
02920–00	Recement crown	35.00
02940–00	Sedative filling	31.00
02950–00	Crown buildup, including any pins	95.00
02960–00	Labial veneer (laminate); chairside	250.00
	Endodontics	
03110–00	Pulp cap; direct (excluding final restoration)	$ 23.00

03120–00	indirect (excluding final restoration)	17.00
03220–00	Therapeutic pulpotomy (excluding final restoration)	52.00
	Root Canal Therapy	
03310–00	One canal (excludes final restoration)	$ 240.00
03320–00	Two canals (excludes final restoration)	285.00
03330–00	Three canals (excludes final restoration)	400.00
	Periapical Services	
03410–00	Apicoectomy; (per tooth) first root	$ 250.00
03430–00	Retrograde filling; per root	94.00
	Other Endodontic Procedures	
03950–00	Canal preparation and fitting of preformed dowel or post	$ 95.00
03960–00	Bleaching of discolored tooth	160.00
	Prosthodontics, Removable Complete Dentures — Including Routine Postdelivery Care	
05110–00	Complete upper	$ 600.00
05120–00	Complete lower	590.00
05130–00	Immediate upper	625.00
05140–00	Immediate lower	600.00
	Partial Dentures — Including Routine Postdelivery Care	
05214–00	Lower partial, predominately base cast base with acrylic saddles (including any conventional clasps and rests)	$ 625.00
05215–00	Upper partial; high noble cast base with acrylic saddles (including any conventional clasps and rests)	750.00
05216–00	Lower partial; high noble cast base with acrylic saddles (including any conventional clasps and rests)	725.00
	Adjustments to Dentures	
05410–00	Adjust complete denture; upper	$ 25.00
05422–00	Adjust partial denture; lower	25.00
	Repairs to Dentures	
05610–00	Repair acrylic saddle or base	$ 55.00
05620–00	Repair cast framework	55.00
05630–00	Repair or replace broken clasp	54.00
05640–00	Replace broken teeth; per tooth	45.00
05650–00	Add tooth to existing partial denture	75.00
05660–00	Add clasp to existing partial denture	100.00
	Denture Relining	
05730–00	Reline complete upper denture (chairside)	$ 125.00

05750–00	Relining complete upper denture (laboratory)	175.00
05760–00	Relining upper partial denture (laboratory)	185.00
	Other Removable Prosthetic Services	
05820–00	Temporary partial stayplate, denture (upper)	$ 195.00
05850–00	Tissue conditioning; per denture unit	42.00
	Bridge Pontics	
06210–00	Pontic; cast high noble metal	$ 405.00
06240–00	porcelain fused to high noble metal	430.00
06241–00	porcelain fused to predominantly base metal	400.00
06242–00	porcelain fused to noble metal	420.00
	Retainers	
06545–00	Cast metal retainer for acid etch bridge	$ 175.00
	Bridge Retainers — Crowns	
06750–00	Crown; porcelain fused to high noble metal	$ 430.00
06751–00	porcelain fused to predominantly base metal	410.00
06752–00	porcelain fused to noble metal	425.00
06790–00	full cast high noble metal	420.00
06792–00	full cast noble metal	385.00
	Other Fixed Prosthetic Services	
06930–00	Recement bridge	$ 50.00
	Oral Surgery Extractions — Includes Local Anesthesia and Routine Postoperative Care	
07110–00	Single tooth	$ 45.00
07120–00	Each additional tooth	41.00
	Surgical Extractions — Includes Local Anesthesia and Routine Postoperative Care	
07210–00	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 100.00
07220–00	Removal of impacted tooth; soft tissue	118.00
07230–00	Removal of the impacted tooth; partially bony	150.00
07240–00	Removal of impacted tooth; completely bony	175.00
07241–00	Removal of impacted tooth; completely bony, with unusual surgical complications	200.00
07250–00	Surgical removal of residual tooth roots (cutting procedure)	95.00

	Other Surgical Procedures	
07280–00	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	$ 215.00
07281–00	Surgical exposure of impacted or unerupted tooth to aid eruption	125.00
07286–00	Biopsy of oral tissue; soft	115.00
	Alveoloplasty — Surgical Preparation of Ridge For Dentures	
07310–00	Alveoloplasty (per quadrant) in conjunction with extractions	$ 78.00
	Surgical Incision	
07510–00	Incision and drainage of abscess; intraoral soft tissue	$ 50.00
	Other Repair Procedures	
07960–00	Frenulectomy	$ 135.00
07970–00	Excision of hyperplastic tissue; per arch	250.00
	Minor Treatment for Tooth Guidance	
08110–00	Removable appliance therapy	$ 290.00
08120–00	Fixed appliance therapy	300.00
	Interceptive Orthodontic Treatment	
08360–00	Removable appliance therapy	$ 832.50
08370–00	Fixed appliance therapy	640.00
	Other Orthodontic Devices	
08750–00	Posttreatment stabilization	$ 100.00
	Adjunctive General Services Unclassified Treatment	
09110–00	Palliative (emergency) treatment of dental pain; minor procedures	$ 33.00
	Anesthesia	
09210–00	Local anesthesia not in conjunction with operative or surgical procedures	$ 12.00
09220–00	General anesthesia; first 30 minutes	130.00
09230–00	Analgesia	15.00
	Professional Consultation	
09310–00	Consultation; per session	$ 37.00
09430–00	Office visit for observation (during regularly scheduled hours); no other services performed	20.00

	Surgery	
11100–00	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); one lesion	$ 136.00
21200–00	Osteotomy (e.g., for prognathism, micrognathism, apertognathism or for reconstruction); mandible, total or horizontal	4,000.00
40808–00	Biopsy, vestibule of mouth	125.00
40819–00	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	160.00
41825–00	Excision of lesion tumor (except as indicated by CPT codes 41820, 41821, 41822, and 41823), dentoalveolar structures; without repair	175.00

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; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2600 OPTOMETRISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of optometry, and to procedures performed within the scope of practice in accordance with Minnesota Statutes, sections 148.52 to 148.62.

Code	Service	Maximum Fee
06501–00	Single vision eyeglass lenses (one lens)	$ 49.50
06502–00	Bifocal eyeglass lenses (one lens)	57.50
06503–00	Trifocal eyeglass lenses (one lens)	77.50
06506–00	Eyeglass frames	85.00
06510–00	Tinting for lenses	15.00
06587–00	Contact lenses, soft (one lens)	80.00
06588–00	Contact lenses, hard (one lens)	86.00
06589–00	Dispensing fee; single vision lenses	20.00
06590–00	bifocal lenses	25.80
06591–00	trifocal lenses	26.00
06636–00	Eyeglass lenses (prosthesis)	58.00
06654–00	Surgical dressings	100.00
09213–00	Eye refraction	32.00

Subp. 2. [Repealed by amendment, 13 SR 2609]

Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 13 SR 2609; 14 SR 722; 15 SR 738*

5221.2650 OPTICIANS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to certified opticians.

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

Code	Service	Maximum Fee
06501–00	Single vision eyeglass lenses (one lens)	$ 52.50
06502–00	Bifocal eyeglass lenses (one lens)	65.00
06503–00	Trifocal eyeglass lenses (one lens)	68.50
06506–00	Eyeglass frames	96.00
06510–00	Tinting for lenses	13.50
06587–00	Contact lenses, soft (one lens)	64.50
06588–00	Contact lenses, hard (one lens)	84.00
06635–00	Contact lenses (prosthesis)	98.00
06636–00	Eyeglass lenses (prosthesis)	92.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738*

5221.2700 [Repealed, 14 SR 722]

5221.2750 SPEECH PATHOLOGISTS.

The following codes, service descriptions, and maximum fees apply to speech pathologists holding a certificate of clinical competency (CCC–SP) or to speech pathologists in their clinical fellowship year (CFY) as certified by the American Speech, Language, and Hearing Association.

Code	Service	Maximum Fee
92506–00	Medical evaluation speech, language, and/or hearing problems	$ 120.00
92507–00	Speech, language, or hearing therapy, with continuing medical supervision; individual	66.00
92508–00	group	40.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to registered physical therapists, registered occupational therapists, a physical therapy assistant serving under the direction of a registered physical therapist or a certified occupational therapy assistant serving under the direction of a registered occupational therapist.

Subp. 2. **Definitions.** The terms defined in this subpart have the meanings given to them when used in subpart 4 unless the context clearly indicates a different meaning.

A. "Therapeutic exercise" (code 97110–00) means instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a therapist present and supervising will not be covered by code 97110.

B. "Neuromuscular reeducation" (code 97112–00) means provision of direct services to a patient who has neuromuscular impairment and is undergoing recovery or regeneration. Examples would be surgery, trauma to neuromuscular system, cerebral vascular accident, and systemic neurological disease.

C. "Functional activities" (code 97114–00) means the development and instruction in specific activities for persons who are handicapped or debilitated by neuromusculoskeletal dysfunction. This applies to counseling and instructions in body mechanics and work–related activities.

D. "Gait training" (code 97116–00) means teaching individuals with neurological or musculoskeletal disorders to ambulate with or without an assistive device.

E. "Pool therapy" or "Hubbard tank with therapeutic exercises" (code 97240–00) means a supervised service in a pool or Hubbard tank, to neurologically or musculoskeletally impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps, or relax in a hot tub or Jacuzzi.

F. "Activities of daily living" (ADL's) (code 97540–00) means services provided to impaired individuals, for example, how to get in and out of a tub; how to make a bed; how prepare a meal in a kitchen. It does not apply to instructions or counseling in body mechanics given to a patient.

G. "Testing for strength, dexterity, or stamina" (code 97720–00) means detailed testing of a patient with neuromusculoskeletal dysfunction.

H. "Kinetic activities" (code 97530–00) means services when there are neuromusculoskeletal dysfunction which limit the patient's performing the activities that are ordinarily prescribed under therepeutic exercise.

Subp. 3. MR 1985 [Repealed, 10 SR 765]

Subp. 3. **Physical and occupational therapy instructions.**

A. The physical and occupational therapy treatment plan must be in writing and shall include objectives, modalities, and frequency of treatment and duration.

B. Physical therapy services must be provided by a Minnesota registered physical therapist or physical therapy assistant under the direct supervision of a registered physical therapist. Upon request, the provider must supply a Minnesota registration number.

C. Occupational therapy services must be provided by a nationally registered occupational therapist or certified occupational therapy assistant under the direction of a nationally registered occupational therapist.

Subp. 4. **Physical therapy and occupational therapy services.** The following codes, service descriptions, and maximum fees apply to physical and occupational therapy procedures when performed within the physical or occupational therapist's scope of practice in an independent clinic, or a doctor's office.

Code	Service	Maximum Fee
	Modalities	
97010–00	Physical medicine treatment to one area; hot or cold packs	$ 19.22
97012–00	traction, mechanical	20.00
97014–00	electrical stimulation (unattended)	18.00
97016–00	vasopneumatic devices	20.00
97018–00	paraffin bath	20.00
97020–00	microwave	17.00
97022–00	whirlpool	20.00
97024–00	diathermy	20.00
97026–00	infrared	32.00
	Procedures	
97110–00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	$ 30.00
97112–00	neuromuscular re–education	25.00
97114–00	functional activities	31.00
97116–00	gait training	24.00
97118–00	electrical stimulation (manual)	20.25

97120–00	iontophoresis	30.00
97122–00	traction, manual	20.00
97124–00	massage	22.00
97126–00	contrast baths	19.50
97128–00	ultrasound	20.00
97145–00	Physical medicine treatment to one area, each additional 15 minutes	16.00
97220–00	Hubbard tank; initial 30 minutes, each visit	55.00
97240–00	Pool therapy or Hubbard tank with therapeutic exercises; initial 30 minutes, each visit	60.00
97241–00	each additional 15 minutes, up to one hour	21.00
97500–00	Orthotics training (dynamic bracing, splinting), upper extremities; initial 30 minutes, each visit	25.00
97501–00	each additional 15 minutes	23.00
97530–00	Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk); initial 30 minutes, each visit	28.00
97531–00	each additional 15 minutes	16.00
97540–00	Training in activities of daily living (self–care skills and/or daily life management skills); initial 30 minutes, each visit	45.00
97541–00	each additional 15 minutes	28.50
	Tests and Measurements	
97700–00	Office visit, including one of the following tests or measurements, with report; initial 30 minutes a. Orthotic check–out; b. Prosthetic check–out; c. Activities of daily living check–out	35.00
97720–00	Extremity testing for strength, dexterity, or stamina; initial 30 minutes, each visit	35.00
97721–00	each additional 15 minutes	16.25
97752–00	Muscle testing with torque curves during isometric and isokinetic exercise, mechanized or computerized evaluations with printout	62.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.2900 CHIROPRACTORS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of chiropractic medicine.

Subp. 1a. **Definitions.** For purposes of this part, the following terms have the meaning given them unless the content clearly indicates a different meaning.

A. "Examination/consultation" means inspection of the patient, review of diagnostic tests to diagnose disease or evaluate progress and preparation of an appropriate record.

(1) "Brief examination" means a condition requiring only a routine history and examination.

(2) "Intermediate examination" means a condition involving a diagnostic or management problem and a history and examination.

(3) "Extensive examination" means an unusual amount of effort or judgment and a detailed history and examination of multiple body systems.

B. "Initial office visit with manipulation/adjustment" means the first time a patient is seen for a brief evaluation to determine the appropriate treatment on that date and all necessary spinal manipulative/adjustment procedures rendered.

C. "Subsequent office visit with manipulation/adjustment" means all office visits, except the first one, where a brief evaluation is done to determine appropriate treatment on that day and all necessary spinal manipulation/adjustment procedures rendered.

D. "New patient" means a patient new to the chiropractor or a known patient with a new industrial injury or condition, whose medical and administrative record needs to be established.

E. "Established patient" means a patient whose medical and administrative records are available to the chiropractor.

Subp. 1b. **Chiropractor instructions.**

A. Use code 09542–00 to report a second or additional manipulation/adjustment if more than one primary area of injury; for example, if there are separate and distinct injuries to more than one part of the body.

B. Conjunctive therapy modalities must be used in conjunction with adjustment or manipulation.

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

Code	Service	Maximum Fee
	Examinations — Includes History and Diagnosis, Office	
X2100–00	New patient; brief examination	$ 30.00
X2110–00	intermediate examination	45.00
X2120–00	extensive examination	65.00
X2125–00	Established patient; brief examination	25.00
X2130–00	intermediate examination	40.00
X2135–00	extensive examination	65.00
	Chiropractic Visit With Manipulation/Adjustment	
X2005–00	Visit with manipulation/adjustment, initial; office	$ 22.00
X2006–00	subsequent; office	24.00
X2009–00	Each additional manipulation/ adjustment on same day; office, home, or nursing home	15.00
	Home/Nursing Home Visits	
X2007–00	Chiropractic visit with manipulation/adjustment	$ 40.00
	Cast Application	
X2070–00	Visit with cast application to one area; for example, short arm, short leg, knee, or elbow	38.00
X2075–00	Visit with cast application to one area; (e.g., long leg, thoracolumbar lumbosacral, or full–body corset type)	40.00

	Medical Conference	
09557–00	Medical conference by chiropractor regarding medical management with patient or relative, guardian, or other; up to 25 minutes	50.00
	Conjunctive Therapy/Modality — Office, Home, or Nursing Home	
X2201–00	Application of hot pack	$ 12.00
X2202–00	Application of cold pack	12.00
X2205–00	Diathermy	12.00
X2210–00	Electrical stimulation, includes: muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic	13.00
X2212–00	Intersegmental motorized mobilization	14.00
X2214–00	Muscle stimulation, manual	14.00
X2220–00	Ultrasound therapy	12.00
X2225–00	Traction	15.00
X2230–00	Acupressure, manual or mechanical	14.00
X2231–00	Acupuncture	15.00
X2235–00	Whirlpool	15.00
X2245–00	Infrared – heat lamp	8.00
X2250–00	Ultraviolet	25.00
X2255–00	Trigger point therapy	14.00
X2392–00	Exercise consultation/instruction	25.00

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.

Code	Service	Maximum Fee
	Chest	
71010–00	Radiologic examination, chest; single view, frontal	$ 35.00
	Spine and Pelvis	
72010–00	Radiologic examination, spine, entire, survey study, anteroposterior and lateral	$ 65.00
72020–00	Radiologic examination, spine, single view, (specify level)	35.00
72040–00	Radiologic examination, spine, cervical; anteroposterior and lateral	50.00
72050–00	minimum of four views	80.00
72052–00	complete, including oblique and flexion and/or extension studies	100.00
72070–00	Radiologic examination, spine; thoracic, anteroposterior and lateral	60.00
72074–00	thoracic, complete, including obliques, minimum of four views	60.00
72080–00	thoracolumbar, anteroposterior, and lateral	61.00
72090–00	scoliosis study, including supine and erect studies	40.00
72100–00	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	60.00
72110–00	complete, with oblique views	100.00

72114–00	complete, including bending views	100.00
72120–00	bending views only, minimum of four views	70.00
72170–00	Radiologic examination, pelvis; anteroposterior only	50.00
72190–00	complete, minimum of three views	40.00
	Upper Extremities	
73020–00	Radiologic examination, shoulder; one view	$ 30.00
73030–00	complete, minimum of two views	60.00
73070–00	Radiologic examination, elbow; anteroposterior and lateral views	50.00
73100–00	Radiologic examination, wrist; anteroposterior and lateral views	40.00
73110–00	complete, minimum of three views	45.00
73120–00	Radiologic examination, hand; two views	30.00
73140–00	Radiologic examination, finger or fingers, minimum of two views	40.00
	Lower Extremities	
73500–00	Radiologic examination, hip; unilateral, one view	$ 33.00
73560–00	Radiologic examination, knee; anteroposterior and lateral views	50.00
73562–00	anteroposterior and lateral, with oblique(s), minimum of three views	60.00
73600–00	Radiologic examination, ankle; anteroposterior and lateral views	45.00
73610–00	complete, minimum of three views	56.00
73620–00	Radiologic examination, foot; anteroposterior and lateral views	35.00
73630–00	complete, minimum of three views	48.00
	Miscellaneous	
76140–00	Consultation on x–ray examination made elsewhere, written report	$ 28.00

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

Code	Service	Maximum Fee
	Laboratory Codes	
81000–00	Urinalysis (pH, specific gravity, protein, tests for reducing substances such as glucose); with microscopy	$ 15.00
81002–00	without microscopy	12.00
81005–00	Urinalysis; chemical, qualitative, any number of constituents	30.00
83524–00	Indican, urine	12.00

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 9 SR 1619; 10 SR 765; 10 SR 974; 11 SR 491; 11 SR 711; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.3000 PODIATRISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees in this part apply to licensed doctors of podiatric medicine.

Subp. 2. **Ancillary services.** Services performed by podiatric assistants must be by order of and under the direct on–site supervision of a licensed doctor of podiatric medicine.

Subp. 3. [Repealed, 10 SR 765]

Subp. 3. **Medicine.** The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
	Surgery	
10060*00	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	$ 45.00
10061–00	complicated	132.00
10100*00	Incision and drainage of onychia or paronychia; single or simple	55.20
10101–00	multiple or complicated	65.00
10160*00	Puncture aspiration of abscess, hematoma, bulla, or cyst	79.00
11000*00	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	28.00
11040–00	Debridement; skin, partial thickness	48.00
11050*00	Paring or curettement or shaving of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	28.00
11051–00	two to four lesions	30.00
11052–00	more than four lesions	45.00
11420–00	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 cm or less	80.00
11421–00	lesion diameter 0.6 – 1.0 centimeters	125.00
11422–00	lesion diameter 1.1 – 2.0 centimeters	150.00
	Nails	
11700*00	Debridement of nails, manual; five or less	$ 25.00
11701–00	each additional, five or less	12.00
11710*00	Debridement of nails, electric grinder; five or less	28.00
11711–00	each additional, five or less	11.00
11730*00	Avulsion of nail plate, partial or complete, simple; single	73.00
11750–00	Excision of nail and nail matrix, partial or complete (e.g., ingrown or deformed nail), for permanent removal	221.00
11752–00	with amputation of tuft of distal phalanx	274.00
11900*00	Injection, intralesional; up to and including seven lesions	35.00

	Other Procedures	
17100*00	Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthesia; one lesion	$ 42.00
17110*00	Destruction by any method of flat (plane, juvenile) warts or molluscum contagiosum, milia, up to 15 lesions	45.00
17340*00	Cryotherapy (CO_2 slush, liquid N_2)	31.00
20550*00	Injection, tendon sheath, ligament, trigger points or ganglion cyst	48.00
20600*00	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g., fingers, toes)	55.00
20605*00	intermediate joint, bursa or ganglion cyst (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	60.00
28080–00	Excision of interdigital (Morton) neuroma, single, each	530.34
28124–00	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis or dorsal bossing), phalanx of toe	394.00
28153–00	Resection, head of phalanx, toe	453.00
28285–00	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)	475.00
28292–00	Hallux valgus (bunion) correction, with or without sesamoidectomy; Keller, McBride, or Mayo type procedure	950.00
28296–00	with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)	1,050.00
28298–00	by phalanx osteotomy	1,100.00
28308–00	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; other than first metatarsal	700.00
29405–00	Application of short leg cast (below knee to toes)	155.00
28425–00	walking or ambulatory type	175.00
29540–00	Strapping; ankle	25.00
29550–00	toes	26.00
29580–00	Unna boot	45.00
36415*00	Routine venipuncture for collection of specimen(s)	10.00
64450*00	Injection, anesthetic agent; other peripheral nerve or branch	50.00
	Radiology	
73600–00	Radiologic examination, ankle; anteroposterior and lateral views	$ 42.00
73610–00	complete, minimum of three views	55.00
73620–00	Radiologic examination, foot; anteroposterior and lateral views	40.00
73630–00	complete, minimum of three views	60.00

73650–00	Radiologic examination; calcaneus, minimum of two views	48.00
73660–00	toe or toes, minimum of two views	38.00
76000–00	Fluoroscopy (separate procedure), up to one hour physician time	40.00
	Pathology and Laboratory	
81000–00	Urinalysis (pH, specific gravity, protein, tests for reducing substances such as glucose); with microscopy	$ 13.00
81002–00	without microscopy	15.00
82947–00	Glucose; except urine (e.g., blood, spinal fluid, joint fluid)	13.00
85000–00	Bleeding time; Duke	6.00
85014–00	Blood count; hematocrit	6.00
85018–00	hemoglobin, colorimetric	6.50
85031–00	Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)	40.00
85345–00	Coagulation time; Lee and White	7.50
87070–00	Culture, bacterial, definitive; any other source	20.00
87101–00	Culture, fungi, isolation; skin	20.00
87184–00	Sensitivity studies, antibiotic; disk method, per plate (12 or less disks)	10.00
88302–00	Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes	50.00
88304–00	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen	45.00
	Patient Visits	
90000–00	Office and other outpatient medical service, new patient; brief service	$ 33.00
90010–00	limited service	38.00
90015–00	intermediate service	40.00
90017–00	extended service	55.50
90020–00	comprehensive service	40.00
90030–00	Office and other outpatient medical service, established patient; minimal service	20.00
90040–00	brief service	25.00
90050–00	limited service	28.00
90060–00	intermediate service	30.00
90070–00	extended service	47.00
90080–00	comprehensive service	50.00
	Home Medical Services	
90115–00	Home medical service, new patient; intermediate service	$ 28.00
90140–00	Home medical service, established patient; brief service	25.59
90160–00	intermediate service	39.00

	Hospital Medical Services	
90200–00	Initial hospital care; brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	$ 76.60
90215–00	intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	50.00
90260–00	Subsequent hospital care, each day; intermediate services	40.00
	Skilled Nursing Facility, Intermediate Care, and Long–Term Care Facilities	
90300–00	Initial care, skilled nursing facility, intermediate care facility, or long–term care facility medical services; brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of medical records	$ 17.00
90340–00	Subsequent care, skilled nursing facility, intermediate care facility, or long–term care facility medical services; brief service	17.00
90360–00	intermediate service	25.00
	Rest Home, Boarding Home, Domiciliary, or Custodial Care Facility Medical Services	
90400–00	Rest home (e.g., boarding home), domiciliary, or custodial care facility medical service, new patient; brief service	$ 24.00
90410–00	limited service	32.00
90440–00	Rest home (e.g., boarding home), domiciliary, or custodial care facility medical service, established patient; brief service	20.00
90450–00	limited service	20.00
	Consultations	
90600–00	Initial consultation; limited	$ 35.00
	Noninvasive Vascular Diagnostic Studies	
93910–00	Noninvasive studies of lower extremity arteries (e.g., segmental blood pressure measurements, continuous Wave Doppler analog waveform analysis, evocative pressure response to exercise or reactive hyperemia, photoplethysmography or pulse volume digit waveform analysis, flow velocity signals)	$ 83.00
	Neurology and Neuromuscular Procedures	
95851–00	Range of motion measurements and report (separate procedure); each extremity, excluding hand	$ 49.50

	Physical Medicine	
97022–00	Physical medicine treatment to one area; whirlpool	$ 24.00
97110–00	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises	45.00
97116–00	gait training	40.00
97118–00	electrical stimulation (manual)	29.00
97120–00	iontophoresis	24.00
97128–00	ultrasound	20.00
97700–00	Office visit, including one of the following tests or measurements, initial 30 minutes, each visit with report: a. Orthotic "check–out"; b. Prosthetic "check–out"; c. Activities of daily living "check–out"	30.00
	Special Services and Reports	
99000–00	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	$ 11.50
99025–00	Initial (new patient) visit when starred (*) surgical procedure constitutes major service at that visit	26.80

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.3100 [Repealed, 14 SR 722]

5221.3150 LICENSED CONSULTING PSYCHOLOGISTS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to licensed consulting psychologists (LCP).

Subp. 2. **Psychological services.** The following codes, service descriptions, and maximum fees apply to psychological services performed by persons meeting the requirements of the Minnesota Board of Psychology as a licensed consulting psychologist (LCP).

Code	Service	Maximum Fee
06043–00	Independent behavior and/or other analyst, counselors, and other therapist (Specialty Manual)	$ 40.00
09046–00	Initial office or outpatient visit with evaluation and history; per session	85.00
09050–00	Initial consultation; one hour	90.00
09061–00	Psychological testing; one hour	90.00
09062–00	Follow–up office visit; 15 minutes	25.00
09064–00	Biofeedback; per hour	90.00
09066–00	Psychotherapy, individual, one hour, inpatient, outpatient, office or home	90.00
09067–00	Psychotherapy, group (maximum ten persons per group); per session	45.00
09068–00	Psychotherapy, individual one–half hour inpatient, outpatient, office, or home	47.50

09070–00	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour	90.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.3155 LICENSED PSYCHOLOGIST.

The following codes, service descriptions, and maximum fees apply to psychological services performed by a person who meets the requirements of the Minnesota Board of Psychology as a licensed psychologist.

Code	Service	Maximum Fee
09046–00	Initial office or outpatient visit with evaluation and history, per session	$ 82.00
09050–00	Consultation, initial, one hour	90.00
09066–00	Psychotherapy, individual, one hour, inpatient, outpatient, office, or home	85.00
09067–00	Psychotherapy, group (maximum 10 persons per group), per session	42.50
09068–00	Psychotherapy, individual one half hour, inpatient, outpatient, office or home	42.50
09070–00	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour	85.00

Statutory Authority: *MS s 176.136*

History: *16 SR 622*

5221.3160 SOCIAL WORKERS.

Subpart 1. **Scope.** The codes, service descriptions, and maximum fees of this part apply to social workers with a master of social work (MSW) degree or a comparable degree.

Subp. 2. **Social worker services.** The following codes, service descriptions, and maximum fees apply to social worker services performed by persons meeting the requirements of the board of social work.

Code	Service	Maximum Fee
06046–00	Independent social worker services	$ 90.00

Statutory Authority: *MS s 176.136; 176.83*

History: *13 SR 2609; 14 R 722; 15 SR 738; 16 SR 622*

5221.3200 HOSPITAL; SEMIPRIVATE ROOM CHARGES.

Subpart 1. **Scope.** The following service descriptions and maximum fees apply to daily charges for semiprivate rooms at the hospitals listed below. The maximum fees do not apply to semiprivate rooms for which a rate higher than the hospital's normal rate applies and which require an unusually high level of service, such as emergency or intensive care rooms. The maximum fees apply to daily semiprivate room charges only. The maximum fees do not apply to private or ward rooms, and do not apply to hospital charges for services not customarily included in the daily room charge.

Subp. 2. **Group 1.** The following metro and Duluth area hospitals make up group 1:

A. Abbott Northwestern Hospital, Minneapolis

B. Bethesda Lutheran Medical Center, Saint Paul

C. The Children's Hospital, Saint Paul

D. Divine Redeemer Memorial Hospital, South Saint Paul

E. Fairview–Ridges Hospital, Burnsville

F. Fairview–Southdale Hospital, Minneapolis
G. Gillette Children's Hospital, Saint Paul
H. Golden Valley Health Center, Golden Valley
I. Mercy Medical Center, Coon Rapids
J. Methodist Hospital, Saint Louis Park
K. Metropolitan Medical Center, Minneapolis
L. Midway Hospital, Saint Paul
M. Miller–Dwan Medical Center, Duluth
N. Minneapolis Children's Hospital, Minneapolis
O. Mount Sinai Hospital, Minneapolis
P. North Memorial Medical Center, Robbinsdale
Q. Riverside Medical Center, Minneapolis
R. Saint Cloud Hospital, Saint Cloud
S. St. John's Hospital Northeast, Saint Paul
T. Saint Joseph's Hospital, Saint Paul
U. Saint Luke's Hospital, Duluth
V. Saint Mary's Hospital, Duluth
W. United Hospital, Saint Paul
X. Unity Medical Center, Fridley

Service	Maximum Fee
Group 1 semiprivate room charge for one day	$ 472.00

Subp. 3. **Group 2.** Group 2 includes, but is not limited to, the following greater Minnesota area hospitals:

A. A. L. Vadheim Memorial Hospital, Tyler
B. Ada Municipal Hospital, Greenbush
C. Aitkin Community Hospital, Aitkin
D. Albany Community Hospital, Albany
E. Appleton Municipal Hospital, Appleton
F. Arlington Municipal Hospital, Arlington
G. Arnold Memorial Hospital, Adrian
H. Buffalo Memorial Hospital, Buffalo
I. Caledonia Community Hospital, Caledonia
J. Canby Community Hospital, Canby
K. Central Mesabi Medical Center, Hibbing
L. Chippewa County–Montevideo Hospital, Montevideo
M. Chisago Lakes Hospital, Chisago City
N. Clarkfield Memorial Hospital, Clarkfield
O. Clearwater County Memorial Hospital, Bagley
P. Cloquet Community Memorial Hospital, Cloquet
Q. Comfrey Hospital, Comfrey
R. Community Hospital—Cannon Falls, Cannon Falls
S. Community Hospital—Saint Peter, Saint Peter
T. Community Memorial Hospital—Deer River, Deer River
U. Community Memorial Hospital—Spring Valley, Spring Valley
V. Community Memorial Hospital—Winona, Winona
W. Community Mercy Hospital—Onamia, Onamia
X. Constance Bultman Wilson Center

Y. Cook Community Hospital, Cook
Z. Cook County Northshore Hospital, Grand Marais
AA. Cuyuna Range District Hospital, Crosby
BB. Dr. Henry Schmidt Memorial Hospital, Westbrook
CC. District Memorial Hospital—Forest Lake, Forest Lake
DD. Divine Providence Hospital, Ivanhoe
EE. Douglas County Hospital, Alexandria
FF. Ely–Bloomenson Community Hospital, Ely
GG. Eveleth Fitzgerald Community Hospital, Eveleth
HH. Fairmont Community Hospital, Fairmont
II. Fairview Princeton Hospital, Princeton
JJ. Fosston Municipal Hospital, Fosston
KK. Gaylord Community Hospital, Gaylord
LL. Glacial Ridge Hospital, Glennwood
MM. Glencoe Municipal Hospital, Glencoe
NN. Granite Falls Municipal Hospital, Granite Falls
OO. Grant County Hospital, Elbow Lake
PP. Greenbush Community Hospital, Greenbush
QQ. Harmony Community Hospital, Harmony
RR. Hendricks Community Hospital, Hendricks
SS. Heron Lake Municipal Hospital, Heron Lake
TT. Holy Trinity Hospital, Graceville
UU. Hutchinson Community Hospital, Hutchinson
VV. Immanuel–Saint Joseph's Hospital, Mankato
WW. International Falls Memorial Hospital, International Falls
XX. Itasca Memorial Hospital, Grand Rapids
YY. Jackson Municipal Hospital, Jackson
ZZ. Johnson Memorial Hospital, Dawson
AAA. Kanabec Hospital, Mora
BBB. Karlstad Health Facilities, Karlstad
CCC. Kittson Memorial Hospital, Hallock
DDD. Lake City Hospital, Lake City
EEE. Lake Region Hospital, Fergus Falls
FFF. Lake View Memorial Hospital, Two Harbors
GGG. Lakefield Municipal Hospital, Lakefield
HHH. Lakeview Memorial Hospital, Stillwater
III. Littlefork Municipal Hospital, Littlefork
JJJ. Long Prairie Memorial Hospital, Long Prairie
KKK. Luverne Community Hospital, Luverne
LLL. Madelia Community Hospital, Madelia
MMM. Madison Hospital, Madison
NNN. Mahnomen County–Village Hospital, Mahnomen
OOO. Meeker County Memorial Hospital, Litchfield
PPP. Melrose Hospital, Melrose
QQQ. Memorial Hospital—Cambridge, Cambridge
RRR. Memorial Hospital—Perham, Perham
SSS. Memorial Community Hospital—Bertha, Bertha
TTT. Mercy Hospital, Moose Lake
UUU. Milaca Area Hospital, Milaca

VVV. Minnesota Valley Memorial Hospital, Le Sueur
WWW. Minnewaska District Hospital, Starbuck
XXX. Monticello–Big Lake Community Hospital, Monticello
YYY. Mountain Lake Community Hospital, Mountain Lake
ZZZ. Murray County Memorial Hospital, Slayton
AAAA. Naeve Hospital, Albert Lea
BBBB. North Country Hospital, Bemidji
CCCC. Northern Itasca Hospital, Big Fork
DDDD. Northfield City Hospital, Northfield
EEEE. Northwestern Hospital, Thief River Falls
FFFF. Olmsted Community Hospital, Rochester
GGGG. Ortonville Hospital, Ortonville
HHHH. Owatonna City Hospital, Owatonna
IIII. Parkers Prairie District Hospital, Parkers Prairie
JJJJ. Paynesville Community Hospital, Paynesville
KKKK. Pelican Valley Health Center, Pelican Valley
LLLL. Pipestone County Hospital, Pipestone
MMMM. Queen of Peace Hospital, New Prague
NNNN. Redwood Falls Municipal Hospital, Redwood Falls
OOOO. Regina Memorial Hospital, Hastings
PPPP. Renville County Hospital, Olivia
QQQQ. Rice County District One Hospital, Faribault
RRRR. Rice Memorial Hospital, Willmar
SSSS. Riverview Hospital, Crookston
TTTT. Roseau Area Hospital, Roseau
UUUU. Rush City Hospital, Rush City
VVVV. Saint Ansgar Hospital, Moorhead
WWWW. Saint Elizabeth Hospital, Wabasha
XXXX. Saint Francis Hospital, Breckenridge
YYYY. Saint Francis Regional Medical Center, Shakopee
ZZZZ. Saint Gabriel's Hospital, Little Falls
AAAAA. Saint John's Hospital, Browerville
BBBBB. Saint John's Hospital, Red Lake Falls
CCCCC. Saint John's Hospital, Red Wing
DDDDD. Saint Joseph's Hospital, Brainerd
EEEEE. Saint Joseph's Hospital, Park Rapids
FFFFF. Saint Mary's Hospital, Detroit Lakes
GGGGG. Saint Mary's Hospital, Winsted
HHHHH. Saint Michael's Hospital, Sauk Centre
IIIII. Saint Olaf Hospital, Austin
JJJJJ. Sandstone Area Hospital, Sandstone
KKKKK. Sanford Memorial Hospital, Farmington
LLLLL. Sioux Valley Hospital, New Ulm
MMMMM. Sleepy Eye Municipal Hospital, Sleepy Eye
NNNNN. Springfield Community Hospital, Springfield
OOOOO. Stevens County Memorial Hospital, Morris
PPPPP. Swift County–Benson Hospital, Benson
QQQQQ. Tracy Municipal Hospital, Tracy
RRRRR. Tri–County Hospital, Wadena

SSSSS. Trimont Community Hospital, Trimont
TTTTT. Trinity Hospital, Baudette
UUUUU. Tweeten Memorial Hospital, Spring Grove
VVVVV. United District Hospital, Staples
WWWWW. United Hospital, Blue Earth
XXXXX. Virginia Regional Medical Center, Virginia
YYYYY. Waconia Ridgeview Hospital, Waconia
ZZZZZ. Warren Community Hospital, Warren
AAAAAA. Waseca Area Memorial Hospital, Waseca
BBBBBB. Watonwan Memorial Hospital, St. James
CCCCCC. Weiner Memorial Medical Center, Marshall
DDDDDD. Wells Municipal Hospital, Wells
EEEEEE. Wheaton Community Hospital, Wheaton
FFFFFF. White Community Hospital, Aurora
GGGGGG. Windom Area Hospital, Windom
HHHHHH. Winona General Hospital, Winona
IIIIII. Worthington Regional Hospital, Worthington
JJJJJJ. Zumbrota Community Hospital, Zumbrota

Service	Maximum Fee
Group 2 semiprivate room charge for one day	$ 310.00

Subp. 4. **Group 3.** The following public metro hospitals make up group 3:
A. Hennepin County Medical Center, Minneapolis
B. Saint Paul Ramsey Medical Center, Saint Paul
C. University of Minnesota Hospitals and Clinics, Minneapolis

Service	Maximum Fee
Group 3 semiprivate room charge for one day	$ 415.00

Subp. 5. **Group 4.** The following Rochester area hospitals make up group 4:
A. Rochester Methodist Hospital, Rochester
B. Saint Mary's Hospital, Rochester

Service	Maximum Fee
Group 4 semiprivate room charge for one day	$ 318.54

Statutory Authority: *MS s 176.136; 176.83*

History: *9 SR 601; 10 SR 765; 11 SR 491; 12 SR 662; 13 SR 2609; 14 SR 722; 15 SR 738; 16 SR 622*

5221.3300 EFFECTIVE DATE.

This chapter is effective October 1, 1984, and applies to all health care services or supplies governed by this chapter provided after October 1, 1984.

Statutory Authority: *MS s 176.136*

History: *9 SR 601*

5221.3310 [Repealed, 14 SR 722]

5221.3400 [Repealed, 13 SR 2609]

5221.3500 EFFECTIVE DATE.

This chapter is effective October 1, 1991, and applies to all health care services or supplies governed by this chapter provided on and after October 1, 1991.

Statutory Authority: *MS s 176.136*

History: *14 SR 722; 15 SR 738; 16 SR 622*